



Senate

Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

**REPORT OF THE SENATE SPECIAL
COMMITTEE ON ILLEGAL DRUGS**

VOLUME II : PART III

CHAIRMAN

DEPUTY CHAIRMAN

PIERRE CLAUDE NOLIN

COLIN KENNY

SEPTEMBER 2002

TABLE OF CONTENTS

INTRODUCTION	1
PART I - GENERAL ORIENTATION	5
CHAPTER 1 - OUR MANDATE	7
WORDING	7
ORIGINS	9
INTERPRETATION	10
CHAPTER 2 - OUR WORK	13
TWO WORKING PRINCIPLES	14
STATE OF KNOWLEDGE	15
Research Program	18
Expert Witnesses	19
The Challenge of Synthesis	21
TAKING OPINIONS INTO ACCOUNT	22
INTERPRETING IN LIGHT OF PRINCIPLES	23
CHAPTER 3 - OUR GUIDING PRINCIPLES	25
ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY	28
GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS	32
Collective governance	34
Governance of the self	35
The role of governance	37
CRIMINAL LAW AND THE LIMITS OF PROHIBITION	38
Requirement for distinctions	38
Criteria for distinction	40
Application to illegal drugs issues	44
SCIENCE OR APPROXIMATE KNOWLEDGE	45
CONCLUSIONS	49
CHAPTER 4 - A CHANGING CONTEXT	51
CHANGES IN THE INTERNATIONAL SPHERE	51
Globalization and Integration	51
Difficulties of the Security Debate	55
From Anti-Drug Policies to Drug Policies	57
CHANGES IN CANADA	58
Judicial Activism	58
A National Crime Prevention Strategy	59
The Fight Against Organized Crime	59
A SOCIETAL DEBATE	60

PART II - CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES	63
CHAPTER 5 - CANNABIS : FROM PLANT TO JOINT	65
ONE PLANT, VARIOUS DRUGS	66
CANNABIS ROADS	69
PROPERTIES OF CANNABIS	77
Δ^9 THC Concentrations	78
Pharmacokinetics	83
CONCLUSIONS	87
CHAPTER 6 - USERS AND USES : FORM, PRACTICE, CONTEXT	89
PATTERNS OF USE	90
Consumption by the population as a whole	91
Consumption among young people	94
Use patterns in other countries	101
To summarize	108
PATTERNS AND CIRCUMSTANCES OF USE	111
Cannabis in History	111
Trajectories of Use	113
Factors Related to Use	119
To summarize	124
STEPPING STONE TOWARDS OTHER DRUGS?	125
CANNABIS, VIOLENCE AND CRIME	127
CONCLUSIONS	128
CHAPTER 7 - CANNABIS : EFFECTS AND CONSEQUENCES	131
EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD	134
ACUTE EFFECTS OF CANNABIS	139
CONSEQUENCES OF CHRONIC USE	143
Physiological Consequences of Chronic Use	143
Cognitive and Psychological Consequences	148
Behavioural and Social Consequences	152
TOLERANCE AND DEPENDENCE	152
Cannabis Dependence	154
Severity of Dependence	160
Tolerance	162
To summarize	163
CONCLUSIONS	164
CHAPTER 8 - DRIVING UNDER THE INFLUENCE OF CANNABIS	167
FORMS OF TESTING	170
EPIDEMIOLOGICAL DATA	175
Studies not involving accidents	175
Studies where an accident was involved	176
Epidemiological studies on youth	179

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Risk assessment	180
EXPERIMENTAL STUDIES	182
Non-driving activities	183
While driving	184
CONCLUSIONS	188
CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES	191
HISTORY	196
CONTEMPORARY KNOWLEDGE	197
Therapeutic uses	198
Marijuana as a drug?	200
CURRENT THERAPEUTIC PRACTICES	203
CONCLUSIONS	205
CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES	209
THE MEDIA	210
SURVEYS	215
ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE	221
CONCLUSIONS	224
PART III - POLICIES AND PRACTICES IN CANADA	225
<hr/>	
CHAPTER 11 - A NATIONAL DRUG STRATEGY?	227
PHASE I - DEVELOPMENT AND IMPLEMENTATION	228
Creation of the Canadian Centre on Substance Abuse	233
Creation of Canada's Drug Strategy Secretariat	236
PHASE II - RENEWAL	237
PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING	240
CANADA'S DRUG STRATEGY – A SUCCESS?	241
CONCLUSIONS	243
CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT	245
1908-1960: HYSTERIA	248
Opium Act, 1908	252
The Opium and Narcotic Drug Act, 1911	253
Amendments to the Opium and Narcotic Drug Act (1920-1938)	255
Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954	263
Senate Report of 1955	264
FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS	268
Narcotic Control Act (1961)	268
An Act respecting Food and Drugs and Barbiturates (1961)	270
The Le Dain Commission (1969-1973)	272
Bill S-19 and Cannabis	283
AFTER LE DAIN: FORGING AHEAD REGARDLESS	284
Controlled Drugs and Substances Act	286
CONCLUSIONS	295

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS	297
BACKGROUND TO THE RECENT REGULATIONS	298
Section 56 – Controlled Drugs and Substances Act	298
Charter Challenges – Therapeutic Use of Marijuana	299
Government Reaction	302
MARIHUANA MEDICAL ACCESS REGULATIONS	302
Authorization to Possess	303
Licence to Produce	306
Other Provisions	307
COMPASSIONATE ACCESS?	308
Eligibility	309
Access to cannabis	312
Products	316
Costs	316
RESEARCH PLAN	317
Scientific Research	318
Research-Grade Marijuana	320
CONCLUSIONS	321
CHAPTER 14 - POLICE PRACTICES	323
ENFORCEMENT AGENCIES	323
RCMP	323
CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT IN 1999	326
TheCanada Customs and Revenue Agency	326
Provincial and Municipal Police	328
COSTS	328
POLICE POWERS	333
Searches and Seizures	335
Entrapment and Illegal Activity	347
Conclusion	352
STATISTICS	353
Reported Incidents	353
Charges	356
Concerns	359
Customs Act - Fines	361
SEIZURES	362
CONCLUSIONS	364
CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM	367
PROSECUTION	367
COURTS	368
Drug Treatment Courts	369
DISPOSITION AND SENTENCING	372
CORRECTIONS	376
CRIMINAL RECORD	379
COURT CHALLENGES	382
CONCLUSIONS	387

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

CHAPTER 16 - PREVENTION	389
INITIATIVES THAT FALL SHORT OF THE MARK	393
Not enough prevention	394
Prevention lacks focus	396
There is not enough evaluation of preventive measures	397
Preventive and social messages in contradiction	398
There is a body of knowledge on which we have to draw	399
PREVENTING WHAT AND HOW?	400
RISK REDUCTION AND HARM REDUCTION	410
CONCLUSIONS	412
CHAPTER 17 - TREATMENT PRACTICES	415
CANNABIS DEPENDENCY	415
FORMS OF TREATMENT	421
EFFECTIVENESS OF TREATMENT	423
CONCLUSIONS	426
CHAPTER 18 - OBSERVATIONS ON PRACTICES	427
DIFFICULTIES IN HARMONIZING THE PLAYERS	427
INCONGRUITIES OF APPROACH	429
SIGNIFICANT ECONOMIC AND SOCIAL COSTS	431
<u>PART IV - PUBLIC POLICY OPTIONS</u>	<u>437</u>
CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT	439
A GENEALOGY	440
The 1909 Shanghai Conference	443
The 1912 Hague International Opium Convention	444
The 1925 Geneva Opium Conventions	446
The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement	447
The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs	448
The Second World War	449
The 1946 Lake Success Protocol	449
The 1948 Paris Protocol	450
The 1953 New York Opium Protocol	450
THE THREE CURRENT CONVENTIONS	451
The Single Convention on Narcotic Drugs, 1961	451
Convention on Psychotropic Substances	455
Protocol amending the Single Convention on Narcotic Drugs, 1961	460
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	462
SOME LEEWAY?	464
CONCLUSIONS	468

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

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

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Statistics	576
CHAPTER 21 - PUBLIC POLICY OPTIONS	581
INEFFECTIVENESS OF CRIMINAL POLICIES	583
Impact on Consumption	583
Impact on Supply	589
Conclusion	590
GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS	591
COMPONENTS OF A PUBLIC POLICY	593
Strong Decision-making Body	593
Interconnection	594
A Shared Definition of Shared Objectives	594
Information Tools	594
LEGISLATIVE OPTIONS	595
Clarification of criminology	595
Criteria for a Legal Policy on Cannabis	602
<u>CONCLUSIONS AND RECOMMENDATIONS</u>	<u>607</u>
LE DAIN – ALREADY THIRTY YEARS AGO	607
INEFFECTIVENESS OF THE CURRENT APPROACH	609
PUBLIC POLICY BASED ON GUIDING PRINCIPLES	610
A CLEAR AND COHERENT FEDERAL STRATEGY	611
NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESOURCES AND TOOLS	612
A PUBLIC HEALTH POLICY	614
A REGULATORY APPROACH TO CANNABIS	617
A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE	618
PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS	619
RESEARCH	620
CANADA’S INTERNATIONAL POSITION	621
<u>PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES</u>	<u>623</u>
<u>BIBLIOGRAPHY</u>	<u>627</u>

GLOSSARY OF KEY TERMS

Abuse

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

Acute effects

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

Addiction

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

Agonist

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

Anandamide

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

At-risk use

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

Cannabinoids

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

Cannabis

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

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis. Other components such as delta-8-tétrahydrocannabinol, cannabinalol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Chronic effects

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

Commission on narcotic drugs (CND)

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

Decriminalization

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

Diversion

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

Depenalisation

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

Dependence

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

Dopamine

Neuromediator involved in the mechanisms of pleasure.

Drug

Generally used to refer to illicit rather than licit substances (such as nicotine, alcohol or medicines). In pharmacology, the term refers to any chemical agent that alters the biochemical

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)

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

Fat soluble

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

Gateway (theory)

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

Half-life

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

Hashish

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

International Conventions

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

International Narcotics Control Board (INCB)

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

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

Intoxication

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

Joint

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

Legalisation

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

Marijuana

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

Narcotic

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

Office of national drug control policy (ONDCP) USA

Created in 1984 under the Reagan presidency, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US \$18 billion.

Opiates

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

Prohibition

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

Psychoactive substance

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

Psychotropic substance (see also psychoactive)

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

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

Regulation

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

Society of Nations (SDN)

International organisation of States until 1938; now the United Nations.

Tetrahydrocannabinol (D9-THC)

Main active component of cannabis, Δ^9 -THC is very fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, leads to higher levels of THC concentration.

Tolerance

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

Toxicity

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

United Nations Drug Control Program (UNDCP)

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

World Health Organization (WHO)

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

PART III

POLICIES AND PRACTICES IN CANADA

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

CHAPTER 11

A NATIONAL DRUG STRATEGY?

There is no arguing that both licit and illicit psychoactive substances affect Canadians in many ways, both positively and negatively, both directly and indirectly. In addition, no one would dispute the fact that psychoactive substance use (again, both licit and illicit) is a widespread phenomenon, not only on the part of adults but also among the youths of this country. Because of the potential problems for those who abuse psychoactive substances, dealing with this issue should be a matter of serious concern for any government, and for society as a whole.

Based on the importance of the subject, it would probably surprise many Canadians to learn that only from 1987 to 1993 did Canada have a fully funded national drug strategy. It is true that Canada has had legislation dealing with the use of psychoactive substances since the passage of the *Opium Act* in 1908. This Act was followed by several pieces of criminal legislation over the years that increased federal enforcement powers over psychoactive substances and expanded the list of illicit substances.¹ These pieces of legislation have historically focused on the supply of psychoactive substances, adopting a prohibitionist approach to use. It is widely acknowledged, however, that a more balanced approach is required if one is to deal effectively with those who abuse psychoactive substances.

This chapter will recount the development and implementation of the 1987 National Drug Strategy, which had as an objective the promotion of a balanced approach to the problem of psychoactive substance abuse. This will be followed by a discussion of what became of the national strategy and whether its goals have been achieved.

¹ A discussion of Canada's legislative history in regard to psychoactive substances can be found in Chapter 12.

PHASE I - DEVELOPMENT AND IMPLEMENTATION

In May 1987, the federal government announced a \$210-million, five-year action plan to curb drug abuse. The government stated that the action plan was in response to mounting concerns regarding increasing rates of drug-related problems. Others have suggested that “(t)his strong political action was undoubtedly influenced by the latest American ‘War on Drugs.’”²

The National Drug Strategy (NDS), *Action on Drug Abuse*, was launched by the then Minister of National Health and Welfare, who was the lead Minister in the federal effort to curb drug abuse.³ Several other departments also participated in the first interdepartmental attempt to co-ordinate Canada’s response to its drug abuse problem. It was believed that there was a need for a coordinated, strategic approach to the problem of drug abuse in Canada. The overall objective of the NDS was “to reduce the harm to individuals, family and communities from the abuse of alcohol and other drugs through a balanced approach that is acceptable to Canadians.”⁴ Other partners included provincial and municipal governments, business, law enforcement agencies, and professional and voluntary organizations.

The federal government recognized that, in the past, the emphasis of its involvement in this area had been largely restricted to supply control measures. Meanwhile, communities, provinces and territories, and many professional and volunteer groups, had focused their efforts on reducing the demand for drugs, through prevention and treatment programs. Given the division of constitutional powers in Canada, this separation of responsibilities is not altogether surprising. It does, however, impose limits on the establishment of a comprehensive national framework.

*The division of powers between Canadian provinces and the federal government has made concerted, comprehensive action against drug and alcohol abuse very difficult to achieve. For example, most program strategies aimed at prevention are generally seen as part of the health or education systems; matters of provincial jurisdiction over which the federal government has little direct control. However, while enforcement activities are controlled at the local level, for the most part, the authority derives from federal powers, and the control largely remains with the federal government.*⁵

In developing the NDS, the federal government noted that, within the provinces and territories, and at the community level, many innovative programs of drug counselling, therapy and rehabilitation had been initiated. It also recognized that much

² Giffen, P.J., Endicott, S. and S. Lambert, (1991) *Panic and Indifference: The Politics of Canada’s Drug Laws*, Ottawa: Canadian Centre on Substance Abuse, page 587.

³ Government of Canada, News Release, *Federal Government Launches Co-ordinated Action on Drug Abuse*, 25 May 1987.

⁴ Government of Canada, *Action on Drug Abuse: Making a Difference*, 1988, page 5.

⁵ Giffen, P.J., *op. cit.*, page 585.

of the program expertise existed at the provincial level. What was lacking, however, was a strong mechanism for national collaboration. The government believed that the NDS provided such a comprehensive national framework and viewed it as “a co-operative program that combines the efforts and resources of the federal government with those of all provincial and territorial governments and addiction agencies across Canada.”⁶

The government identified six core components of the NDS: education and prevention; enforcement and control; treatment; international cooperation; research and information; and national focus. Of the \$210 million in new federal funds allocated to enhance existing programs and to fund new initiatives, \$20 million was allocated for the first year, \$40 million for the second year, and \$50 million for the last three years of the strategy. A significant amount (70%) of the resources was committed to education and prevention (32%) and treatment and rehabilitation (38%); 20% was committed to enforcement and control; and the other 10% to information and research (6%), international co-operation (3%) and national focus (1%).⁷ The government noted that, while enforcement agencies were given more resources to combat supply, most of the money was allocated to address the demand for psychoactive substances, thus providing a better balance between reducing both the demand for drugs and reducing their supply.⁸ According to information received from Health Canada, the resources were generally spent as planned.

In order to illustrate the comprehensive nature of the NDS, the following sets out the goals and initiatives announced during the week of its launch:

Prevention, treatment, research, control components⁹

- ❖ To create improved public awareness and information:
 - A media campaign, developed in consultation with provinces;
 - Federal endorsement of Drug Awareness Week;
 - Telephone information lines.

- ❖ To encourage involvement in prevention activities:
 - Support for a range of prevention initiatives developed within local communities;
 - Support for the development of innovative and improved treatment services at the community level;

⁶ Government of Canada, *Action on Drug Abuse: Making a Difference*, 1988, page 7.

⁷ *Ibid.*

⁸ From 1987 to 1991, an additional \$19.5 million was provided for the Driving While Impaired (DWI) Strategy. The DWI strategy included national awareness programs, driver education curricula, national surveys and hundreds of local initiatives aimed at making drinking and driving socially unacceptable to Canadians.

⁹ Government of Canada, *National Drug Strategy: Prevention, Treatment, Research, Control Components*, 25 May, 1987.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- Development and expansion of training and training materials;
 - A National Action Conference on Drug Abuse.
- ❖ To encourage prevention initiatives targeted to particular groups:
- Efforts to encourage youth employment activities that improve life-skills development as well as employability;
 - Support for demonstration projects by police to develop new prevention initiatives for youth in school, and for urban youth at risk and Aboriginal communities;
 - A review of all current programming directed at drug abuse among Aboriginal people;
 - New initiatives focussed particularly at Aboriginal youth;
 - Support for northern communities wishing to exchange experiences with other Arctic Rim communities on drug abuse issues.
- ❖ To encourage more effective treatment services tailored to specific needs:
- An examination of future federal cost-sharing of new or expanded drug and alcohol treatment and rehabilitation programs;
 - Measures to improve detection of drug abuse by health professionals and to support their rehabilitation;
 - Establishment of an advisory committee on methadone and measures to prevent diversion of methadone;
 - Development of training materials and information for health care professionals and others working in the addictions field;
 - A review of current efforts to address the problem of drugs in the workplace;
 - Continued efforts to eliminate the use of banned drugs in sport within Canada and internationally.
- ❖ To update and improve Canada's drug laws and regulations:
- New legislation to replace the outdated *Narcotics Control Act* and *Food and Drugs Act*;
 - Improved co-ordination among federal organizations and with provinces to improve regulatory control of drug use;
 - Increased federal capacity for drug identification, analysis and monitoring;
 - Co-ordinated policies concerning illegal supply of drugs in Canada.
- ❖ To improve the knowledge base in the drug abuse field:

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- Support research on patterns and trends in the drug abuse field and on prevention and treatment;
 - A study and recommendations on priority data needs.
- ❖ To ensure a long-term commitment to the drug abuse field where long-term solutions are needed:
- A Task Force to review different means of ensuring that provincial expertise and experience can be made available for the benefit of the country as a whole and to ensure national ongoing commitment to promoting the study and prevention of drug abuse.

Enforcement components¹⁰

- ❖ To provide strengthened and co-ordinated drug law enforcement:
- Strengthening of the RCMP's drug intelligence capabilities and liaison with other forces;
 - A co-ordinated approach to improved coastal enforcement against drug smuggling;
 - Improved co-ordination of drug law enforcement at the federal level as well as between federal and provincial organizations.
- ❖ To help take the profit out of illegal drug trafficking:
- Expansion of the RCMP's Anti-Drug Profiteering Program and improved public awareness of program activities and objectives;
 - Improved techniques for tracing illicit funds will be developed.
- ❖ To strengthen Canada's international efforts:
- RCMP special training in drug enforcement for police officers of selected drug source or transit countries.
- ❖ To create improved public awareness and information about drug abuse:
- An expansion in the RCMP's capacity across the country to promote drug awareness.
- ❖ To address the problems of drug abuse in federal correctional institutions:
- A study will be undertaken on drug use among inmates and on the effectiveness of current treatment programs in correctional institutions;
 - Improved drug control in penitentiaries;

¹⁰ Government of Canada, *National Drug Strategy: Enforcement Components*, 26 May 1987.

- Development of programs for inmates with drug abuse problems to help them cope better after their release;
- Improved prevention through training for staff and development of information programs for inmates.

Interdiction components¹¹

- ❖ To strengthen Canada Customs' capacity to interdict illegal drugs entering Canada:
 - Expansion of Canada Customs resources to strengthen capability in the critical areas of targeting and examination of high-risk cargo shipments and travellers in all modes of transportation, and of high-risk mail;
 - Development and acquisition of X-ray equipment to increase drug detection capabilities during the examination of cargo, baggage and mail;
 - Expansion of the Canada Customs Detector Dog Service to provide service in all Customs regions across Canada, and increase our present capabilities at high-volume points of entry;
 - Enhanced training to Customs Inspectors in the identification of drug couriers and high-risk commercial shipments: this training will increase the awareness of Customs Inspectors relating to the identification of indicators (characteristics) that may be present during the examination of a person or commercial shipment;
 - Expansion of Canada Customs involvement in the Crime Stoppers programs of municipal police forces across Canada;
 - Co-operation with airlines and shipping companies engaged in the international transport of people and goods, with a view to Canada Customs obtaining assistance in the detection of illicit drugs destined for Canada;
 - Co-operation with foreign Customs services in targeting in-transit drug couriers.

- ❖ To ensure appropriate immigration policies:
 - Review of immigration policy on drug traffickers.

International components¹²

- ❖ To ensure that Canada plays an active role in international forums on drug abuse:

¹¹ Government of Canada, *National Drug Strategy: Interdiction Components*, 27 May 1987.

¹² Government of Canada, *National Drug Strategy: International Components*, 28 May 1987.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- Canada's active participation at the International Conference on Drug Abuse and Illicit Trafficking to be held in Vienna, 17-26 June 1987;
- Accession to the 1971 United Nations Convention on Psychotropic Substances;
- Increase in Canada's contribution to the United Nations Fund for Drug Abuse Control (UNFDAC) to a target level of \$1 million by 1991;
- Inclusion of reduction of drug abuse as a factor in considering requests for assistance under Official Development Assistance;
- Hosting of an international conference of experts on Recommended Methods for Testing Drugs of Abuse.

❖ To improve public awareness and information:

- Information for Canadians travelling abroad about the hazards of illicit drug possession in other countries.

Proceeds of crime components¹³

❖ To take the profit out of illicit drug trafficking:

- Proceeds of Crime legislation to reduce the profitability of drug trafficking.

Creation of the Canadian Centre on Substance Abuse

The Canadian Centre on Substance Abuse (CCSA) was created by an act of Parliament in 1988. It is a non-governmental organization with the aim to promote "*increased awareness on the part of Canadians of matters relating to alcohol and drug abuse and their increased participation in the reduction of harm associated with such abuse, and to promote the use and effectiveness of programs of excellence that are relevant to alcohol and drug abuse.*"¹⁴ This is to be done by:

- ❖ Promoting and supporting consultation and co-operation among governments, the business community and labour, professional and voluntary organizations in matters relating to alcohol and drug abuse;
- ❖ Contributing to the effective exchange of information on alcohol and drug abuse;
- ❖ Facilitating and contributing to the development and application of knowledge and expertise in the alcohol and drug abuse field;
- ❖ Promoting and assisting in the development of realistic and effective policies and programs aimed at reducing the harm associated with alcohol and drug abuse; and

¹³ Government of Canada, *National Drug Strategy: Proceeds of Crime Components*, 29 May 1987.

¹⁴ *Canadian Centre on Substance Abuse Act*, R.S., 1985, c. 49 (4th Supp.), s. 3.

- ❖ Promoting increased awareness among Canadians of the nature and extent of international efforts to reduce alcohol and drug abuse, and supporting Canada's participation in those efforts.¹⁵

Thus, the CCSA was created to provide a national focus and leadership in the area of reducing the harm associated with alcohol and other drug abuse. It works closely with federal and provincial partners, both governmental and non-governmental. As the NDS indicated, the government had recognized that a coordinated response including all partners was required if long-term solutions were to be found. Co-operation and coordination between all partners is a key function of the CCSA.

*The CCSA works with the private sector, provincial addiction agencies, and many special interest groups to make it possible for all Canadians to benefit from the best prevention programs. One way of doing this is by keeping people working in the field in touch with what's happening across the country.*¹⁶

The CCSA is primarily responsible for providing “credible, objective information and policies on addiction to the federal government, the not-for-profit and private sectors, and provincial/territorial and municipal governments.”¹⁷ It has set out the following seven goals:

- ❖ Policy Formulation
 - Goal 1: To monitor significant research and policy developments, and to provide informed comment on issues of national significance.
- ❖ Information Development
 - Goal 2: To maintain and continually improve national information on the nature, extent and consequences of substance abuse, and problem gambling in Canada.
- ❖ Best Practices Development
 - Goal 3: To monitor significant programs and practices, and contribute to the identification and dissemination of best practices.
- ❖ Communications
 - Goal 4: To develop a communications strategy that includes a series of focused activities and information products aimed at increasing the

¹⁵ *Ibid.*

¹⁶ Government of Canada, *Canada's Drug Strategy*, 1991, page 4.

¹⁷ *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, “Illicit Drugs: The Federal Government's Role”, page 6.

awareness of Canadians of addictions issues, and influencing and informing CCSA's key target audiences.

- ❖ Network Development
 - Goal 5: To develop, co-ordinate and support networks that facilitate the sharing and application of information and expertise.
- ❖ Information and Reference Service
 - Goal 6: To maintain an efficient and responsive information and reference service.
- ❖ Administration/Management
 - Goal 7: To organize the policy, administrative and human resource functions in an effective and financially responsible manner.¹⁸

An important contribution of the CCSA is the establishment of a Clearinghouse on Substance Abuse, which links all major sources of information on alcohol and other drugs in a single computer network.

The CCSA, which is within the portfolio of the Minister of Health, is structured as a corporation, with a chair and a board of directors. It is funded by the NDS and through its own revenue-generating efforts. The CCSA was originally allocated an annual \$2 million of core funding but the cuts that occurred as a result of Program Review in 1997 reduced its core funding to \$500 000. This necessitated the release of almost all full-time staff. Michel Perron, the CCSA's chief executive officer, indicated that the budget cuts affected the CCSA's ability to carry out its mandate.

*Since 1997, the CCSA has basically survived by working for a number of departments on contract. Those contracts ensured our survival, but significantly hindered our efforts to fulfill our legal mandate in a proactive way.*¹⁹

In early 2002, the government increased the CCSA's core funding to \$1.5 million. We were told that, with this increase, the CCSA can stabilize its activities and Canada runs a lower risk of losing its only collective memory as well as the only drug addiction specialists working at the federal level.²⁰

¹⁸ For more information on the CCSA, visit its website at <http://www.ccsa.ca> and see Government of Canada, *Canada's Drug Strategy - Phase II: A situation paper*, Canada, 1994, pages 38-40.

¹⁹ Michel Perron, Executive Director, Canadian Centre on Substance Abuse, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament 2001-2002, 10 June 2002, Issue no. 22, page 69.

²⁰ *Ibid.*,

Creation of Canada's Drug Strategy Secretariat

In 1990, Canada's Drug Strategy Secretariat was given the mandate to coordinate activities within the federal government and with other governments (both nationally and internationally). The secretariat was given many responsibilities, including ensuring the visibility of the NDS, coordinating the evaluation of the NDS and examining the issue of substance abuse from a strategic standpoint. One of its key responsibilities was to act as a facilitator.

*An important function of the Secretariat is to serve as an information source, a central point of entry to the federal government directing those with questions toward people with the answers. Members of the Secretariat also provide advice from outside groups to the federal partners. They attempt to bring groups together to facilitate issues of common concern.*²¹

The Secretariat was disbanded in 1996 during Phase II of the strategy. In the evaluation of Phase II of the CDS, it was suggested that the function of overseeing the coordination should be given to a body that is not an integral part of one of the partner departments—otherwise, such a body would be in a potential or perceived conflict of interest.²² In the past, some had regarded the Secretariat as representing primarily the interest of Health Canada rather than representing the drug strategy itself.

Today, the Office of Canada's Drug Strategy is the focal point within the federal government for the drug strategy. It describes itself as follows:

*The Office of Canada's Drug Strategy of Health Canada is the focal point within the federal government for harm reduction, prevention, and treatment and rehabilitation initiatives concerning alcohol and other drugs issues. Our efforts aim to prevent the use of drugs by those not currently using them, reduce the harm for those who use them, and promote effective and innovative treatment and rehabilitation for those affected by substance abuse. The Office works collaboratively with other federal departments and provincial and territorial governments, and provides national leadership and co-ordination on substance abuse issues, conducts research into the risk factors and root causes of substance abuse, synthesizes and disseminates leading-edge information and best practices to key partners, and collaborates with multilateral organizations to address the global drug problem.*²³

The Auditor General, in her 2001 Report, indicated that there are limits on Health Canada's authority as coordinator and recommended that the government "review the current mechanisms for leadership and co-ordination within the federal government as well as mechanisms for co-ordination with provincial/territorial and municipal governments in addressing the problem of illicit drugs."²⁴ We agree with the Auditor General's assessment and recommend

²¹ Government of Canada, *Canada's Drug Strategy - Phase II: A situation paper*, Canada, 1994, pages 11-12.

²² Health Canada, *Evaluation of Canada's Drug Strategy: Final Report*, June 1997, page 22.

²³ Information regarding the Office of Canada's Drug Strategy can be found on the Health Canada web site at <http://www.hc-sc.gc.ca/hppb/cds-sca/cds/about.html> (revised: 1 December 2000).

²⁴ *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 24.

the creation of a position of National Drug Advisor, responsible for ensuring interdepartmental co-ordination at the federal level. In addition, the CCSA would be given a coordinating role with respect to the provinces and territories, cities and with research bodies and universities.

PHASE II - RENEWAL

In order to determine the future of the NDS, the federal government undertook a national consultation process in March and April 1991. The purpose of the consultations, held with local and provincial partners, was to prepare for the possible renewal of the NDS, obtain information on the strengths and weaknesses of the strategy and identify renewal priorities. During the consultations, alcohol abuse was identified as the major problem in Canada, and the abuse and misuse of pharmaceuticals was the second most frequently mentioned concern. Tobacco use was also seen as a major substance abuse and health problem. Street drugs, while still a concern, were not a major worry of those consulted. It was noted that cannabis use continued to be widespread.

Many at the consultations advocated incorporating the Driving While Impaired (DWI) Strategy into the NDS, and there was also strong support for a comprehensive national alcohol policy. It was also suggested that use of steroids by athletes and youth be included in the NDS. Finally, others called for a comprehensive tobacco policy and for tobacco's inclusion within the NDS. A long-term commitment to the drug strategy was one of the issues stressed by the participants.

To address many problems in substance abuse, participants in the consultation process stressed the need for a long-term commitment to CDS. Substance abuse has been a problem since the dawn of time. To expect significant changes in the level and nature of substance abuse over a five, or even a ten, year period is not realistic. The impact of initiatives to counteract the problem of substance abuse may not be visible for generations. Therefore, CDS must become an ongoing program with political and government support and endorsement. Bringing about fundamental long-term societal changes in attitude and behaviour requires base funding, without a sunset provision.²⁵

In 1992, the NDS was renewed under the designation Canada's Drug Strategy (CDS). Funding was increased to \$270 million over the five-year period and the Strategy principally involved six federal departments.²⁶ As had been suggested, the DWI Strategy became a component of CDS, although the same could not be said for

²⁵ Government of Canada, *Canada's Drug Strategy: Consultations 1991*, page 7. For more information on comments made regarding supply issues, demand issues and the role and impact of CDS, see pages 3-7.

²⁶ Health and Welfare Canada, Solicitor General Canada, Revenue Canada (Customs and Excise), Labour Canada, External Affairs and International Trade Canada and Justice Canada.

tobacco. Once again, CDS called for a balanced approach to reducing both the demand for drugs and their supply. The funding was to be allocated as follows: prevention (30%); treatment (30%); enforcement and control (28%); information and research (5%); national focus (5%); and international co-operation (1%). According to Health Canada, over the five-year period, about \$104.4 million was actually provided.²⁷ In fact, resources that were originally approved were almost immediately reduced, and this reduction continued over the course of CDS as a result of budget cuts.

In renewing CDS, the federal government acknowledged the concerns of stakeholders and stated that solutions to substance abuse require long-term commitment—that to expect significant changes over five or even ten years was not realistic. Thus, it was stated that CDS should become an ongoing program. In addition, it was thought that a balanced approach between demand and supply reduction was critical to the success of CDS. Finally, it was recognized that partnerships (both governmental and non-governmental) at all levels (locally, nationally and internationally) were needed.²⁸

On the whole, it was concluded that the strategy was working well and that it was important to maintain the momentum created by Phase I. The primary and overall objective of Phase II was to make Canada's alcohol and other drug interventions more effective at reducing harm to individuals, families, and communities caused by the problem use of alcohol and other drugs. This would be accomplished through the following secondary objectives:

- ❖ Improved program targeting through a focus on high-risk populations (especially young children, street kids, dropouts, off-reserve Aboriginals, the unemployed, seniors and women);
- ❖ Improved coordination and collaboration across federal departments and with external partners (provincial and territorial governments, non-governmental organizations, etc.);
- ❖ An improved information base on substance abuse-related issues, to assist policy-makers, program developers, researchers, professionals, and others concerned with substance abuse issues in addressing this problem; and
- ❖ Enhanced resources that would enable departments to continue certain ongoing activities and redirect attention to emerging issues or new activities.²⁹

The decision to renew CDS was accompanied by a requirement for its evaluation. In June 1997 a report evaluating Phase II of CDS was published by Health Canada. Its main findings were as follows:

²⁷ Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament 2001-2002, 10 June 2002, Issue no. 22, page 27.

²⁸ Government of Canada, *Canada's Drug Strategy – Phase II*, 1992, page 3.

²⁹ Health Canada, *Evaluation of Canada's Drug Strategy: Final Report*, June 1997, p. iv.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- ❖ Improved program targeting was implemented in all participating departments, with justifiable variation according to their respective mandates;
- ❖ Interdepartmental coordination at the working level and for task-specific initiatives was effective. However, interdepartmental co-ordination at the strategic planning level was identified as a concern over the course of Phase II and would not appear to have been resolved (clear coordination goals were not identified, nor was the role of the CDS Secretariat properly defined);
- ❖ CDS did not have national visibility at either political or public levels;
- ❖ The information available in Canada on the issue of substance abuse increased as a result of Phase II funding;
- ❖ Departmental resources were increased through Phase II. However, there were significant subsequent cuts to some departmental budgets that may have limited the potential achievements of Phase II; and
- ❖ Phase II resources were used in a manner consistent with a harm reduction approach, although a formal harm reduction policy was not in place during the course of the strategy.

The report also identified effective leadership, coordination and strategic planning as essential to the strategy, and found weaknesses in these areas during Phase II. In addition, a common vision and a set of clear and measurable objectives were also found to be fundamental requisites. Lack of accountability for strategy-wide objectives was also identified as a problem. As will be discussed later, most of these issues were again raised as concerns in 2001 (five years later) by the Auditor General of Canada

To coordinate the strategy, two groups were established at the federal level, both chaired by Health Canada: the Assistant Deputy Ministers' Steering Committee on Substance Abuse, and the Interdepartmental Working Group on Substance Abuse. Their purpose has been described as follows:

*The Steering Committee is mandated to meet at least twice a year to improve the overall effectiveness of the strategy and provide direction to the Working Group. Its aims are to co-ordinate federal activities, develop consensus on priorities, address emerging issues, and monitor implementation of the federal strategy.*³⁰

PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING

In 1997, the *Controlled Drugs and Substances Act* (CDSA) was enacted. This legislation formed part of CDS; it was focused, according to the government, on

³⁰ *Report of the Auditor General of Canada to the House of Commons, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 6.*

modernizing and enhancing the drug abuse control policy underlying the previous legislation and on fulfilling Canada's international obligations. It should be noted that since the introduction of the CDSA, most changes to federal legislation dealing with illicit drugs have focused on supply reduction.

In 1998, CDS was renewed in principle but without any specified funding, despite warnings of possible negative consequences. An evaluation of Health Canada's contributions to CDS stated that:

We must conclude that short-term initiatives such as the CDS Phase II are useful in that they inspire a higher sense of priority for a certain issue; at the same time, they hold inherent disadvantages in addressing an issue such as substance abuse, that is widely recognized to require a longer-term intervention than time-limited initiative funding will allow.³¹

The following was also added:

The CDS Phase II Health Canada Component made a considerable investment in research and program development, and information monitoring systems. In many areas, Health Canada is now poised to reap benefits from the knowledge gained – however it is feared that this will not be the case due to non-renewal.

There are also concerns that the sunseting of the Health Canada component of the CDS will not only leave a void but see the balance in the federal harm reduction policy list too far in the direction of supply reduction, and that Canada's international credibility will also suffer.³²

The signatories were limited to federal departments and agencies, with Health Canada again responsible for providing national leadership and coordination. CDS still states that it reflects a balance between reducing the supply of drugs and reducing the demand for drugs. The long-term goal of the strategy remains unchanged: it is to reduce the harm associated with alcohol and other drugs to individuals, families and communities. The goals of CDS are to:

- ❖ Reduce the demand for drugs;
- ❖ Reduce drug-related mortality and morbidity;
- ❖ Improve the effectiveness of and accessibility to substance abuse information and interventions;
- ❖ Restrict the supply of illicit drugs and reduce the profitability of illicit drug trafficking; and
- ❖ Reduce the costs of substance abuse to Canadian society.³³

³¹ Health Canada, *Evaluation of Health Canada's Contributions to Canada's Drug Strategy: Final Report*, December 1996, pages 33-34.

³² *Ibid.*, pages 34-35.

³³ Government of Canada, *Canada's Drug Strategy*, 1998, pages 4-5.

The strategy states that it is built on four pillars: prevention; enforcement and control; treatment and rehabilitation; and harm reduction. Within this general framework, seven separate components have been identified: research and knowledge development; knowledge dissemination; prevention programming; treatment and rehabilitation; legislation, enforcement and control; national coordination; and international co-operation.³⁴

The Drug Strategy and Controlled Substances Program, within the Healthy Environments and Consumer Safety Branch of Health Canada, currently spends \$34 million annually on substance abuse.³⁵ The Office of Canada's Drug Strategy currently manages \$16.5 million of the \$34-million total budget. The Alcohol and Drug Treatment and Rehabilitation program, which was originally managed by HRDC, was transferred to Health Canada in October 1997. It is currently managed by the Office of Canada's Drug Strategy, which provides \$14 million to the provinces for treatment and rehabilitation programs. The other \$2.5 million is allocated to the CCSA (\$1.5 million) and for research and program management (\$1.0 million). The remaining \$17.5 million is allocated by the Healthy Environments and Consumer Safety Branch as follows: administration of regulations other than the Marijuana Medical Access Regulations (\$5.0 million); Medical Marijuana Program (\$5.0 million); drug analytical services (\$4.5 million); policy, research and international affairs (\$3.0 million).³⁶

Health Canada does spend other resources on substance abuse through the department's varied activities. For example, the Population and Public Health Branch allocates resources to deal with HIV/AIDS and Hepatitis C, and to deal with FAS/FAE.

CANADA'S DRUG STRATEGY – A SUCCESS?

This section does not claim to provide an in-depth analysis of CDS since its implementation and development in 1987. Certain key objectives, however, will be reviewed in order to determine whether or not the CDS can be deemed a success. It is important to note that, despite the considerable amounts of money spent at the federal level to control psychoactive substances, many would argue that Canada does not even have a funded national drug strategy.

³⁴ While CDS deals with both licit and illicit substances, a separate strategy has been developed to identify specific approaches to tobacco.

³⁵ This does not include expenditures made by the First Nations and Inuit Health Branch, which total approximately \$70 million.

³⁶ Health Canada, Presentation to the Special Committee on Illegal Drugs, 10 June 2002.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

In 1997 the government implemented “Program Review”, and severe financial cuts were applied to all departments, including Health Canada. The drug strategy did not escape these cuts and it sunset in 1997. In fact, there has been very little new money from the federal government for the field of addictions since.

Canada currently has no national strategy. We therefore simply do not have research data to guide us. In fact, no one knows the extent of drug consumption or prevalence in Canada because no national inquiry has been done since 1994. We therefore have to come up with hypotheses and resort to other tools to get a picture of the current situation in Canada.³⁷

As mentioned, research, knowledge development and knowledge dissemination are severely lacking in Canada, despite the fact that these are intended to be key components of the CDS. A more complete analysis of these deficiencies in knowledge development and dissemination is set out in Chapter 6. To summarize, Canada has not given itself the means to conduct proper research and to acquire knowledge in this field. For example, only two general national drug surveys have been conducted - in 1989 and 1994. Much of the problem with respect to research and knowledge development can be attributed to the almost non-existent funding allocated to the CCSA. Considering the importance of the CCSA’s role in knowledge development and the costs of substance abuse in Canada, it is clear that its funding has been totally inadequate over the years. The recent increase to its core funding may temporarily stop the bleeding but will not allow Canada to acquire the tools necessary to conduct vital and necessary research in this area.

The CDS has, since its implementation, stated that it reflects a balance between reducing the supply of drugs and reducing the demand for drugs. While such policy objectives are easy to pronounce, they have not been reflected in reality. The Auditor General has recently indicated that, of the approximately \$500 million spent annually by 11 departments or agencies at the federal level to address illicit drug use in Canada, roughly 95% is spent on supply reduction. Notwithstanding the division of constitutional powers in Canada, one would be hard pressed to argue that this allocation of funds represents a balanced approach.

Another of the key objectives of the CDS is to ensure coordination and collaboration across all federal departments and with the provinces and municipalities. The Auditor General has recently criticized the leadership provided at the federal level and recommended a drug strategy with sound co-ordination and with clear objectives and results.

Canada requires stronger leadership and more consistent co-ordination to set a strategy, common objectives, and collective performance expectations. It must be able to respond quickly to emerging concerns about illicit drug use or the illicit drug trade. The present structure for leadership and for co-ordination of

³⁷ Michel Perron, *loc. cit.*, page 71.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*federal efforts needs to be reviewed and improved. The mechanisms for co-ordination with the provinces and municipalities also need review since they cross three levels of government.*³⁸

One of the obvious weaknesses of the CDS is the failure to provide comprehensive evaluations of its objectives. For example, we are unaware of any evaluations of the prevention and treatment programs that have been funded by the federal government. This lack of evaluation is an overall concern.

*Although the federal government provides leadership and co-ordination for dealing with the illicit drug problem, it has not produced any comprehensive reports that demonstrate how well Canada is managing the problem. It would be logical for Health Canada, as the lead department, to report government-wide results of Canada's efforts to reduce the demand for and the supply of illicit drugs.*³⁹

In summary, it would be difficult to declare the CDS a success when we do not even have the tools needed to determine whether or not the objectives of the strategy have been satisfied. The current strategy has, at the very least, many fundamental weaknesses. As several critics have argued one must question whether we in fact even have a comprehensive drug strategy in Canada.

CONCLUSIONS

While we recognize that the federal government cannot act alone if it is to deal effectively with substance abuse problems, our conclusions with respect to a national strategy regarding psychoactive substances are generally limited to the role played at the federal level.

Conclusions of Chapter 11

- **Canada urgently needs a comprehensive and coordinated national drug strategy for which the federal government provides sound leadership.**
- **Any future national drug strategy should incorporate all psychoactive substances, including alcohol and tobacco.**
- **To be successful, a national drug strategy must involve a partnership with all levels of government and also with non-governmental organizations.**

³⁸ *Report of the Auditor General of Canada to the House of Commons 2001, Chapter 11 – Illicit Drugs: The Federal Government's Role, page 1.*

³⁹ *Ibid.*, page 22.

- **Over the years, the intermittency of funding has diminished the ability to co-ordinate and implement the strategy; adequate resources and a long-term commitment to funding are needed if the strategy is to be successful.**
- **Clear objectives for the strategy must be set out, and comprehensive evaluations of these objectives and the results are required.**
- **At the developmental stage, there is a need to identify clear and shared criteria for “success”.**
- **The core funding for the CCSA has been insufficient for it to carry out its mandate; adequate funding for the CCSA is essential.**
- **There is a need for an independent organization – the CCSA – to conduct national surveys at least every second year; there is also a need to achieve some level of consistency, comparability and similar time frames for provincially based school surveys.**
- **Coordination at the federal level should be given to a body that is not an integral part of one of the partner departments.**
- **Canada’s Drug Strategy’s should adopt a balanced approach – 90% of federal expenditures are currently allocated to supply reduction.**

CHAPTER 12

THE NATIONAL LEGISLATIVE CONTEXT

Drugs have been prohibited for fewer than one hundred years; cannabis for slightly more than 75. It is tempting to think that the decisions made over the years to use criminal law to fight the production and use of certain drugs are in keeping with social progress and the advancement of scientific knowledge about drugs. Pre-twentieth century societies were less “advanced” and did not have the sophisticated tools that medicine, molecular biology and biochemistry, psychology and the cognitive sciences have provided over the course of this century of technological revolution. The prohibition measures adopted by parliaments, and on a wider scale, by the international community were therefore a more or less accurate reflection of the knowledge gradually acquired by scientists. The gradual conquest of territory occupied not so long ago by the irrational and its gang of charlatans and other shamans continued, for the greater good of humanity. As proof, phenomenal technical advances in medicine and pharmacology over the course of this century have resulted in increased longevity and decreased infant mortality in Western countries.

But is this really the case? Is civilization one long march towards progress, towards greater, and increasingly invincible, rationality? If we consider the state of the planet and the alarms sounded by more than one scientist today, we may have our doubts. From a social standpoint, the twentieth century has not brought fewer wars, less destruction, or more equality between people than previous centuries. With respect to drugs, is the legislation a more or less faithful translation of scientific knowledge for the greater good of all? Can we discern a rational structure in the national laws and international conventions that govern certain drugs and other substances? Are they based on knowledge of the effects of drugs on the psyche and human behaviour? Do they reflect the desire to ensure the well-being of the public?

The history of legislation governing illegal drugs in Canada, like the analysis in Chapter 19 of the structure of international conventions, suggests that this is highly doubtful. We do not deny that knowledge has advanced; the second part of our report testifies to this. But scientific knowledge itself is a structure that develops in a given historical context and responds to paradigms in the way problems are posed and research is conducted. The dominant scientific positivism is a temporary result in the long evolution of knowledge. It is not the “end of the story”. Within the scientific process, a “selection” is made of pertinent questions and ways in which to ask them,

such that any question is not necessarily a good question and certain ways of answering are more acceptable to the community of researchers.

Moreover, legislation adopted by parliaments is influenced at least as much by prejudices and preconceptions resulting from “*pop science*” as by partisan, personal and international considerations. In this sense, the parliamentarian is no different from any other citizen, as we pointed out in the report’s general introduction.

We were told several times that we could not compare the effects of cannabis to those of alcohol or tobacco. And yet, even at the risk of being unreadable if not unacceptable to the community, public policy on “drugs” must propose some rationale of the type: “this is prohibited, because..., and this is not, because...”. Most of the time the “reason” – or the justification? – is presented as risks or dangers on the one hand and as medical usefulness on the other. Thus, under the current control regime, because of the risks or dangers they are believed to present, some drugs must be regulated, that is, they are not sold over the counter. When they present a danger **and** they have no known medical application, the regulatory controls prohibit their manufacture, production, growth, use, possession, etc., entirely. That is the case with the legislation and conventions governing opium and its derivatives (heroin), the coca plant and its derivatives (cocaine, crack) and the cannabis plant and its derivatives (marijuana, hashish). When the drug presents a danger but is medically useful, it is subject to more or less severe regulatory controls. That is the case with benzodiazepines and other powerful medications, which are sold by pharmacists and cannot be obtained without a medical prescription. Other drugs present a “health risk”: nicotine, alcohol, as well as several other over-the-counter drugs. The packaging must indicate the risks (except for alcohol – which is very telling) so as to “warn” the user.

To what extent is such reasoning really rational?

Three researchers at the University of Toronto (Lazarou, Pomeranz, Corey, 1998) have estimated that correctly prescribed legal medications kill, on average, 100,000 people a year in North America. Although for methodological reasons that figure was cut back by one half or two thirds, it nonetheless illustrates the enormous losses of human life that go undetected by any monitoring system, including the legal system. No one thinks that this danger should be avoided by prohibiting medical prescriptions - the risky decisions made by physicians - or denying the "right to use" medications. Why? Because we do not see how that solution could be preferable to the solution of taking risks responsibly. Knowing that this problem exists, we will try to find other solutions, such as better quality control for the products, etc. Nor (fortunately) do we consider assigning criminal responsibility to physicians for taking the risk of writing a correct prescription, knowing that even correctly prescribed medications can cause death. ¹

¹ Pires, A.P., (2002) *op. cit.*, page 43.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

The 2001 report from the International Narcotics Control Board indicates a “worrisome” increase in the abuse of various prescription drugs in the United States and notes that several of these medications are found on the black market, in particular through the Internet.²

Tobacco use causes more than 400,000 deaths a year in the United States, and approximately 45,000 in Canada. As for alcohol, it is linked to physical aggression and violence, especially marital, and to road accidents, and its abuse causes thousands of deaths each year.

It is a mistake to see illegal drugs in a separate category from the legal drugs insofar as the history of criminalization is concerned. We have compounded that difficulty today because we do not tend to see the legal drugs in the same limelight as the illegal drugs. To demonstrate that, we use the phrase "alcohol and drugs" as if alcohol were not a drug, as if police officers who go to domestic disputes do not know already that the major drug problem they will likely find at that dispute is alcohol abuse, as if we do not already know that more than 70 per cent of all homicides involve alcohol abuse as a critical factor. For us to pretend that the consumption of alcohol is on a morally different plane from the consumption of illegal drugs seems to be a kind of cultural folly that speaks volumes about the cultural blinders we wear as we go about our business in everyday life.³

Is the rationale of the system of controls acceptable in the eyes of civil society, users as well as abstainers? What criteria motivated the legislators' decisions? For that matter, were there any criteria? What motivated parliamentarians from Canada and elsewhere to prohibit certain substances, to control access to certain others, and to permit still others to be sold over the counter?

Knowing where you have been helps you to understand where you are going. That is the goal of this chapter, which retraces the evolution of Canadian drug laws from 1908 to the present day.⁴ We have identified three legislative periods. The first, and longest, spans the years from 1908 to 1960. That is the period of hysteria. The second, which is much shorter, runs from 1961 to 1975 and is the period involving the search for lost reason. Lastly, the contemporary period, which really starts at the beginning of the 1980s, is the period of forging ahead regardless. As it would be too much to describe the different sections in the various bills adopted over the years, we have appended a table that explains and presents the clauses of the legislation adopted from 1908 to 1996 on the control of narcotics.

² INCB (2002) pages 58-60 in particular.

³ Testimony by Neil Boyd, Professor of Criminology, Simon Fraser University, before the Special Senate Committee on Illegal Drugs, Canadian Senate, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue 1, page 49.

⁴ This chapter is based largely on the excellent report prepared at the Committee's request by François Dubois, research assistant to Senator Pierre Claude Nolin: *Le Parlement fédéral et l'évolution de la législation canadienne sur les drogues illicites*, Ottawa: Special Senate Committee on Illegal Drugs, June 2002. This report is available on line at www.parl.gc.ca/illegal-drugs.asp

1908-1960: HYSTERIA

At the time of the Shanghai Conference on opium in 1909⁵, European societies had known for hundreds of years about opium, coca leaves, and cannabis, having discovered them through contact with other societies. These “drugs” were used in medical practice, as well as by a certain worldly or artistic elite, and especially as a commercial tool by colonial powers. In the midst of advances in chemistry, the 19th century saw the arrival of a large number of new drugs—primarily opiate-based—and their enthusiastic adoption by physicians, pharmacists, general store owners and traveling salesmen as miracle elixirs. What happened so that Canada in 1908, and the seven countries gathered in Shanghai in 1909, decided to prohibit this “drug”? At least four factors figured in the game of chance and necessity that led to prohibition.

First of all, geopolitical issues, commercial dealings with China in particular and the political stability of the Middle Kingdom in general, played a considerable role, as shown in Chapter 19. But from a domestic standpoint, these factors do not explain everything, especially since the concerns of the Dominion of Canada and its people about international politics were still relatively minor.

Initially, physicians noticed, sometimes from their own experience as a user, that use of opium derivatives resulted in a certain degree of dependence and health problems.⁶ At first, these cases of drug addiction were limited to the leisured classes and to artists, who were rarely labeled as “delinquents”. However, the increasing availability of these drugs⁷ and the subsequent development of dependence problems within the working classes had a profound effect on public opinion about these drugs. There was no longer talk of “the ill” but rather of “delinquents” who [translation] “*could not face up to the demands of life as a good citizen and worker*”⁸. A few doctors, worried about protecting their monopoly, did not hesitate to demand laws from the government to restrict the use of drugs produced by pharmaceutical companies and thus avoid the propagation of this “scourge” that threatened the foundation of North American society.

⁵ See Chapter 19 for more details.

⁶ We note in passing that in fact these were synthetic opium derivatives such as morphine. It was not discovered until much later that smoking heroin was much less harmful to the user than injecting it or using its synthetic derivatives. We can also draw a parallel with synthetic derivatives of cannabis, which cause more problems than smoking cannabis, as we saw in Chapter 9.

⁷ Line Beauchesne talks about large pharmaceutical companies that flooded the market by manufacturing these products en masse and then trying to dispose of them in any way possible. Beauchesne, L., (1991) *La légalisation des drogues... Pour mieux en prévenir les abus*. Montreal: Méridien, pages 95-96.

⁸ Beauchesne, L. *op. cit.*, page 98.

Even though the use of opium did not result in a social crisis before the beginning of the 1880s, whites who frequented Chinese opium dens were often seen as suspicious or dangerous. At the time, [translation] “*Frequenting the Chinese quarter and its opium dens is seen by several moral groups as a preference for the foreign, as willingly straying from white Anglo-Saxon values. This judgment is even more severe where women are concerned.*”⁹

Associated with the problem of alcoholism in the working classes, the question of the use of drugs then became the metaphor par excellence for the decay of western Judeo-Christian civilization, and the favourite theme of temperance leagues in the United States as well as Canada. Born in the 19th century, these movements had a very strong religious basis, especially in the protestant ethic of responsibility for personal health through work and self control: [translation] “*work and sobriety were valued as a means to avoid loss of production and to maintain the economic superiority of the white Anglo-Saxon race.*”¹⁰ Waging “war” against alcohol that causes male violence and adultery, against drugs that kill young people, and also against prostitution, cigarettes and gambling suited these movements perfectly.¹¹ From community support groups designed to help those who wanted to break their bad habits, these leagues transformed themselves into powerful pressure groups demanding the complete prohibition of alcohol first, and then supporting the prohibition of opium and other drugs.

The third factor, closely related to the previous two, was population movement and especially Chinese immigration – it would be more accurate to talk about the importation of Chinese workers. The Chinese had immigrated to the United States in the middle of the 19th century to work in the mines and build the railroads in the American West. Once these large projects were completed, certain labour disputes broke out on the American West Coast, pitching the Chinese, who offered cheap labour to owners of agricultural enterprises, against powerful unions, largely composed of white workers. Following the appearance of the union-based anti-Chinese movement and legislation that prevented any further Chinese immigration, many Chinese had no choice but to develop the opium trade in the ghettos where they lived in large American cities. The temperance movement did not hesitate to adopt the racist feeling driving certain segments of American society in order to denounce the use of opium, seen as a scourge that promoted immorality, crime and the decline of the white Anglo-Saxon race. It was in this context of social unrest, although limited to the American West Coast, that the first American legislation governing the opium trade was adopted.

In Canada, in the middle of the 19th century, the Chinese became a major source of manpower for building the Canadian Pacific Railway. As the economy of British Columbia diversified, these immigrants found work in fish processing plants, coal mines and the forestry industry, although the jobs available to them remained limited.

⁹ *Ibid.*, page 126

¹⁰ Beauchesne, L. (1999) “À propos du cannabis, que faire?” *L'écho-toxico*, page 14.

¹¹ Ati-Dion, G., (1999) *The Structure of Drug Prohibition in International Law and in Canadian Law (Doctoral Paper)*, Montreal, Université de Montréal, École de criminologie, page 24.

This worsened the competitiveness of the local labour market and increased their marginalization in society.¹² Beginning in the 1880s, the massive influx of Chinese juxtaposed with the economic slowdown brought on by the end of construction of the Canadian Pacific railway and the economic recession that marked the end of the 19th century and the early years of the 20th century caused several union and popular demonstrations demanding the end of Chinese immigration, the source of British Columbia's economic and moral problems.

According to Giffen, this fear was not justified since white immigration from other regions of Canada more than offset the increase in British Columbia's Chinese population. In fact, the proportion of Chinese in the province declined from 20% at the beginning of the 1880s to less than 6% in 1921¹³, just before a clause in the *Opium and Narcotic Drug Act* was adopted authorizing the deportation of an immigrant found guilty of a drug-related offence.

But,

*Tolerance for the habit of smoking opium lasted only as long as British Columbia's tolerance for the Chinese. In the early years of the twentieth century, both a labour surplus and anti-Asian resentment developed. The Asiatic Exclusion League was formed, supported by an amalgamation of the Vancouver Trades and Labour Council and federal Conservative politicians. Opposed to the Liberals' immigration policies [under Sir Wilfrid Laurier], the league demanded an end to immigration from Asia, claiming that the "yellow peril" was about to "swallow" a white British Columbia.*¹⁴

In fact, well before the development of this "social crisis", the British Columbia government had tried to halt Asian immigration by adopting the *Chinese Immigration Act* in 1884, which imposed an annual tax of \$10 on the Chinese and other Asians living in British Columbia and prohibited them from buying land belonging to the province. The federal government disallowed this Act, but in 1885 it created a Royal Commission to investigate Chinese immigration and this commission recommended imposing a \$10 entry tax on every Asian immigrant. In 1885, as a result of public pressure, the federal government adopted the *Chinese Immigration Act* which imposed a \$50 entry tax that was increased to \$500 in 1904, as many had criticized the fact that despite the imposed tariff, 20,000 Asians had immigrated to the country between 1889 and 1900.

A major incident in 1907 led the federal government to intervene in matters of Chinese immigration and labour disputes in British Columbia. During the year, a demonstration organized by the *Asiatic Exclusion League* and attended by more than 10,000 people, most of whom were union workers and members of the middle class, turned into a riot when the angry crowd headed into Vancouver's Chinese district, attacking people and causing serious property damage. After convincing Prime Minister

¹² Giffen, P.J. et al., (1991) *Panic and Indifference: The Politics of Canada's Drugs Laws*, Ottawa: Canadian Centre on Substance Abuse, page 53.

¹³ *Ibid.*, page 53

¹⁴ Boyd, N. (1991) *High society: Illegal and Legal Drugs in Canada*, Toronto, Key Porter Books, page 27

Laurier of the wisdom of compensating the Chinese, William L. Mackenzie King, then Deputy Minister of Labour, returned to Vancouver in the Spring of 1908, where he wrote a report¹⁵ that would lead to the adoption of the *Opium Act*. Based primarily on moral, ethical, political, diplomatic and ethnic considerations, Mackenzie King's report, rather than attacking labour disputes between white and Chinese workers, shifted the problem to opium use by Asian foreigners.

*[...] the amount [of opium] consumed in Canada, if know, would probably appall the ordinary citizen who is inclined to believe that the habit is confined to the Chinese, and by them indulged in only to a limited extent. The Chinese with whom I conversed on the subject, assured me that almost as much opium was sold to white people as to Chinese, and that the habit of smoking opium was making headway, not only among white men and boys, but also among women and girls.*¹⁶

As in the United States, Chinese immigrants brought with them not only their labour but also their practice of smoking opium. They preferred this practice to the widespread habit of white workers of using alcohol and opiate-based drugs to cure illnesses and to momentarily forget their social and working conditions.¹⁷ Thus the first opium den opened its doors in Vancouver in 1870. Some Chinese even opened factories to produce opium for smoking; the opium was then used in opium dens in Vancouver's Chinese district or was simply sold to white clientele. As Professor Boyd mentioned during his testimony before the Committee:

*Over time, equal amounts of smoking opium were sold to whites as to Chinese. If you look back through the issues of Vancouver Province or the Victoria Times Colonist, you find advertisements. You do not find any expression of concern or anger about those smoking opium establishments, but you find advertisements.*¹⁸

In 1883, there were three factories producing smoking opium in Victoria and in 1891, there were more than 10 opium dens in the Chinese districts of large cities in the Canadian West.¹⁹ The surge in this industry was beneficial to the British Columbia government since it imposed a customs tariff on crude opium of 10% to 25%.

If I could turn back the clock 100 years to Vancouver, Victoria and New Westminster, I could show you opium-smoking factories which were started in the late 1870s and persisted for 30 years without complaint. The labour surplus and the depression in the first decade of the 20th century led to concerns that led to the original legislation. It is noteworthy that the Opium and Narcotic Drug Act of 1908 was

¹⁵ William L. Mackenzie King, *The Need for the Suppression of Opium Traffic in Canada*. Ottawa, Parliamentary Document 36b, 1908, 18 pages

¹⁷ Beauchesne, L., (1991) *op. cit.*, page 125

¹⁸ *Ibid.*

¹⁹ Giffen, P.J. et al., (1991) *op. cit.* page 125

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

introduced by the Minister of Labour. When he introduced the act, he said, "We will get some good out of this riot yet," referring to the anti-Asiatic riot in Vancouver in September of 1907.

Imagine, today, the idea of illegal drug legislation coming forward from the Minister of Labour because he or she is seeking to get some good out of a labour crisis on Canada's West Coast. The situation in California was similar.²⁰

Even though the Royal Commission of 1885 did not recommend specific measures governing the production or use of smoking opium, it did indicate that smoking such a substance was a pagan practice incompatible with the lifestyle of a Christian nation.²¹ According to Line Beuchesne, the crusade against opium that followed this report gradually resulted in a decline in opium smoking.²² The results of an investigation conducted by the *American Pharmaceutical Association* in 1903 into drug use claimed that drug consumption was widespread throughout American society, but involved two social groups more specifically: Chinese immigrants and Blacks. This study probably influenced some federal politicians and temperance movements that used similar arguments until the beginning of the 1930s to justify the prohibition of opium and other drugs.²³

In short, while economic considerations were at the heart of anti-Asian feeling, temperance movements and religious groups took advantage of the situation to promote their views, not only in the immediate area of British Columbia but also across the rest of the country. These events drew the public's attention to the "dangers" of opium for Canadian society.

Opium Act, 1908

In the House of Commons on July 10, 1908, the Minister of Labour proposed the adoption of a motion prohibiting: "*the importation, manufacture and sale of opium for other than medicinal purposes.*"²⁴ The motion was adopted without debate. The Minister introduced Bill 205, *An Act to prohibit the importation, manufacture and sale of opium for other than the medicinal purpose. (Opium Act, 1908).*²⁵ The first section of the Act prohibited the importation of opium without authorization from the Minister of Customs. Additionally the drug could be used for medical purposes only. The manufacture, sale and possession for the purpose of selling crude opium or opium prepared for use by smokers was also prohibited. Whoever violated these provisions could be found guilty of a criminal offence punishable by a maximum prison term of three years and/or a

²⁰ Testimony by Neil Boyd, Professor of Criminology, Simon Fraser University, before the Special Senate Committee on Illegal Drugs, Canadian Senate, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue 1, page 49.

²¹ Beuchesne, L., *op. cit.* page 128

²² *Ibid.*, page 128

²³ Ati-Dion, G., (1999) *op. cit.* page 25

²⁴ Hansard, House of Commons, July 10, 1908, page 12550

²⁵ Statutes of Canada 1908, c. 50

minimum fine of \$50 and not exceeding \$1,000. Even though it prohibited the use of opium, the legislation was aimed at opium dealers, most of whom were Chinese, and not users. The bill was given Royal Assent on July 20, 1908.

The Opium and Narcotic Drug Act, 1911

The enactment of the *Opium Act* led to the introduction of 8 new bills intended to make it both more restrictive and effective on January 26, 1911, Mackenzie King, who had just become the Minister of Labour, introduced Bill 97, an *Act to prohibit the improper use of Opium and other Drugs* (the *Opium and Narcotic Drug Act, 1911*).²⁶ During the deliberations on second reading, Mackenzie King gave three reasons for introducing the bill: the Shanghai Commission, the panic in Montreal caused by cocaine use and the need to grant special powers to the police to ensure that the Act could be enforced effectively. The Shanghai Commission had adopted a number of non-binding resolutions, including: putting a gradual stop to the opium smoking habit, with due regard to the specific circumstances of each country; prohibiting the use of opium and its alkaloids and derivatives (morphine, heroin, etc.) and other drugs for non-medical purposes; and prohibiting the export of these substances to countries that prohibited their use.

No member raised any objections about the four drugs added to the Schedule to the Act, namely cocaine, opium, morphine or eucaïne. Section 14 of the Act also provided that the Governor in Council had the power to order any alkaloid, by-product or drug preparation added to the Schedule when its addition was deemed necessary in the public interest—a power which still exists today. The justification given for this was that if the use of a new drug were to become widespread in society, it would be possible to add it more quickly to the Schedule than by having to enact new legislation.²⁷ Other provisions of the Act related to the use of opium, search powers granted to the police, orders for the confiscation or restitution of seized drugs and a reverse onus for cases of simple possession of drugs. The possibility of requesting that a higher Court issue a writ of *certiorari* with respect to prosecutions carried out under this Act was eliminated.

The post-war period led to a string of major amendments to the offences, penalties, police powers and criminal procedure provided in the *Opium and Narcotic Drug Act*. There are several factors to explain this legislative ferment: the concerns raised by Emily Murphy's writings about the extent of the "scourge" of drugs in Canada²⁸; the renewed conflicts between Whites and Asians in British Columbia; the mobilization of doctors' and pharmacists' associations to prevent the Act from infringing on their activities; the establishment in 1919 of the Department of Health and the powerful Narcotics Division (the predecessor of the current (Office of Controlled Substances), which were responsible for enforcing international conventions on drugs in Canada; the

²⁶ Statutes of Canada 1911, c. 17

²⁷ Hansard, House of Commons, January 26, 1911, page 2549.

²⁸ This was discussed in Chapter 10.

establishment in 1919 of the Royal Canadian Mounted Police (RCMP), responsible for enforcing the *Opium and Narcotic Drug Act*; the enactment of the *Harrison Narcotic Act* in the United States in 1914; and the mobilization of the international community to enforce the *International Opium Convention* (The Hague - 1912) imposed on a number of countries by the 1919 Treaty of Versailles.

The establishment of the narcotics division

The enactment of the *Harrison Narcotic Act* in the United States and the mobilization of the international community to enforce The Hague Convention quickly brought to light three major shortcomings of the *Opium and Narcotic Drug Act*, 1911.²⁹

The first problem appeared when the time came to control drug imports and exports. The Act had only vague instructions concerning trading in drugs for medical or scientific purposes. That being the case, customs officials were reluctant to seize cargo containing opium or other drugs.

The second problem stemmed from the enactment in the United States of the *Harrison Narcotic Act*, which was similar to the Act passed in Canada in 1911. However, it imposed a system of licences issued to businesses by the federal government authorizing them to import or export drugs. This led to a significant demand for illegal drugs in the United States. As the supply of these substances in Canada exceeded consumer demand, traffickers quickly took advantage of this business opportunity and exported their surpluses to the United States. This had become so profitable that in 1918, a committee of the US Senate filed an official complaint with the Canadian government concerning drug trafficking.

The third and final problem stemmed from the fact that traffickers quickly found ways to avoid the provisions of the 1911 Act because its enforcement was not centralized within a single government agency. On the one hand, Customs was attempting as best it could to control legal trade in drugs whereas on the other hand, municipal police departments handled illegal trafficking, which was becoming increasingly sophisticated every year, requiring that new powers be granted to the police.³⁰

The many amendments to the Act to deal with these problems were orchestrated in part by F. W. Cowan the first Chief of the new Narcotics Division (1919-1927) of the Department of Health, and in particular by Colonel C. H. L. Sharman, the former RCMP officer who succeeded him (1927-1946). Cowan quickly understood after becoming Chief of the new division that he would have to centralize control over both legal and illegal trade in drugs to ensure that the Act could be enforced effectively, thereby assuring the long-term survival of his organization. During his tenure, an impressive communications network was created, and by the end of the 20s, it included the other divisions of the Department of Health, the Department of Justice and the

²⁹ Giffen, P.J., et al., *op. cit.*, page 105.

³⁰ *Ibid.*, pages 105-121.

lawyers hired to prosecute drug offences, the RCMP, the media, municipal police departments, associations representing doctors and pharmacists, governments and agencies responsible for enforcing the laws of other countries, including the United States, and international narcotics control agencies established by the League of Nations.

Under Sharman's impetus, the administration of information from all of these participants was eventually conducted solely by the Division, and no longer by the Department of Justice or the RCMP. This made it possible for the director to have an overall picture of the narcotics situation, thereby making him an "expert" in the field. A former official of the Division described Colonel Sharman as "a *Czar running an empire of his own*."³¹ His influence grew when the Division was placed under the authority of the Deputy Minister of Health. The reorganization fostered a closer and more direct relationship with the Minister and Members of Parliament, making it possible for him to short-circuit proposals from other divisions within the Department. And when the time came to add further offences, penalties, criminal procedures or new police powers in the 20s, the Division never hesitated to take advantage of the "panic" generated by the media in Vancouver, or Emily Murphy's writings, to justify such amendments.³²

From the standpoint of enforcing the Act, this structure was very useful. For example, up until the 50s, from the moment a police officer or a lawyer, anywhere in Canada, informed the Chief of the Division of a weakness in the Act, he would draft proposed amendments, pass them on to his network for rapid consultation, and if necessary, he would encourage the Minister of Health to introduce a bill to correct the problem situation. The federal drug bureaucracy as we know it today was born!

In such a context, the establishment of a network like this had a significant impact on the direction that would be taken by Canadian narcotics legislation:

*In short, the establishment of an administrative organization to enforce narcotic law had the unintended consequence of creating a centralized pressure group which had the motivation and influence to play a major role in shaping the future course of the legislation. This centralization of power and expertise together with the fact that the resources were directed mainly at a socially powerless group helps to explain the virtual absence of an effective criticism and alternative proposals for control from 1920 to 1950.*³³

Amendments to the Opium and Narcotic Drug Act (1920-1938)

Many amendments were made to the 1911 Act prior to an in-depth overhaul of the Act in 1938. It was during this period that cannabis was added to the schedule of the Act.

³¹ *Ibid.*, page 144.

³² *Ibid.*, pages 138-146.

³³ *Ibid.*, page 127.

Amendments to list of substances in schedule: Addition of cannabis

From 1911 to 1938, many drugs were added to the schedule of the *Opium and Narcotic Drug Act*. The 1911 Act was introduced to control only four drugs. In 1938, when the *Act to amend the Opium and Narcotic Drug Act*³⁴ was enacted, the schedule listed more than 15 drugs, including derivatives or salts, one of which was cannabis, added in 1923.

During a sitting of the Committee of the Whole in connection with a review of the 1923 Act, Minister of Health Henri-Séverin Béland simply said about the substance that, “*There is a new drug in the schedule.*”³⁵ That is how cannabis ended up in the schedule to the Act. According to Giffen, the circumstances leading to the decision remain obscure because, until 1932, the issue of the effects of cannabis on people’s physical, psychological or mental health had never been raised in Parliament. Giffen described the criminalization of the drug as a solution without a problem.

In the United States, beginning in 1890, some American doctors were worried that the potency of cannabis appeared to be variable and that individual reactions when cannabis was taken orally appeared to be unpredictable. Thus despite the continued use of much more dangerous drugs like barbiturates and opiates, cannabis was abandoned by doctors. At the beginning of the century, the discovery of the hallucinogenic nature of cannabis contributed considerably to its reputation as a dangerous drug. However, the people who wrote the *Harrison Narcotic Act* had not deemed it appropriate to subject it to the controls provided in the Act.³⁶ But in 1915, California became the first American state to prohibit the use of marijuana, and in the early 20s, marijuana had “become a major ‘underground drug’ traced to an influx of Mexican workers into Southern United States in the 1910s and 1920s.”³⁷ As with opium, labour disputes, the economic interests of big business and morality served as catalysts to create a popular movement in favour of the prohibition of cannabis in the United States, which led to the passage of the *Marijuana Tax Act* in 1937, prohibiting the use and production of cannabis.

Unlike in the United States, there were no reliable accounts of the non-medical use of cannabis in Canada before the 1930s.³⁸ And unlike California, Canada was not faced with an influx of Mexican workers. Why then was cannabis added to the Opium Act schedule?

In 1922, Emily Murphy referred to the harmful effects of cannabis on human behaviour in her book *The Black Candle*, in which she worked over most of the articles she had published in *MacLean’s* magazine. In the chapter entitled “*Marihuana – A New*

³⁴ Statutes of Canada, 1938, c. 9.

³⁵ Hansard, House of Commons, April 23, 1923, page 2117.

³⁶ Beauchesne, L., (1991) *op. cit.*, page 117.

³⁷ Spicer, Leah, (2000) *Historical and Cultural Uses of Cannabis and the Canadian “Marijuana Clash”*, Ottawa: Law and Government Division, Library of Parliament, Report prepared for the Senate Special Committee on Illegal Drugs, p. 20, available online at www.parl.gc.ca/illegal-drugs.asp

³⁸ *Ibid.*, page 21.

Menace” she reported comments made by the Chief of the Los Angeles Police Department, who described the terrible effects of cannabis.

But Giffen’s research in the archives of the Department of Health indicates that these scare tactics, which were steeped in morality, were not behind the placing of cannabis in the *Opium and Narcotic Drug Act* schedule, particularly given that at the time, it was virtually unknown in Canada and its use was not a problem.³⁹ This is confirmed in section 7 of the 1932 Act, which amended a provision of the 1920 Act by allowing the manufacture, sale or distribution, without a permit, of medicines if they contained only small quantities of certain drugs listed in the schedule. In 1932, the measure would henceforth apply to cannabis. During parliamentary debate on the introduction of this statute, the discovery of the existence of this drug appeared to elicit the interest of certain parliamentarians. During Committee of the Whole, MP Ernest Lapointe asked the Minister of Health, “*What is cannabis sativa?*”, and the Minister replied “*Hitherto this was a drug which was not included in the list which might be used. It is one form of the drug used in India which, I believe, goes under the popular name of hashish. There is no objection to the use of it*”⁴⁰

In short, it is remarkable that, over seventy-five years later, we should still not know why cannabis was placed on the list of prohibited drugs. On the other hand, no shortage of “reasons” were found in the years that followed.

Under the influence of American media campaigns, which were taken up by Canadian newspapers, and of horrifying accounts by police officers about young Canadians who were physically and mentally destroyed after using cannabis, the attitude of federal parliamentarians towards the drug would become less and less tolerant. The 1938 Act, enacted one year after the passage of the *Marijuana Tax Act* in the United States, was the end result of this “new panic”. Section 3 of the Act prohibited anyone from growing cannabis or opium poppy without first having obtained a permit from the Department of Health. The penalties for this new offence were the same as those provided for trafficking in, and simple possession of, cannabis. This measure was unusual because Canada, for the first time, had climate conditions conducive to the growing and production of a drug, which it did not for the other drugs in the schedule. An analysis of parliamentary debates shows that the Department of Agriculture conducted scientific experiments on industrial hemp by growing cannabis at the Experimental Farm in Ottawa and at another research centre near Montreal. A number of entrepreneurs in Ontario were still growing hemp. The 1938 Act put an end to the practice.

Following the introduction of the Bill, Minister of Health Charles Power said in connection with section 3: “*The proposed amendments deal to a considerable extent with the attempt which is being made by the department to control what, though it cannot be called a new drug,*

³⁹ Giffen, P.J. et al., *op. cit.* page 179.

⁴⁰ Hansard, House of Commons, 1932, page 1792.

is a new menace to the youth of the country”.⁴¹ Later, he said that it was very dangerous to smoke marijuana cigarettes. To demonstrate his comment, he cited a report prepared by Harry J. Anslinger, the first commissioner of the *Federal Bureau of Narcotics*, in which the drug was described as, “the assassin of youth ... one of the greatest menaces which has ever struck that country.”⁴² The Minister of Health nevertheless said that the situation in Canada was not as serious as in the United States. The statements by the Minister of Health about the harmfulness of cannabis were not disputed by any members, even though no research was put forward in defence of the statements made.

The most important amendments to the schedule were made in 1932, following the enactment of the *Act to amend the Opium and Narcotic Drug Act, 1932*.⁴³ In the amendments, over 10 psychoactive substances were added to the schedule, both natural drugs (like coca leaf) and synthetic drugs. The inclusion of these substances coincided with the adoption in 1931 of the *Geneva Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*, with Colonel Sharman making a major contribution to the negotiations leading to the signing of the convention. It was also at this time that Canada had begun to play an active role internationally with respect to drugs in support of the efforts of the United States and Harry J. Anslinger to better control international drug trafficking, particularly in the producing countries.⁴⁴

During the debates on the enactment of the 1932 Act, which would implement the provisions of the 1931 Convention into Canadian law, no questions were asked of the Minister of Health, Murray McLaren, concerning the reasons leading the Minister to include the above-mentioned drugs in the schedule.

Amendment of penalties

The penalties for trafficking or illegal possession of narcotic drugs were amended several times during this period. Furthermore, other offences were created as trafficking techniques to get around the law became increasingly sophisticated. According to Giffen, there were several reasons why the authorities responsible for enforcing the Act wanted more flexibility:

*“Latitude in regard to penalties helped to overcome the reluctance of the courts to convict in cases of lesser culpability and respectable social status; such cases were inevitable in the early years when the addict population was still relatively heterogeneous. Moreover, popular support for the law was more likely to be maintained if sentences that were regarded as unjust by local people could be avoided.”*⁴⁵

⁴¹ Hansard, House of Commons, February 24, 1938, page 772.

⁴² Hansard, House of Commons, February 24, 1938, page 773.

⁴³ Statutes of Canada, 1932, c. 20

⁴⁴ Sinha, Jay (2001) *The History and Development of the Leading International Drug Control Conventions*, Ottawa: Library of Parliament, Law and Government Division, report prepared for the Senate Special Committee on Illegal Drugs, page 15. Available at www.parl.gc.ca/illegal-drugs.asp

⁴⁵ *Ibid.*, page 199.

This flexibility gave more options to the police and Crown attorneys allowing them to negotiate guilty pleas more easily, to decide on the type of proceeding or to make use of people who had been charged as informers or undercover agents by promising them a reduced sentence or the withdrawal of the charges. In some instances, it also allowed for minimum sentence thereby reducing the Court's discretion during sentencing. The increase in the severity of penalties also sent a clear message to judges about the severity and level of social reprobation for drug offences. The possibility of proceeding by summary conviction also reduced the time period between the arrest and the sentencing. This made it possible to significantly increase the number of convictions. This was particularly important, because the higher the number of convictions, the more the people would be able to see the extent of the problem and the effectiveness of the act.⁴⁶

The 1911 Act provided for a maximum sentence of imprisonment of one year and/or a maximum fine of \$500. In 1920, after the *Act to amend the Opium and Narcotic Drug Act, 1920*,⁴⁷ was passed, a minimum fine of \$200 was assessed with the maximum increased to \$1,000. In 1921, the *Act to amend the Opium and Narcotic Drug Act, 1921*,⁴⁸ significantly amended the penalty for this type of offence. Hybrid offences were created (summary conviction and indictment) for these two illegal activities. For an indictment, a maximum term of imprisonment of seven years could be imposed. For a proceeding by summary conviction, the maximum prison sentence was increased to 18 months, with the possibility of an additional 12 months for default of payment of any fine assessed by the Court. In 1922, the *Act to amend the Opium and Narcotic Drug Act, 1922*,⁴⁹ amended the sentence of imprisonment for a summary conviction by providing for the imposition of a minimum prison sentence of six months. In 1925, Parliament passed an amendment providing for the imposition, at the judge's discretion, of a sentence of forced labour for a summary conviction, for simple possession of a drug.

In 1921, an offence was created for the sale, gift or distribution of drugs by a trafficker to a minor. In such cases, one could only proceed by way of indictment and anyone convicted could receive a maximum prison sentence of seven years. Following a highly emotional debate, the sentence of whipping, which had been suggested by a Member, was withdrawn. However, the next year, while reviewing the 1922 Act in the Committee of the Whole, the same member once again suggested the imposition of a sentence of whipping for traffickers selling drugs to minors. At the end of the debate, the Minister of Health agreed to add the penalty of whipping to the Act. In 1929, federal parliamentarians stated their opinions about extending the punishment of whipping to trafficking and simple possession of drugs, as provided for in the *Act to amend and consolidate the Opium and Narcotic Drug Act, 1929*.⁵⁰

⁴⁶ *Ibid.*, pages 199-200

⁴⁷ Statutes of Canada, 1920, c. 31

⁴⁸ Statutes of Canada, 1921, c. 42

⁴⁹ Statutes of Canada, 1922, c. 22

⁵⁰ Statutes of Canada, c. 49.

Another important penalty was introduced in the 1922 Act: the deportation of immigrants. Section 5 of this statute provided that, except as may otherwise be provided in the *Immigration Act*, any immigrant convicted of trafficking, simple possession or selling drugs to a minor could be deported from Canada. From 1922 to 1944, when the last immigrants were deported for drug offences, over 1,082 Chinese (82%) were deported, compared to 163 Americans (13%) and 68 other persons of various ethnic origins (5%), for a total of 1,313 deportations. In 1930, the “panic” in British Columbia was a thing of the past, but during the previous eight years, over 638 Chinese had been deported by the Canadian authorities.⁵¹

There were other offences as well in the legislation, for example possession of pipes, lamps or any other equipment for the preparation or use of opium; drug trafficking by mail; and obtaining drugs by consulting two doctors. Between 1922 and 1930, 7,096 persons were convicted for an offence under the *Opium and Narcotic Drug Act*. Of these, over 4,900 were Chinese, or 69%.⁵²

Police powers

From 1920 to 1930, various amendments to the *Opium and Narcotic Drug Act* led to the police being granted new powers. These amendments specifically had to do with powers of search. Section 7 of the 1911 Act provided for the issuance of a search warrant authorizing police officers who had reasonable grounds to search the following kinds of premises: a dwelling-house, shop, boutique, warehouse, garden or ship, and to seize drugs found there as well as any containers in which the drugs had been found. Section 3 of the 1922 Act provided for the possibility of conducting a search for drugs without a warrant, either during the day or at night, in the above-mentioned premises. However, police officers were required to have a warrant to search a dwelling-house.

Section 8 of the 1911 Act provided that any drugs seized and the containers in which the drugs were found could be confiscated and delivered to the Court, and be destroyed after the accused’s conviction. However, section 9 imposed a number of conditions on the procedure provided under section 8. Indeed, if the person charged was acquitted, there was a three-month period during which the Court could be asked to issue an order to give back the seized drugs. If they were not claimed during this period, they were to be destroyed. The 1921 Act slightly amended these two provisions by specifying that henceforth, drugs and the containers in which they were found were to be confiscated and turned over to the Department of Health, which would dispose of them as it saw fit. This amendment was deemed necessary by the Narcotics Division because several judges, rather than order the destruction of the goods, sent them to hospitals. The Division was afraid that the drugs so returned might fall into the hands of traffickers.

⁵¹ Giffen, P.J. et al., *op. cit.*, page 596.

⁵² *Ibid.*, page 594.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

In 1923, the powers to search and the orders of forfeiture were extended to vehicles in which drugs were found. In 1929, this procedure was extended to all traffickers' vehicles, whether or not any such substances were found in them. The purpose of this was to impede the activities of traffickers and to prevent their vehicles from being used by other criminals after they were convicted. The procedure was later extended to aircraft. In 1925, Parliament, by enacting the *Act to amend the Opium and Narcotic Drug Act, 1925*,⁵³ authorized police officers to search any person found on the premises searched, with or without a warrant.

The 1929 Act granted special search powers to police officers. Section 22 of this statute allowed a writ of assistance to be issued to a police officer. This was a general power, without any restrictions of time or place, to remain valid throughout the career of the peace officer. Such a writ authorized its recipient to enter a dwelling-house at any time of the day or night accompanied by whatever persons were deemed necessary to conduct searches and seize drugs. The writ of assistance thus made it possible to get around the prohibition on searches and seizures of drugs in a dwelling-house without a warrant. At the same time, the Act was amended to authorize police officers, during searches or seizures, with or without a warrant, to use force if required to conduct a search and to be assisted by persons other than peace officers.

Criminal procedure

In the 1920s, another major amendment was introduced to facilitate convictions in drug cases, a reverse onus provision. The onus was now on the accused, not on Crown prosecutors, to prove that he had not committed the crime with which he was charged. Under British criminal law, the task of proving an accused's guilt traditionally falls on the Crown, hence the expression "presumed innocent until proven guilty".

Section 10 of the Act of 1911 provided that, in a prosecution for drug possession or trafficking (with the exception of importing and exporting), in order to be acquitted, the accused had to prove that he had a legitimate excuse or that he had used such substances for therapeutic or scientific purposes. When Parliament amended the Opium and Narcotic Drug Act in 1920 to provide a better framework for dealing with importing and exporting, the manufacture, sale and prescription by physicians of scheduled drugs by means of a permit, the procedure established in 1911 was amended to specify that, in order to be acquitted, the accused had to prove that he had had a permit duly issued by the Department of Health.

Section 1 of the Act of 1921 expanded the application of the reverse onus to include any person who possessed or occupied a place (dwelling, store, boutique, warehouse, garden or ship) where drugs had been found. According to the wording of the section, that person was deemed to possess such a substance if he was unable to prove that it had been in that place without his consent or that he did not know that the drug was there.

⁵³ Statutes of Canada, 1925, c. 20

The article also provided that this procedure would apply when a person was charged with trafficking in raw or prepared opium for smoking purposes without having first obtained a permit issued by federal authorities. In 1923, the *Act to Prohibit the Improper Use of Opium and Other Drugs* (Act of 1923)⁵⁴ extended application of the reverse onus to offences involving the import or export of drugs without a permit. In cases involving the prescription or administration of a scheduled substance for non-therapeutic purposes, a physician or pharmacist had to prove that that substance had been used solely for medical purposes.

The Act of 1923 also cancelled another fundamental legal guarantee, the right of appeal. Section 25 eliminated the right of appeal in summary conviction cases involving possession, drug trafficking without a permit or for the sale, gift or distribution of a drug to a minor, the latter being an indictable offence. Section 26 of the Act of 1929 expanded this procedure to include possession of or trafficking in a substance similar to a drug. This new procedure rendered moot the provision enacted in 1911 prohibiting any application for a writ of *certiorari*, and the Narcotics Division sought its removal from the act, which was actually done in 1929.⁵⁵

Two other important amendments were made to the *Opium and Narcotic Act* between 1920 and 1930 to provide for the admissibility of the certificate of a federal analyst and the application of the *Identification of Criminals Act* to summary conviction offences. Section 1 of the Act of 1921 had amended the legal procedure applicable in drug prosecutions by making the certificate of a federal analyst admissible in evidence with respect to one or more drugs seized by police officers. However, the courts were reluctant to accept the certificate because they could not authenticate the analyst's signature⁵⁶ or confirm his appointment. In 1929, an amendment was made to the *Opium and Narcotic Drug Act* (section 18) providing that the certificate would henceforth constitute *prima facie* evidence of the status of the person who gave or issued it. In this context, proof of that person's appointment or authentication of his signature was no longer necessary.

In 1923, the *Opium and Narcotic Drug Act* was amended to apply the provisions of the *Identification of Criminals Act* to persons convicted of an offence by way of summary conviction. Section 2 of that act permitted police officers to fingerprint, photograph and measure the accused solely in cases where they were indicted. That information constituted the accused's official "criminal record", which was kept in the national police records, with all the consequences that entailed for social, professional or family stigmatization. However, from the standpoint of the Narcotics Division, this amendment would prove beneficial since it would henceforth make it possible to establish files and more effectively monitor drug addicts convicted by way of summary conviction.

⁵⁴ *Statutes of Canada*, c. 22.

⁵⁵ P.J. Giffen *et al.*, *op. cit.*, page 261.

⁵⁶ *Ibid.*, pp. 278-279.

Control measures

The *Act to Amend the Opium and Narcotic Drug Act* (Act of 1920)⁵⁷ established a control system for the legal trade in narcotics through a system of permits issued to businesses, pharmacists and physicians by the Department of Health in order to regulate Canada's supply of drugs for medical or scientific purposes. The Act provided for: a prohibition against importing or exporting drugs at a port not designated for that purpose by federal authorities; the issue of permits for the import, export, manufacture, sale and distribution of drugs; the imposition of criteria regarding packaging and labelling of packages containing such substances; an obligation for businesses to keep a record of their drug importing, exporting, manufacturing, sale and distribution activities duly authorized by federal authorities; an obligation for physicians to provide the information requested by federal authorities concerning the purchase, manufacture or prescription of medications containing drugs; an obligation for pharmacists to keep a record of their purchases and sales of drugs, the preparation of their own medications containing such substances and renewals of prescriptions signed by a physician;⁵⁸ and the authorization to sell medications (such as ointments and liniments) containing very small quantities of scheduled drugs without a permit, provided they were not administered to children under two years of age and met certain labelling criteria.

Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954

In 1954, Parliament passed the *Act to Amend the Opium and Narcotic Drug Act* (Act of 1954),⁵⁹ repealing offences relating to opium use and the possession of equipment intended for that purpose, the sale of drugs to a minor and drug trafficking through the mail. It also made two other significant amendments to the act.

Under the impetus of R.E. Curran, Deputy Minister of Health, it now included a definition of the offence of drug trafficking in order to make the act more comprehensible and increased the maximum prison term for that offence from seven to 14 years. The minimum prison term of six months and the fine were repealed. Henceforth, this offence could only be prosecuted by way of indictment. However, a person convicted of the offence was still liable to whipping and deportation.⁶⁰

⁵⁷ *Statutes of Canada*, 1920, c. 31.

⁵⁸ This provision was added to the Act of 1911. In the years that followed, the criteria for renewing prescriptions issued by physicians were restricted so that the legal trade in narcotics could be monitored and drug addicts prevented from obtaining prescriptions and using the drugs thus obtained for trafficking purposes. For example, the Act of 1921 provided that a pharmacist could not fill or refill a prescription unless it had been signed by a physician. The Act of 1923 went further by prohibiting multiple refills of prescriptions of a drug based on the original prescription. The patient thus had to consult a doctor each time he wanted to renew.

⁵⁹ *Statutes of Canada*, 1954, c. 38.

⁶⁰ The provisions respecting the deportation of immigrants were transferred to the Immigration Act in 1952 but still applied to drug offences.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Subsection 4(3) of the Act of 1954 created the offence of possession for the purpose of trafficking, for which the new penalties provided for drug trafficking applied. This new offence would mean that those possessing large quantities of narcotic drugs would no longer be convicted for simple possession. As we have seen, a reverse onus was part of Canada's drug legislation from 1911 to 1929. In 1954, subsection 4(4) added a new criminal procedure to facilitate convictions for possession of drugs for the purpose of trafficking.

Thus, in every criminal prosecution for this offence, Crown prosecutors first had to prove that the accused was illegally in possession of the drug. The defendant then had to prove that he had not possessed the substance for the purpose of trafficking. If he succeeded, he was found guilty of possession; otherwise he was convicted of trafficking. In this specific case, Canadian courts established a distinction between the so-called secondary burden, which is to prove a specific fact (in this case the intention to traffic) and the primary burden (illegal possession), which consists in proving that fact where all the evidence is adduced. Thus the Crown prosecutor had the primary burden of establishing that an offence was indeed committed. In this particular case, however, the Crown did not have to prove that the accused intended to engage in trafficking. Proof of illegal possession was sufficient for the court to conclude that there was an intention to traffic.

This amendment was enacted in response to the recommendation by the RCMP and the Narcotics Office (former Narcotics Division) since, failing an admission by the accused, it was very difficult to prove the intention to traffic. However, this new procedure considerably undermined the rights of the accused, particularly since the act did not specify the quantity of drugs necessary to determine whether the accused had actually possessed it for the purpose of trafficking. The accused was thus guilty of trafficking in the absence of evidence to the contrary.⁶¹

Senate report of 1955

On February 24, 1955, the Senate passed a motion creating a Special Committee of the Senate on the Traffic in Narcotic Drugs in Canada following the motion made a few weeks earlier by Senator Thomas Reid. At that time, Senator Reid had asked the Senate government leader, W. Ross MacDonald, whether the federal government intended to create such a committee since, based on his information, the traffic in opium and other narcotics in the City of Vancouver was beyond the control of police authorities. In debate on the motion, Senator MacDonald accurately summed up the task before the members of the Senate Special Committee as follows:

The work of the committee will largely be to consider the causes of this unfortunate problem with which this country is faced, to hear expert witnesses and to determine in what way the Government can make

⁶¹ Giffen, P.J. *et al.*, *op. cit.*, pages 448-450.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*its most valuable contribution in resolving this unfortunate condition. The reports of this committee, based upon an objective, cautious and factual assessment of the problem, may well become a document of the utmost importance and have far-reaching consequences in helping to found policy upon which the successful solution of this problem can rest.*⁶²

Upon adoption of the motion, Senator Reid was appointed chairman of the Committee. From March 25 to June 17, 1955, the committee organized public hearings in Ottawa and was the first to travel outside the capital, holding meetings in Montreal, Toronto and Vancouver. In addition to specialists, public servants and police officers, the senators also met a group of 150 people suffering from a drug dependency at Oakalla Prison in Vancouver to gain a better understanding of the reasons leading them to use drugs. The Committee heard 52 witnesses: 13 from law enforcement agencies, 10 from the various federal departments concerned by the fight against drug trafficking and 12 addiction treatment specialists. On June 23, 1955, Senator Reid tabled the Committee's report containing a series of recommendations for the treatment of people suffering from a drug dependency and the fight against the traffic in narcotic drugs.

According to the report, the figures provided by the Department of Health revealed that there were 515 “medical addicts” in Canada, that is to say individuals who had become dependent on a drug as a result of treatment for a disease, 333 “professional addicts” (doctors, pharmacists and so on) and 2,364 “criminal addicts”, for a total of 3,212. Of the persons belonging to the last category, 1,101 were located in Vancouver.⁶³ Only 26 of the 2,364 “criminal addicts” were under 20 years of age.

To establish a relationship between crime and drug dependency and to explain the difficulties in establishing treatment programs, the Committee cited a study conducted by the RCMP noting that, of 2,009 “criminal addicts”, 341 had first been convicted of an offence under the *Opium and Narcotic Drug Act*, 1,220 had first been convicted for other crimes and 478 had already had a criminal record. Thus, 1,668 of the total 2,009 “drug addicts” were criminals, which was sufficient in the Committee's view to confirm the thesis of the “criminal” or “contaminating” user.⁶⁴ It was therefore clear that drug addiction was not a disease. In the Committee's view, most “addicts” came from disadvantaged backgrounds in which crime and family problems were omnipresent.

The evidence of medical authorities was to the effect that drug addiction is not a disease in itself. It is a symptom or manifestation of character weaknesses or personality defects in the individual. The addict is usually an emotionally insecure and unstable person who derives support from narcotic drugs. The Committee was gravely concerned to learn that relatively few cases could be authenticated where drug addicts, while out of custody, had been successful in abstaining from the use of drugs for any lengthy

⁶² *Hansard*, Senate, February 24, 1955, page 239.

⁶³ *Hansard*, Senate, June 23, 1955, page 739.

⁶⁴ *Hansard*, Senate, June 23, 1955, p. 739.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*period of time. The complications and difficulties in the successful treatment of drug addiction, having regard to the pattern of development of the addict and his almost invariable criminal tendencies, cannot be too heavily stressed.*⁶⁵

In the circumstances, the Committee unanimously rejected the idea of creating government clinics which, on certain conditions, would provide “criminal addicts” with ambulatory treatment. The Committee moreover emphasized that a resolution adopted at the time at the tenth annual session of the United Nations Narcotic Drug Commission, stated that this form of treatment was not advisable.⁶⁶ It also rejected the United Kingdom's model after confirming, with the aid of British specialists, that doctors should not encourage drug addicts to persist in their addiction if they could not, even after lengthy treatment involving gradual reduction of the prescribed doses abstain from drugs. On this point, the report states: “[...] *dangerous (narcotic) drugs in the United Kingdom are subject to a wide degree of control of the exacting standards demanded by the international agreements to which the United Kingdom, in common with Canada, is a party.*”⁶⁷

Considering that “addicts” were “basically criminals who daily violate the *Opium and Narcotic Drug Act*”, the Committee argued that municipal and police authorities, more particularly those of Vancouver, should more effectively invoke the provisions of the *Criminal Code* dealing with theft, vagrancy and prostitution. Citing the testimony of Harry J. Anslinger before a U.S. Congress committee, the Committee stated that such an initiative would solve much of the problem caused by drug addiction. Second, it noted that “*the evidence of many witnesses recommended the compulsory segregation and isolation of all addicts for long periods of time for the purpose of treatment and possible rehabilitation.*”⁶⁸

Thus, to prevent this “scourge” from spreading in the penitentiaries and to cure “criminal addicts” convicted of crimes, the Committee suggested that “*the penitentiary authorities might give further consideration to the particular problems presented by criminal addicts in terms of segregation, treatment including specialized training and rehabilitation and other measures necessary in view of the special problems which addiction superimposes.*”⁶⁹ In fact, as Minister of Health, Paul Martin had done a year earlier, the Committee instead emphasized the limits of federal jurisdiction and the efforts the provinces should devote to the treatment of “drug addicts” who had not been convicted of a crime. Still advocating the segregation of these individuals, the Committee indicated that the federal government wanted to make available to British Columbia the federal William Head quarantine station on Vancouver Island so that it could transform it into a treatment centre similar to that in Lexington, Kentucky. It further proposed the creation of a national health program to provide financial support for provincial drug addiction initiatives.

⁶⁵ *Hansard, Senate, June 23, 1955, p. 742.*

⁶⁶ *Hansard, Senate, June 23, 1955, p. 740.*

⁶⁷ *Hansard, Senate, June 23, 1955, p. 740.*

⁶⁸ *Hansard, Senate, June 23, 1955, p. 744.*

⁶⁹ *Hansard, Senate, June 23, 1955, p. 745.*

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

The Committee also encouraged the creation of groups similar to Alcoholics Anonymous, but rejected the idea of national education campaigns for the general public and teenagers on the ground that “*such programs should not be used where they would arouse undue curiosity on the part of impressionable persons or those of tender years*”.⁷⁰ The Committee supported the position of the UN Narcotic Drug Commission, recommending instead that a “mental health” program be established to detect behaviour in the schools that might lead to drug addiction.

Since treatment programs could not cure all “drug addicts”, the Committee also proposed that certain measures be adopted to fight illegal trafficking in narcotics. It thus recommended:

- that a separate offence be created for the illegal importing/exporting of narcotic drugs in order to put an end to drug smuggling;
- that a maximum prison term be imposed of up to 25 years (life) for that new offence;
- that the maximum prison term be increased from 14 to 25 years for trafficking offences; and
- that it be possible to establish proof of a conspiracy in order to facilitate the conviction of the leaders of criminal organizations not directly involved in the sale of narcotics but which benefit therefrom.

In the Committee’s view, the severity of these penalties would “*act as an effective deterrent to an individual in smuggling drugs into Canada for the profit of a ‘higher up.’*”⁷¹ Rather than waste police and court resources in trying to convict organized crime leaders who were the cause of the problem, an attempt had to be made to eliminate the “trafficker-distributors” in the neighbourhoods of the large cities and the problem would be solved.

Although the Committee's proposals were much more conservative than those advanced in the debates preceding its establishment, contrary to a number of other reports by parliamentary committees or royal commissions of inquiry, most of its recommendations would be followed by federal authorities. First, it contributed to a number of research projects in British Columbia and Ontario in 1956. And second, the Senate Committee’s report was at the origin of most of the new provisions of the *Narcotic Control Act*, which was passed in 1961 to replace the *Opium and Narcotic Drug Act*.

⁷⁰ *Hansard, Senate*, June 23, 1955, page 741.

⁷¹ *Hansard, Senate*, June 23, 1955, page 746.

FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS

The period following World War II witnessed new attitudes toward narcotic drug control that would call into question the approach adopted by Canada since 1908 in fighting the abuse of and trafficking in narcotic drugs. The international human rights movement, the creation of organizations dedicated to the defence of civil liberties, the gradual democratization of access to universities, the appearance and development of new disciplines in the social sciences such as criminology, psychology, sociology, political science and the sociology of law, scientific progress and research into drug addiction were factors in the creation of new pressure groups consisting of more articulate individuals who disputed the use of criminal law as a “miracle” solution in responding to drug problems. However, it was not until the explosive increase in drug use in the 1960s, the hippie protest movement and the work of the Le Dain Commission that these demands materialized.

Narcotic Control Act (1961)

Passage of the *Narcotic Control Act* (Act of 1961)⁷² coincided with the coming into force of the *Single Convention on Narcotic Drugs* of 1953, which played an important role in the creation of the modern international narcotic drug control system, an extension and expansion of the international legal infrastructure developed between 1909 and 1953. Work to group together the nine multilateral treaties signed during that period into a single international enactment began in 1948, and Canada played a significant role in the negotiations and drafting that led to its adoption.

While the Act retains most of the criminal procedures and offences established over the previous years, two amendments formed the subject of major parliamentary debate: the creation of an offence for illegal importing or exporting of narcotics and the increase in penalties for the offence of trafficking, and the treatment of drug addicts?. The minimum prison term of six months for simple possession was repealed, as was the procedure that provided that the *Identification of Criminals Act* would apply in the case of a summary conviction and the provision eliminating the right of appeal for certain offences.

The Act of 1961 was divided into two parts: the first, entitled “Offences and Enforcement”, was placed under the authority of the Minister of Health, and the second, “Preventive Detention and Detention for Treatment”, was to be administered by the Minister of Justice.

As the Senate Committee had recommended, section 5 of the Act of 1961 created the offence of importing and exporting narcotic drugs. Whoever was convicted of that offence (solely by way of indictment) was liable to a minimum prison term of seven years to a maximum of 25 years. That provision was designed to combat drug

⁷² *Statutes of Canada*, 1961, c. 35.

smuggling between the United States and Canada and to comply with the international undertakings Canada had made in ratifying the Single Convention.⁷³

In accordance with another recommendation from the Senate Committee report, section 4 of the Act of 1961 raised the maximum prison term for trafficking in narcotic drugs from 14 to 25 years. The provision for whipping was also repealed. These amendments also applied to the penalty provided for possession for the purposes of trafficking.

Part II of the Act, which comprised sections 15 to 19, defined the new federal policy regarding preventive detention and detention for treatment. First, the courts henceforth had the power to order that an individual convicted of trafficking, possession for the purpose of trafficking or importing/exporting drugs, and only if the accused had previously been convicted of similar offences, be placed in preventive detention for an indeterminate period of time. This measure replaced any other sentence which might have been imposed. Second, when a person was charged with simple possession, possession for the purpose of trafficking, trafficking or import/export, the court, at the request of Crown counsel or the accused, could order the accused detained for examination purposes to determine whether he was eligible for a drug addiction treatment program. If that was the case, the accused had to be sentenced to detention for treatment at a specialized federal institution for an indeterminate period of time in lieu of any other sentence provided for under the act. For a first offence, preventive detention could not exceed 10 years. The individual had a right of appeal, was subject to the *Parole Act* and could be referred to preventive detention at any time if he used drugs during his probation period.

Lastly, the Act of 1961 provided that, if a province adopted a preventive detention policy combined with a drug addiction treatment program (in cases not involving an offence under the act), the federal government could enter into an agreement with the competent authorities of that province to transfer drug addicts to the specialized federal institutions. These new provisions in fact enacted the Senate Committee's proposals.

Despite the intervention of two ministers, this treatment policy, based on a penal approach and, to a certain degree, oriented toward repression of the “contaminating user” or “criminal user”, failed to stir up interest among parliamentarians. The measures were passed without opposition but, for reasons that remain unclear, were never proclaimed. The Le Dain Commission moreover questioned this decision by the federal government: “*Whether this is because of doubts about the constitutional validity of these provisions or the failure to develop suitable treatment methods and facilities or later reservations by the government as to the advisability of compulsory treatment in principle, or some combination of these, it's not clear.*”⁷⁴

⁷³ Hansard, House of Commons, June 7, 1961, page 6794.

⁷⁴ G. Le Dain et al., *Cannabis: Report of the Commission of Inquiry into the Non-Medical Use of Drugs*. Ottawa: Government of Canada, page 221.

Another provision of the Act of 1961, but not the least, was passed by Parliament without debate: the schedule. The Single Convention of 1961 contained a series of schedules prepared by the World Health Organization containing the list of drugs subject to rigorous control for the purpose of preventing them from being used for other than medical or scientific purposes. Most were on the schedule to the Act of 1961, which now comprised more than 92 drugs and their derivatives, spread over 14 major classes (opium, cannabis, coca, phenypipedridine, and so on). No member of Parliament questioned the Minister of Health to determine the criteria or reasons advanced by his department for subjecting such a large number of substances to the restrictive provisions of the act.

An Act respecting Food and Drugs and Barbiturates (1961)

In the early 1960s, the use of drugs not included in the schedule to the *Opium and Narcotic Drug Act*, or, later, in the *Narcotic Control Act*, began to concern medical and government authorities. These drugs were barbituric acids or “goof balls”, amphetamines, methamphetamines and the salts and derivatives of those three substances. These so-called psychotropic drugs could be used to reduce stress, eliminate insomnia, stimulate muscle and brain activity and eliminate appetite.

When physicians and other health professionals began to notice the number of barbiturate dependence cases and the serious secondary effects of those drugs in the 1950s, they asked the government to regulate their distribution and use more effectively. In addition, in 1957, following a Health Department survey of 2,500 pharmacies, more than 300 pharmacists were convicted for failing to comply with regulations respecting the prescription of barbiturates and amphetamines. This time, it should be pointed out, the position of health professionals had more influence on government authorities than the positions of police officers or the Narcotic Control Office. These substances were included in the *Food and Drugs Act* as “controlled drugs” and not in the *Narcotic Control Act*, for two reasons. First, certain harsh provisions of the Act of 1961 were coming under increasing criticism. Second, the use of those substances in a number of prescription medications meant that their use was widespread among the general public, particularly among persons holding good jobs, which ultimately was quite different from the unflattering picture hitherto painted of “drug addicts”. In the circumstances, having recourse to the provisions of the Act of 1961 was out of the question.⁷⁵

In 1961, Parliament thus passed the *Act to Amend the Food and Drugs Act* (Food and Drugs Act of 1961)⁷⁶ to better regulate the trade in barbiturates and amphetamines. The new act created Part III concerning the “controlled drugs” listed in Schedule G. It also created the offence of trafficking or possession for the purpose of trafficking, for

⁷⁵ P.J. Giffen *et al.*, *op. cit.*, pages 471-475.

⁷⁶ *Statutes of Canada*, 1961, c. 37.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

which an accused was liable to a maximum prison term of 10 years, if convicted by way of indictment, or 18 months by summary conviction. However, simple possession of the substances was not illegal. Furthermore, unlike the *Narcotic Control Act*, the definition of trafficking excluded the distribution or giving of a controlled drug, but included the offences of importing and exporting.

In the case of criminal procedures applicable in a trial, a number of aspects were retained from the Act of 1961, such as the procedure concerning the reverse onus in a prosecution for possession for the purpose of trafficking, the use of a certificate from a federal analyst to confirm the nature of the drug, search and seizure writs of assistance, and the forfeiture and restitution of seized substances.

Lastly, Schedule G of the Act included three drugs: amphetamines, barbituric acids and methamphetamines, as well as the salts and derivatives of those drugs. During the debates, one member asked why other similar substances were not included in the schedule. The Minister of Health answered that, based on scientific research, only those three drugs were considered dangerous to human health.⁷⁷ Furthermore, as had been the case with the *Opium and Narcotic Drug Act* and the new *Narcotic Control Act*, the Governor in Council could make regulations upon recommendation by the Minister of Health, and where the public interest warranted it, to amend the schedule.⁷⁸

Food and Drugs Act and hallucinogenics (1969)

In 1969, Parliament extended the application of legislative and bureaucratic controls to hallucinogenic drugs by passing the *Act to Amend the Food and Drugs Act* (Food and Drugs Act of 1969).⁷⁹ That enactment created Part IV, which was to govern the use of and trade in “restricted drugs” enumerated in the new Schedule J. Those drugs were lysergic acid diethylamide (LSD), N-Diethyltryptamine (DET) and Methyl-2,5-dimethoxyamphetamine (STP).

To better control the use of and trade in hallucinogenic drugs, the act provided for the same offences and procedures as those applying to barbiturates. It also created an offence of possession in order to deter anyone from using such drugs. In that instance, an accused was liable, on summary conviction, to a maximum prison term of three years and a fine of \$5,000.⁸⁰ If found guilty of a first offence, on summary conviction, an accused was liable to a prison term of up to six months or a maximum fine of \$1,000. For subsequent convictions, the act provided for a maximum prison term of one year or a fine of \$2,000.

Narcotic Control Act and the offence of possession of cannabis

In the parliamentary debates on the Food and Drugs Act of 1969, the Minister of Health moved a very important amendment to the *Narcotic Control Act*. From 1921 until

⁷⁷ Hansard, House of Commons, May 30, 1961, page 5799.

⁷⁸ Subsection 37(2) of the *Food and Drugs Act, 1961*.

⁷⁹ *Statutes of Canada*, c. 41.

⁸⁰ Section 9 of the *Food and Drugs Act, 1969*.

the *Narcotic Control Act* was passed, Canadian legislation had provided for a hybrid offence in the case of simple possession of a drug. Since 1961, however, that offence was solely an indictable offence punishable by a prison term of up to seven years. The amendment proposed in 1969 maintained the offence, but again offered the option of proceeding by way of summary conviction, thus recreating a hybrid offence. In the case of a first offence in which an accused was found guilty on summary conviction, the Act provided for a maximum prison term of six months or a fine of up to \$1,000, and a term of up to one year and a fine of \$2,000 for subsequent offences. The amendment was considered necessary by the Minister of Health since the number of prosecutions for cannabis possession had increased from 493 in 1966 to 1,727 in 1969.⁸¹ In his view

*[...] in spite of the enormous variety of individual situations involved in that number of cases, the relevant section of that act provides very little scope for flexibility, either on the part of the Crown prosecutors or presiding judges or magistrates. There is no provision for the Crown to choose to proceed summarily. [...] This rigidity has been the subject of increasing criticism from a wide variety of sources such as the addiction research agencies of several provinces.*⁸²

Lastly, the Food and Drugs Act of 1969 amended the procedure adopted in 1929 providing for the admissibility of a certificate from a federal analyst at trial for an offence involving a scheduled drug under the *Narcotic Control Act* or a Schedule G or J drug under the *Food and Drugs Act*. Crown prosecutors would henceforth be permitted to prove orally, under oath, by affidavit or solemn declaration, the status of the signatory of the certificate, who thus no longer had to appear in court. However, a judge could require the analyst to appear before him for examination or cross-examination to better assess the information contained in the affidavit or solemn declaration. The amendment was designed to ensure greater respect for the fundamental rights of the accused.

The Le Dain Commission (1969-1973)

When parliamentarians were examining the provisions of the *Food and Drugs Act* in 1969, they asked that a special committee be struck to look into the issue of drug use in Canada, particularly the use of cannabis. On May 29, 1969, the Liberal government headed by Pierre Elliott Trudeau passed Order-in-Council P.C. 1969-1112, establishing the Commission of Inquiry into the Non-Medical Use of Drugs, more commonly known as the Le Dain Commission. One of the reasons put forward to justify its creation was:

That notwithstanding these measures and the competent enforcement thereof by the R.C.M. Police and other enforcement bodies, the incidence of possession and use of these substances for non-medical purposes

⁸¹ *Hansard*, House of Commons, March 27, 1969, page 7203.

⁸² *Hansard*, House of Commons, March 27, 1969, page 7203.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*has increased and the need for an investigation as to the cause of such increasing use has become imperative.*⁸³

The Commission's activities and reports

The Commission carried out its activities from mid-October 1969 until December 14, 1973, when its final report was tabled. During this period, it heard from 639 groups and individuals: 295 organizations presented briefs and 43 appeared before the members of the Commission; 212 individuals made submissions and 89 gave oral presentations. In total, the Commission held public hearings in 27 cities, including Ottawa and the ten provincial capitals, travelling some 50,000 miles around the country. During its term, the Commission published four reports: an interim report (1970), a special report on cannabis (1972), a report on treatment (1972) and a final report (1973). In addition to its Chairman, Gerald Le Dain, the Commission comprised four members: Ian L Campbell, Heinz Lehman, Peter Stein and Marie-Andrée Bertrand.

Before reviewing the Commission's recommendations in relation to cannabis, it is worthwhile to look into four aspects of the Commission's work that Dr. Marie-Andrée Bertrand brought up at a hearing of our Committee.

The first relates to the Commission's mandate, which was "extremely generous and broad." She presented it thus:

(a) to marshal from available sources, both in Canada and abroad, data and information comprising the present fund of knowledge concerning the non-medical use of sedative, stimulant, tranquillizing, hallucinogenic and other psycho tropic drugs and substances;

(b) to report on the current state of medical knowledge respecting the effect of the drugs...;

(c) to inquire into and report on the motivation underlying the non-medical use referred to in (a);

(d) to inquire into and report on the social, economic, educational and philosophical factors relating to the use for non-medical purposes... in particular, on the extent of the phenomenon, the social factors that have led to it, the age groups involved, and problems of communications; and

(e) to inquire into and recommend with respect to the ways or means by which the Federal Government can act, alone or in its relation with Government at other levels, in the reduction of the dimensions of the problems involved in such use.

Because the mandate was so broad, commissioners and the Commission's personnel got involved in a vast project which, in my opinion, had a great deal of impact on Canadian society. I am convinced that even though it had no influence at all on criminal legislation, the Le Dain Commission brought about a

⁸³ Le Dain, G., et al., (1973) *Canadian Government Commission of Inquiry into the Non-Medical Use of Drugs*, Ottawa: Government of Canada, page 4.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*considerable change in the mentalities of Canadians, as it raised, for instance, awareness about the effects of traditional drugs.*⁸⁴

Second, the method used by the Commission to seek the opinions of Canadians. After mentioning the Commission's travel, she recalled that the public hearings gave the public an opportunity to ask questions and to confront the experts.

*Thus, we raised a wide national debate on the factors whereby Canadian society . . . can, frequently resort to psychotropic substances to alleviate some of its suffering. In my opinion, the generosity of the mandate, the method of consultation, the style and attitude of the commissioners - and more specifically those of the Commission's chairman - brought about an effervescence of ideas about democracy, about how the State functions, and about the feeling of alienation that many Canadians felt and still feel vis-à-vis their national, provincial or municipal government.*⁸⁵

Third, the Commission's research mandate. Dr. Bertrand stated that the Le Dain Commission, at the height of its mandate, employed 100 persons, 30 of whom were full-time researchers. These researchers basically worked on four targets: (1) the effects of the drugs – and especially of cannabis, (2) drug use, (3) treatment problems, and (4) the influence of the media on the phenomenon.

Fourth, the Commission's impact. Dr. Bertrand believes that the democratic debate kicked off by the Commission had significant impact on knowledge about drugs. Many people came to understand that stereotypes of drug users as criminals were just that—stereotypes. The Commission also kicked off a deep debate about the factors pushing people to take drugs and increased awareness of these issues. What became apparent very quickly after the Commission started its work was Canadians' feeling of alienation from Canadian politicians and lawmakers, and the frustration that ordinary people are not listened to in this country.

The special report on cannabis

Before presenting their recommendations in connection with a new public policy on cannabis, the Commissioners made a number of observations about Canadian cannabis legislation.

- ❖ The decision to criminalize cannabis was made “*without any apparent scientific basis nor even any real sense of social urgency [.]*”⁸⁶
- ❖ The reversal of the evidentiary burden of proof for an offence of possession for the purpose of trafficking places a very heavy burden on the accused – significantly

⁸⁴ Dr. Marie-Andrée Bertrand, Professor Emeritus of Criminology, Université de Montréal, Evidence presented to the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001, page 45.

⁸⁵ *Ibid.*, page 46.

⁸⁶ Le Dain, G. *et al.*, (1972) *Cannabis: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs*, Ottawa: Government of Canada, page 230.

weakening the principle of the presumption of innocence – since he must prove that he did not intend to traffic by a preponderance of evidence, not just by raising a reasonable doubt in the mind of the judge or jury.

- ❖ Law enforcement is made very difficult by the very nature of the offences that take place secretly and often on a consensual basis, and extraordinary methods of law enforcement must be used. However, “*the combined effect of their use in connection with [drug] laws has been one of the chief causes of concern about the impact of the criminal law in this field.*”⁸⁷
- ❖ RCMP officers and officers in the provincial or municipal police services do not have the necessary financial, human or technical resources to curb narcotics trafficking as well as dealing with simple possession offences. All too often, possession cases are discovered accidentally in the course of other police investigations or surveillance activities over several months, resulting in a discriminatory application of the law.
- ❖ The decision as to whether to proceed by indictment or summary conviction varies considerably from one area to another of the country, and is influenced by the number of ongoing cases involving narcotics and the significant discretion exerted by crown attorneys. This inequitable application of the law can have extremely serious consequences on a defendant’s future, particularly if a criminal record is the outcome.⁸⁸
- ❖ Sentencing practices in drug cases are characterized by a wide disparity across Canada because of individual judges’ perceptions about drug addiction, and their relative experience in criminal law and with cases involving simple possession or drug trafficking. According to the Commission’s research, judges with greater experience in these types of cases handed down more lenient sentences. For example, sentences for simple possession involved fines or probation when a defendant did not have a criminal record, and, in trafficking cases, imprisonment of less than two years;⁸⁹ and
- ❖ From 1968 to 1971, the proportion of fines imposed for simple possession of cannabis increased from 1 % of all dispositions to more than 77 %.⁹⁰

While the Commissioners agreed with these observations, their conclusions and recommendations were not unanimous.

The majority opinion – the recommendations of Gerald Le Dain, Heinz Lehman and Peter Stein

In order to explain the underlying reasons for their recommendations, the majority based their conclusions on the concept of harm, considering this the most

⁸⁷ *Ibid.*, page 239.

⁸⁸ *Ibid.*, page 245.

⁸⁹ *Ibid.*, pages 248-249.

⁹⁰ *Ibid.*, page 249.

useful criterion for laying down a new social policy for cannabis. This principle is associated both with the harm caused to an individual who uses a harmful substance, particularly his physical or mental health, and with the harm the individual causes to society, i.e. the impact on his family and colleagues. The concept of harm was of significance to the majority, since it made it possible to assess whether society should be concerned about the adverse effects of cannabis on human health and on society and, if such were the case, to what extent should criminal law apply in order to reduce those adverse effects. Should one criminalize simple possession of cannabis or only trafficking? Should measures such as decriminalisation or legalization be considered?

Initially, the majority wanted to eliminate some of the myths about the danger of cannabis:

*The evidence of the potential for harm of cannabis is far from complete and far from conclusive. It is possible to find some fault with the methodology or the chain of reasoning in virtually all of the evidence. [...] On the whole, the physical and mental effects of cannabis, at the levels of use presently attained in North America, would appear to be much less serious than those which may result from excessive use of alcohol. However, there has not been sufficient experience with long-term, excessive use of cannabis under North American conditions to justify firm and final conclusions.*⁹¹

Regarding the amotivational syndrome, the Commission said it did not have conclusive data about personality change.

*Some observers have spoken of apathy and a loss of goals, an absorption in the present with little or no thought for the future. All of these symptoms might be equally associated with a profound change of values and outlook which many might regard as salutary.⁹² In our opinion, these concerns justify a social policy designed to discourage the use of cannabis as much as possible, particularly among adolescents.*⁹³

The Commission did not have specific and conclusive scientific data to identify the harmful or beneficial effects of cannabis. On the other hand, while it believed that the dangers of cannabis (particularly those involving operation of a motor vehicle, poly-drug use, long-term mental deterioration and disorder, and criminality) were exaggerated, the Commission recognized that cannabis, like all other drugs, can have particularly harmful effects when it is used along with other drugs and that its use by adolescents could have a harmful effect on their maturation. The majority of members explained that, even if the use of cannabis is not a threat to the foundations of Canadian society or to our system of values based, for example, on a productive life, this element could not be excluded from the formulation of a new policy on cannabis.

⁹¹ *Ibid.*, pages 266-267.

⁹² *Ibid.*, page 270.

⁹³ *Ibid.*, page 274.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Secondly, since, in addition to health problems, cannabis use entails significant costs to the family, to society and to the economy, the majority justified the use of the criminal law, stating:

*In our opinion, the state has a responsibility to restrict the availability of harmful substances-and in particular to prevent the exposure of the young to them-and that such restriction is a proper object of the criminal law [...] where, in its opinion, the potential for harm appears to call for such a policy.*⁹⁴

For this reason, the majority rejected a public policy model based on legalization of the use and distribution. Even if legalization would have had the benefit of better controlling supply and quality, without a considerable increase in the number of long-term users, it could have led to some users moving on to hashish, with its higher concentration of THC, or encouraged users to smoke more marijuana or other cannabis products in order to obtain the desired psychoactive effect, and this would have cancelled out the effectiveness of control measures and increased the likelihood of abuse.⁹⁵

Therefore, the majority recommended maintaining the offences of cannabis trafficking, of possession of cannabis for the purpose of trafficking, and importing and exporting cannabis. However, it adopted a much more liberal position with regard to controlling the demand:

*The criminal law should not be used for the enforcement of morality without regard to potential for harm. [...] If we admit the right of society to use the criminal law to restrict the availability of harmful substances in order to protect individuals (particularly young people) and society from resultant harm, it does not necessarily follow that the criminal law should be applied against the user as well as the distributor of such substances.*⁹⁶

In this context, the majority felt it was necessary to amend the Narcotic Control Act, because “we do not believe that a change in the law need have an adverse effect on a proper appreciation of the caution with which we believe cannabis should be treated.”⁹⁷ It was necessary to restore Canadians’ confidence in and respect for the cannabis policy by reclassifying the drugs listed in the appendix to the Act, particularly cannabis. The majority opinion was based on the fact that:

While the Single Convention groups cannabis with the opiate narcotics it does not insist that it be given identical treatment in the law of the member states. The Single Convention has certainly been responsible for reinforcing the erroneous impression that cannabis is to be assimilated to the opiate narcotics but it does not prevent domestic legislation from correcting this impression. Because the present classification and legislative treatment of cannabis is so generally recognized to be erroneous and indefensible, any change in

⁹⁴ *Ibid.*, page 281.

⁹⁵ *Ibid.*, pages 283-286.

⁹⁶ *Ibid.*, page 282.

⁹⁷ *Ibid.*, page 291.

*it which corresponded more closely to the facts could be expected to command much more respect and careful attention [to the law].*⁹⁸

Restoring Canadians' confidence in the *Narcotic Control Act* also involved a comprehensive review of criminal penalties relating to cannabis. To justify this view, the majority pointed out that the harm caused by the criminal law, particularly on mere users, was more serious than the harm to their health and their environment caused by using the drug. In its analysis, the majority focussed on the consequences of sentences on young people, since over 85% of those convicted for cannabis possession or trafficking in 1970 and 1971 were under the age of 25.

A criminal record could have serious consequences for the future of young people, limiting the right to travel, and because of the family, social or professional stigma it caused. The majority were of the view that the possibility of obtaining a pardon is not sufficient to resolve this situation, since: "*the knowledge which a lot of people invariably possess of a conviction and the knowledge which can be obtained by interested parties through careful investigation cannot be eliminated.*"⁹⁹ In fact, the *Criminal Records Act* provides only for removing information about the criminal record stored in national police files following a pardon, but not information in police investigation reports, or in legal documents stored in the law courts about the trial and the sentence, let alone newspaper articles.

Moreover, the majority of members deplored the extreme severity of sentences for cannabis use, stating, "*they are out of all proportion to the harm which could possibly be caused by cannabis. Moreover, they are excessive by comparison with those of most other nations.*"¹⁰⁰ It disapproved of the maximum penalty of seven years' imprisonment for cannabis cultivation for one's own use, the mandatory minimum penalty of seven years' imprisonment for cannabis importing or exporting, as well as the possibility of life imprisonment for cannabis trafficking. The majority's criticism also covered the definition of trafficking, which included giving or offering, so that people who are merely passing a joint among friends in an evening could be charged with trafficking. The majority also mentioned that these sentences were made even more severe because:

- ❖ in the cases relating to possession of cannabis for the purpose of trafficking, the Crown could only proceed by way of indictment, with the consequence of more severe sentences; and
- ❖ the enforcement of the *Narcotic Control Act* was discriminatory (police investigations, the Crown Attorneys' discretion in deciding how to proceed, reversal of the burden of proof to the detriment of the accused, and judges' past experience).

⁹⁸ *Ibid.*, page 292.

⁹⁹ *Ibid.*, page 293.

¹⁰⁰ *Ibid.*, page 293.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

The criminalization of cannabis had another negative effect: the illegal nature of simple possession and cultivation was conducive to the development of an illicit market, where some people must engage in crime or at least deal with criminals in order to obtain a supply. In some cases, people were exposed to other, more dangerous drugs. According to the majority:

*Making cannabis legally available would not isolate people from contact with the illicit market in other drugs. From the point of view of influence, the important contacts are between drug users rather than between users and traffickers. Most users are initiated into new forms of drugs by other users. Interest in other drugs would not cease if cannabis were made legally available.*¹⁰¹

Finally, the use of extraordinary police powers, such as writs of assistance, often against users, only discredited the law further and adversely affected the morale of law enforcement authorities.¹⁰²

For all these reasons, the majority recommended:

- ❖ that importing and exporting should be included in the definition of trafficking (as they are under the Food and Drugs Act), and they should not be subject to a mandatory minimum term of imprisonment;
- ❖ that it be possible to proceed by indictment or summary conviction in the case of trafficking and possession for the purpose of trafficking, and, on indictment, the penalty for this offence should be five years, and on summary conviction, eighteen months. It should be possible in either case to impose fine in lieu of imprisonment;
- ❖ that the prohibition against the simple possession of cannabis be repealed;
- ❖ that trafficking should not include the giving, without exchange of value, of a quantity of cannabis which could reasonably be consumed on a single occasion;
- ❖ that the prohibition against cultivating cannabis for personal use be repealed; and
- ❖ that the burden of proof on a person charged with possession for the purposes of trafficking be lightened, by stipulating in the Act that it is sufficient for the accused to raise a reasonable doubt as to his intention to traffic.

¹⁰¹ *Ibid.*, page 296.

¹⁰² *Ibid.*, pages 295-299.

Minority Opinion—the recommendations of Marie-Andrée Bertrand

According to Marie-Andrée Bertrand, Canada's cannabis policy required an in-depth reform that went far beyond merely amending the *Narcotic Control Act*. Dr. Bertrand took a much more liberal approach than the majority, and particularly Ian L. Campbell, as we will see below. Dr. Bertrand wrote that the Commission's research findings "establish that a large number of people have used cannabis-more than a million in Canada. Very few of them have ever required medical or psychological treatment as a consequence. Smoking marijuana or hashish generally produces no serious personal problems, nor does it result in criminality."¹⁰³ Cases of habitual and excessive use were exceptional, as most users used cannabis recreationally. Any new public policy aiming at controlling cannabis use effectively without causing harm both to users and to society should consider these determinants. The use of the criminal law was out of the question. According to the Commissioner, there were several arguments in support of this conclusion.

Like the majority, she rejected a number of prejudices concerning harm caused by cannabis to human health, in particular its effects on brain activity and the ability to drive a vehicle, but recognized nevertheless that in large amounts cannabis could cause psychoses. While Marie-Andrée Bertrand commented that cannabis might have an effect on adolescent maturation, she said that very few facts supported the hypothesis put forward by the majority.¹⁰⁴ She also concluded that there was no relationship between cannabis use and criminality, aggression or the infamous amotivational syndrome.¹⁰⁵ Moreover, she rejected claims that cannabis use leads to poly-drug use in most users:

*[...] a certain proportion of cannabis users take other drugs [...]. We are not dealing with a phenomenon that is limited to cannabis, LSD and the amphetamines (which are used in combination by only a few), but with an almost indiscriminate use of mood-changing substances in our society. When we include alcohol, it can be said that Canadians consume great quantities of a variety of psychoactive drugs, even if cannabis is excluded.*¹⁰⁶

Second, users could not be sure of the quality of cannabis they bought, with all the concomitant repercussions, given the illicit and clandestine nature of production and distribution activities. Dr. Bertrand responded to the argument made by the majority that quality control of cannabis in a legal market would encourage a number of users to move to hashish by saying that no evidence points to such a possibility.¹⁰⁷

Third, the prohibition of cannabis trade and illicit use was expensive and ineffective. Attempts to curb trafficking, despite all the efforts made by RCMP officers and municipal police forces, along with severe penal sanctions, were ineffective. The

¹⁰³ *Ibid.*, page 303.

¹⁰⁴ *Ibid.*, page 308.

¹⁰⁵ *Ibid.*, pages 307-309.

¹⁰⁶ *Ibid.*, page 308.

¹⁰⁷ *Ibid.*, page 309.

sentences provided for simple possession no longer had any dissuasive effect, since a million Canadians were using or had used cannabis.

Fourth, in its current form, the law had no educational or dissuasive impact, since Canadians' perception of the harm caused by cannabis was no longer the same as the government's. In this connection, Marie-Andrée Bertrand wrote:

A more important factor underlying problems in the application of the law is the gradual change in opinion taking place among Canadians regarding the harmfulness of this substance. The evidence has been taken into account - cannabis is not an opiate, its use does not induce physical dependence. The earlier opinions of society have been challenged and modified. [...] However, the continued prohibition of cannabis has precipitated, among many users, a generalized disrespect for the law.¹⁰⁸

For all these reasons, Marie-Andrée Bertrand recommended a “controlled legalization” policy for cannabis. She concluded that the federal government should remove cannabis from the *Narcotic Control Act* and initiate discussions with the provinces to have the sale and use of cannabis placed under controls similar to those governing the sale and use of alcohol. Such a system would entail regulations prohibiting the sale or distribution of cannabis to minors, and governing the distribution of a quality product at a price that would make smuggling impractical. To guarantee the success of the new approach, the federal and provincial governments were to work together in developing all stages of the production and distribution of cannabis, while undertaking multidisciplinary epidemiological research to evaluate the repercussions of a controlled legalization policy on health and human behaviour and to monitor patterns of use.¹⁰⁹

Lastly, Marie-Andrée Bertrand considered that this policy would prove beneficial, not only for users, but also for the federal and provincial governments because of the considerable revenue they might well derive from the sales taxes on such a popular product.¹¹⁰

Minority Opinion—the recommendations of Ian Campbell

In comparison with the very liberal recommendations made by Marie-Andrée Bertrand, the recommendations by Ian Campbell were much more conservative in tone. Although he was in almost full agreement with the conclusions of the majority, he firmly believed that decriminalizing simple possession of cannabis would be misinterpreted by the media and by Canadians. If cannabis were legalized, the signal that would be sent out to society, particularly to young people, would be that cannabis is harmless, and might eventually lead to the accepted use of other, much more dangerous drugs. In this regard, he stated that, in both cases:

¹⁰⁸ *Ibid.*, p. 304

¹⁰⁹ *Ibid.*, pp. 310-311

¹¹⁰ *Ibid.*, p. 304

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

I think there is also a risk that the repeal of the prohibition on the possession of cannabis, even by the young, would be misunderstood as indicating a willingness by the society to condone and accept the use of the drug. There is little evidence to suggest that such a willingness exists. [...] The risk of such progression is probably not as great among those who have been deterred from use by the present law as among those who have already used cannabis. But the risk of progression is nonetheless real for some considerable number.¹¹¹

He also felt that maintaining the prohibition had a positive benefit—that of protecting young people from the harm caused by cannabis:

The potential for harm from adult use of cannabis is probably very much less than from use by the young. But, I find sufficient reasons to recommend the continuation of the general prohibition. Not the least of these reasons is the practical impossibility, at this time, of using the law to convey a perception of the dangers of cannabis without maintaining the prohibition for all, whether young or old.¹¹²

Against this backdrop, the law was in the interest of prevention and morality, protecting as it did both individuals and society. Continuing in this vein, Mr. Campbell spoke about cannabis and young people's lack of maturity, saying:

We have properly been concerned about the damage done by placing too many duties and responsibilities on the individual too early. But it seems to me that recently we have been far too little concerned with the consequences of placing too many rights and freedoms on the shoulders of the young.¹¹³

Despite it all, like other members of the Commission, Mr. Campbell recognized that some penal sanctions provided by the law could cause harm that was disproportionate in comparison with the real harm caused by cannabis on human health and society. He therefore recommended that the prohibition on the possession of cannabis be maintained, with possession of cannabis being punishable, upon summary conviction, by a fine of \$25.00 for the first offence and a fine of \$100.00 for any subsequent offence. Maintaining the prohibition would benefit not only users, but also police officers, since it:

Is entirely reasonable to assume that a high proportion of those currently arrested for possession as a result of systematic police investigation are in fact guilty of trafficking.¹¹⁴

The work of the Le Dain Commission ended on December 14, 1973 when its final report was tabled. On July 31, 1972, John Munro, Minister of Health, revealed the policy that the federal government wanted to pursue following the tabling of the Commission's special report on cannabis. Even though he refused to legalize the use of

¹¹¹ *Ibid.*, page 311

¹¹² *Ibid.*, page 313

¹¹³ *Ibid.*, page 314

¹¹⁴ *Ibid.*, page 316

cannabis, the Minister stated his intention to remove cannabis from the *Narcotics Control Act* and place it under the *Food and Drugs Act*. This measure would be accompanied by lighter sentences for certain cannabis-related offences, research and education programs about its non-medical use, and less severe legal consequences for users. This measure would have covered hashish since the government “*wanted to make a clear distinction between this drug [cannabis] and dangerous narcotics like heroin.*”¹¹⁵ Two years later, on November 26, 1974, the federal government met its commitments by tabling Bill S-19 in the Senate.

Bill S-19 and cannabis

Bill S-19 created Part V of the *Food and Drugs Act* entitled “Cannabis”. Thus, as recommended in the majority opinion expressed in the Le Dain Commission’s special report, cannabis and cannabis users were no longer subject to the harsh provisions of the *Narcotic Control Act*.

Clause 7 of Bill S-19 defined “cannabis” as hashish, marijuana, cannabidol and THC. It continued the offence of possession, which, however, could only be prosecuted summarily. Anyone convicted of a first offence would be liable to a maximum fine of \$5000 or, failing payment, to a maximum prison term of six months. For repeat offences, the fine would be fixed at an amount not exceeding \$1,000 or, failing payment, a prison term not exceeding six months could be imposed. As may be seen, fines were favoured over imprisonment for simple possession.

The Bill also maintained the offences of trafficking, possession for the purposes of trafficking and cultivation of cannabis without a permit provided for by the *Narcotic Control Act*, punishable on summary conviction by a maximum fine of \$1,000 or a prison term of up to 18 months or, if prosecuted by way of indictment, by a prison term of up to 10 years. The penalties provided were thus less severe than those provided for by the Act of 1961, except for the cultivation of cannabis. Although Bill S-19 created a dual-procedure offence for this crime, the maximum prison term was more severe (10 years rather than seven if prosecuted by way of indictment).

Lastly, a person convicted of importing or exporting cannabis was liable, on summary conviction, to a maximum prison term of two years or, if prosecuted by way of indictment, to a prison term of three to 14 years. Parliament thus wanted to show that cannabis trafficking and smuggling were crimes which it still considered very serious.

Apart from these offences, Bill S-19 also contained the criminal procedures included in Parts III and IV of the *Food and Drugs Act* (evidence of possession for the purpose of trafficking, certificate of the analyst, police powers and so on). Lastly, the provisions respecting regulations that the governor in council may make concerning the

¹¹⁵ VALOIS, Donat, “La marijuana et le haschisch ne seront pas légalisés”, *Le Droit*, Ottawa, August 1, 1972.

issuing of cultivation permits and possession of cannabis were now contained in the new Part V.

The Bill was considered by the Senate Standing Committee on Legal and Constitutional Affairs, which, in its report, recommended three amendments. The first added a provision for an exception to the *Criminal Records Act* so that any person receiving an absolute or conditional discharge would be automatically pardoned. The purpose of this measure was to eliminate the possibility that a criminal record might remain with the Canadian Police Information Centre (CPIC) following discharge. The second amendment increased the maximum prison term for trafficking in a narcotic from 10 to 14 years less a day. The third repealed the minimum term of three years for smuggling.

Bill S-19 was passed on third reading on June 15, 1975 and referred to the House of Commons, where it never passed second reading. In the fall of 1976, Mitchell Sharp stated in an interview that the bill would not be reintroduced since more important legislation was under consideration.

AFTER LE DAIN: FORGING AHEAD REGARDLESS

Throughout the 1970s, a number of federal politicians promised major reforms to lessen, even eliminate, the criminal penalties imposed on cannabis users. In 1972, the Liberal Party of Canada stated in its election platform that it intended to amend Canada's policy on marijuana,¹¹⁶ which likely gave birth to Bill S-19. In 1978, Joe Clark, Leader of the Progressive Conservative Party, declared that a government formed by his political party would decriminalize possession of that drug.¹¹⁷ However, promises of reform ceased in the early 1980s.

In the mid-1980s, Canadians witnessed a significant change in the federal government's position on drugs. This new situation was perhaps not unrelated to the U.S. policy of "war on drugs" adopted in the early 1980s by President Ronald Reagan. The United States once again became very active within international drug control agencies to encourage the international community to take energetic measures to put an end to drug trafficking, which "threatened American youth".

In 1987, Canada became actively involved in the work of the International Conference on Drug Abuse and Illicit Trafficking.¹¹⁸ Two important events occurred at that meeting organized under the aegis of the United Nations. First, delegates passed a full multidisciplinary plan for future activities to combat drug abuse encouraging the

¹¹⁶ Spicer, L. (2002) *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"*. Ottawa: Parliamentary Research Branch, Library of Parliament.

¹¹⁷ Giffen, P.J. et al., (1991) *Panic and Indifference: The Politics of Canada's Drugs Laws*. Ottawa: Canadian Centre on Substance Abuse, page 571.

¹¹⁸ Briefing notes, Research Office of the Progressive Conservative Party of Canada, June 1, 1987.

states to comply with their obligations under existing treaties. That initiative targeted four important areas: prevention and reduction of demand for illicit drugs, control of supply, suppression of illicit trafficking and treatment and rehabilitation. For the first time, international legal instruments made express provision for the reduction of supply. Second, delegates put the final touches on the treaty to suppress drug trafficking on a global scale. That treaty was passed in Vienna on December 20, 1988 as the *Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Convention of 1988).

In addition to taking part in the work leading to the adoption of that convention, starting in the mid-1980s, Canada stepped up its international efforts with regard to drugs. In June 1987, it ratified the Convention on Psychotropic Substances of 1971¹¹⁹ and promised to increase its financial participation in the United Nations Fund for Drug Abuse Control to \$1 million by 1991. The Canadian government justified its participation in the international drug effort as follows:

*“The Government is acting to stem the flow of drugs in and out of Canada, not only because Canadians are among the victims of drug abuse, but also because we have a role to play as responsible citizens of the world.”*¹²⁰

Canada was influenced by this international effort when, on September 13, 1988, before it had even signed or ratified the Convention of 1988 – which was not done until 1990 – Parliament passed Bill C-61, designed to combat laundering of the proceeds of crime (money laundering, enterprise crime, etc.). The Bill was aimed at organized crime and the financing of its operations through drug trafficking. The *Criminal Code* and the *Narcotic Control Act* were thus amended to create two new offences: laundering of proceeds of crime and possession of property obtained through drug trafficking. These new provisions also applied to the illegal activities of drug cultivation, trafficking and importing and exporting in or outside Canada if they were committed by Canadian citizens. Parliament did not need to legislate to criminalize the other activities prohibited by the Convention of 1988 since, as noted above, many had already been covered since 1961.

Controlled Drugs and Substances Act

In accordance with the commitment the federal government made in 1987, Minister of Health Perrin Beatty tabled Bill C-85, *An Act respecting psychotropic substances*, on June 11, 1992. It merged Parts III and IV of the *Food and Drugs Act* as well as the

¹¹⁹ International Narcotics Control Board, *Report of the International Narcotics Control Board for 1987*, Vienna, United Nations Organization, 1988, p. 21.

¹²¹ The tables of penalties in this section are reproduced from *Bill C-8: An Act to regulate certain drugs and other substances*, Legislative Summary 240, prepared by Allain, J., (1996; revised May 1997) Ottawa: Law and Government Division, Parliamentary Research Branch, Library of Parliament.

Narcotic Control Act into a single piece of legislation. Bill C-85 never passed report stage and died on the Order Paper in September 1993, when the 34th Parliament was dissolved.

On February 2, 1994, the new Minister of Health, Diane Marleau, retabled the legislation proposed by the former government under a different name, the *Controlled Drugs and Substances Act* (CDSA), which was passed by the House of Commons on October 30, 1995. After the first session of the 35th Parliament was prorogued, the bill was reintroduced in the Senate on March 6, 1996, and renumbered Bill C-8. The legislation went into effect on June 20, 1996.

This was the first major reform of Canada's drug legislation since the 1960s. Apart from the amendments made in 1988 under Bill C-61, the *Narcotic Control Act* had been amended in 1985 to abolish the writ of assistance and the procedure for establishing proof of possession of narcotics for the purpose of trafficking. In 1987, in *R. v. Smith*, the Supreme Court of Canada ruled that the minimum prison term of seven years for importing or exporting was unconstitutional under section 12 of the *Canadian Charter of Rights and Freedoms* (cruel or unusual punishment), as a result of which it was repealed.

One of the objects of the bill was to meet Canada's international obligations under the *Single Convention on Narcotic Drugs* (1961), the *Convention on Psychotropic Substances* (1971), and the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (*Vienna Convention, 1988*). It was further designed to introduce a legislative framework for regulating the import, production, export, distribution and use of scheduled substances under previous acts. The following sections describe the main provisions of this legislation.

Substances

The merger of the schedule of the *Narcotic Control Act* with those of the *Food and Drugs Acts* of 1961 and 1969, combined with the addition of new substances such as benzodiazepines and the precursors of this long list of substances, considerably increased the number of drugs subject to the restrictive provisions and procedures of the CDSA.

The expression "controlled substance" means a substance included in Schedule I, II, III, IV or V. In addition, the Act defines the term "analogue" as any substance that, in relation to a controlled substance, has a substantially similar chemical structure. Furthermore, anything that contains or has on it a controlled substance and that is used or intended or designed for use in producing or introducing the substance into the human body will be treated in the same way as that illegal substance.

- ❖ **Schedule I:** narcotic drugs such as opium, morphine and cocaine.
- ❖ **Schedule II:** cannabis, hashish, cannabino, etc.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- ❖ **Schedule III:** stimulants such as amphetamines, hallucinogenics, such as mescaline, LSD and DET, and sedatives such as methaqualone, commonly called quaalude.
- ❖ **Schedule IV:** among others, anabolic steroids, hypnotics such as barbiturates and benzodiazepines (better known by their trademarks Seconal, Luminal, Valium and Librium).
- ❖ **Schedule V:** enumerates other substances that may be abused.
- ❖ **Schedule VI:** precursors, which produce no effects on the mind but can be converted or used to produce designer drugs, "simili-drugs" or substances contained in the schedules under Canada's international obligations under the *Single Convention on Narcotic Drugs* (1961) and the *Vienna Convention* of 1988.
- ❖ **Schedules VII and VIII:** concerning application of penalties for cannabis offences.

A total of more than 150 drugs, psychotropic substances and precursors now appear in the schedules of the act. It should be noted that section 60 of the CDSA continues the provision adopted in 1911 that the Governor in Council may, by order, amend any one of the schedules of the act by adding or deleting one or more substances where the Governor in Council deems the amendment to be necessary in the public interest.

Part I: Offences and Punishment

Participation in the aforementioned activities would not necessarily result in criminal penalties. As will be seen below, the act provides for regulations authorizing the possession, import and export and production for medical, scientific, industrial purposes or for the purposes of the act. Part I of the CDSA enumerates a number of types of offences:

(1) Possession of a Schedule I, II or III substance (subsection 4(1)); obtaining or seeking to obtain a Schedule I, II, III or IV substance, or the order necessary to obtain it from a practitioner (subsection 4(2)). The following table shows the maximum penalties for the offence of possession:¹²¹

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Possession of a Schedule I Substance	
Indictable offence	Seven years' imprisonment
Summary conviction	Fine of \$1,000 or 6 months' imprisonment or both
Reoffence	Fine of \$2,000 or one year's imprisonment or both
Possession of a Schedule II Substance (cannabis in all its forms):	
Indictable offence	Five years' imprisonment less a day
Summary conviction	Fine of \$1,000 or 6 months' imprisonment or both
Reoffence	Fine of \$2,000 or one year's imprisonment or both
Possession of a Schedule VIII Offence (less than 1 g of cannabis resin (hashish) or less than 30 g of marijuana)	
Summary conviction only	Fine of \$1,000 or 6 months' imprisonment or both
Possession of a Schedule III Substance	
Indictable offence	3 years' imprisonment
Summary conviction	Fine of \$1,000 or 6 months' imprisonment or both
Reoffence	Fine of \$2,000 or one year's imprisonment or both

The penalties imposed for the offence under subsection 4(2) are similar but slightly different from those provided for possession.

(2) Trafficking in a Schedule I, II, III or IV substance or any substance represented to be such a substance. Trafficking is defined as any transaction to sell, administer, give, transfer, transport, send or deliver a schedule substance, or to offer to do any one of those things. To “sell” means offering for sale, exposing for sale, having in one's possession for sale and distributing a substance, whether or not the distribution is made for consideration (subsection 5(1)); possessing any Schedule I, II, III or IV substance for the purpose of trafficking (subsection 5(2)). The following table shows the maximum penalties for these offences:

Trafficking in a Schedule I or Schedule II Substance (except in cases involving less than 3 kg of cannabis)	
Indictable offence	Life imprisonment
No summary conviction offence	
Trafficking in a Schedule III Substance	
Indictable offence	10 years' imprisonment
Summary conviction	18 months' imprisonment
Trafficking in a Schedule IV Substance	
Indictable offence	Fine of \$1,000 or 6 months' imprisonment or both
Summary conviction	One year's imprisonment

Trafficking in cannabis is not always punishable by the maximum penalty of life imprisonment. In cases of trafficking involving less than 3 kg of cannabis, a person is

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

guilty of an indictable offence and subject to a maximum term of five years' imprisonment less a day.

(3) Importing or exporting any Schedule I to VI substance (subsection 6(1)); having in one's possession any Schedule I to VI substance for the purpose of exporting it (subsection 6(2)). The following table shows the maximum penalties for these offences:

Importing or Exporting a Schedule I or II Substance	
Indictable offence No summary conviction	Life imprisonment
Importing or Exporting a Schedule III or IV Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Importing or Exporting a Schedule IV Substance	
Indictable offence Summary conviction	3 years' imprisonment One year's imprisonment

(4) Producing a Schedule I, II, III or IV substance. The expression "produce" is defined as meaning to obtain a substance by any method or process including manufacturing, synthesizing or using any means of altering the chemical or physical properties of the substance, or cultivating, propagating or harvesting the substance or any living thing from which the substance may be extracted or otherwise obtained. The following table shows the maximum penalties for this offence:

Producing a Schedule I or II Substance (other than cannabis/marijuana)	
Indictable offence No summary conviction	Life imprisonment
Producing cannabis (marijuana) (less than 1 g of cannabis resin (hashish) or less than 30 g of marijuana)	
Indictable offence No summary conviction	7 years' imprisonment
Producing a Schedule III Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Producing a Schedule IV Substance	
Indictable offence Summary conviction	3 years' imprisonment One year's imprisonment

(5) Possession of property obtained by crime (section 8) and offences relating to the laundering of proceeds of crime (section 9).

The penalties are obviously closely related to the schedule in which the substance in question appears. Furthermore, the penalties determined for cannabis offences also vary considerably depending on the quantity involved, a subject discussed in greater detail below.

Section 10 of the Act states the purpose of sentencing, which is to contribute to the respect for the law and the maintenance of a just, peaceful and safe society while encouraging rehabilitation, and treatment in appropriate circumstances, of offenders and acknowledging the harm done to victims and to the community. This section also provides a list of circumstances which the court is required to consider as “aggravating” factors in determining the sentence that shall be imposed on a person convicted of a designated substance offence. Those factors are: the use of a weapon or use of or threat to use violence, trafficking in a substance on or near school grounds or in or near any public place frequented by minors or by persons under the age of 18 years, and previous convictions of a designated substance offence. In addition, the use of the services of a minor in the commission of a designated substance offence is an aggravating factor. Any judge deciding not to sentence a person to imprisonment despite the presence of one or more aggravating factors is required to give reasons for that decision.

Part II: Enforcement

Sections 11 and 12 of the act concern search and seizure activities, which are discussed in greater detail in Chapter 14.

Section 13 incorporates certain *Criminal Code* provisions establishing a detailed plan for the return, reporting and detention of seized property. In the case of offence-related property, the *Criminal Code* provisions apply subject to sections 16 to 22 of the Act. Furthermore, a separate procedure is established under sections 24 to 29 to determine the disposal of controlled substances. It should be noted that section 14 provides for the issuing of a restraint order in respect of offence-related property.

Sections 16 and 17 concern the forfeiture of offence-related property. Offence-related property is defined as any property, within or outside Canada, by means of or in respect of which a designated substance offence is committed, that is used in any manner in connection with the commission of a designated substance offence, or that is intended for use for the purpose of committing a designated substance offence, but does not include a controlled substance or real property, other than real property built or significantly modified for the purpose of facilitating the commission of a designated substance offence. A court which convicts a person of a designated offence shall order the forfeiture of offence-related property where it is satisfied, on a balance of probabilities, that the property is offence-related property. Where the offence-related

property cannot be related to the offence with which the person is charged, the court may nevertheless order its forfeiture. The court may make such order where it is satisfied, beyond a reasonable doubt, that it is offence-related property. Furthermore, offence-related property may be forfeited even if legal proceedings were never instituted. The court shall render an order of forfeiture of property if it is satisfied (1) beyond a reasonable doubt that any property is offence-related property, and (2) that proceedings in respect of a designated substance offence in relation to the property were commenced, and (3) that the accused charged with the offence has died or absconded.

Sections 18 to 22 are essentially a restatement of sections 462.4 to 462.45 of the *Criminal Code*. The purpose of these provisions is to protect the interests of innocent third parties and good-faith buyers. As a general rule, if the court is satisfied that the claim is lawful, it may order the return of the property (or payment of its value if restitution is impossible) to the person who is its legitimate owner or who is entitled to own it.

Section 23 merely incorporates the *Criminal Code* provisions on forfeiture of proceeds of crime. The same terms and conditions are thus established in the case of the forfeiture of the proceeds of designated offences.

Part III – Disposal of Controlled Substances

Under subsection 13(4) of the Act, where a controlled substance has been seized, a report identifying the place searched, the substance seized and the location where it is being detained shall be filed with the justice of the peace of the territorial division concerned. Sections 24 to 29 of the Act govern the disposal of controlled substances.

Section 24 establishes the pre-trial procedure for the return of controlled substances. For example, any person may, within 60 days after the date of the seizure, finding or acquisition by a peace officer or inspector, apply to a justice of the peace for a restitution order. If the justice is satisfied that the application is valid, he shall order that the substance be returned to the applicant. In the opposite case, the justice orders forfeiture to the Crown. The substance is then disposed of in accordance with the applicable regulations or as the Minister directs. Where no application for return is made, the substance is delivered to the Minister and disposed of in accordance with the applicable regulations or, failing such regulations, in such manner as the Minister directs.

It should be noted that section 26 enables the Minister to ask the justice of the peace to order that a controlled substance be forfeited, at any time, if he has reasonable grounds to believe that it constitutes a potential security, public health or safety hazard. The application is essentially made *ex parte*. If the justice of the peace finds that the Minister has reasonable grounds to believe that the substance constitutes a potential security, public health or safety hazard, he orders its forfeiture. The substance is then disposed of in accordance with the applicable regulations or, if there are no applicable regulations, in such a manner as the Minister directs.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Section 27 regulates the post-trial procedure for returning controlled substances seized—the persons whose substances were seized is entitled to have them returned where the court rules his activities legitimate. Otherwise, the substance is returned to the true legitimate owner, provided that that person can be identified. If neither is possible, the substance is forfeited to the Crown, which disposes of it in accordance with the applicable regulations or, if there are no applicable regulations, in such manner as the Minister directs.

Section 28 enables the Minister to dispose of a controlled substance with the owner's consent.

Lastly, under section 29, the Minister may destroy any plants from which a Schedule I, II, III or IV substance may be extracted and that is being produced without a regulatory licence or in violation thereof.

Part IV – Administration and Compliance

This part concerns the powers assigned to inspectors to ensure that holders of a regulatory authorization or licence to deal in controlled substances or precursors are complying with the regulations.

The inspector may, at any reasonable time, enter any place he believes on reasonable grounds is used for the purpose of conducting that person's business or professional practice. The Act authorizes inspectors to conduct a series of inspection acts, including seizing and holding any controlled substance or precursor which he deems on reasonable grounds must be seized or held. The Act makes provision for the return of seized property. It should be noted that, in the case of dwelling-places, the inspector must first obtain the occupant's consent or hold a warrant.

Part V – Administrative Orders for Contraventions of Designated Regulations

This part makes provision for the administrative procedure that is to be followed where a regulation designated by the Governor in Council has been contravened. Under section 33 of the CSDA, the Governor in Council may proclaim certain regulations made under section 55 as "special regulations". Non-compliance with those regulations may result in administrative orders providing for severe penalties, including revocation of the permit or licence issued by the Minister of Health (subsection 40(4)).

Part VI – General

Sections 44 to 60 are general provisions. For example, sections 44, 45 and 51 concern the designation of analysts, the scope of their duties and the admissibility of their reports at trial.

Section 46 creates a general penalty applying to anyone who contravenes a provision of the Act for which no penalty is specifically provided or contravenes a regulation. An indictable offence is punishable by a maximum fine of \$5,000 and/or three years' imprisonment. An offence punishable on summary conviction results in a \$1,000 fine and/or six months' imprisonment.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Under section 47, summary convictions for certain offences under the act and regulations must be commenced within one year of the commission of the offence. All other summary procedures must be commenced within six months of the offence.

Other sections concern the following matters: that the prosecutor is not required, except by way of rebuttal, to prove that a certificate, licence, permit or other qualification does not operate in favour of the accused (section 48); that a copy of any document filed with a department is admissible in evidence without proof of the signature of the authority (section 49); that a certificate issued to a police officer exempting him from the act or its regulations is admissible in evidence at trial and, in the absence of evidence to the contrary, is proof that the certificate or other document was validly issued, without proof of the signature or official character of the person purporting to have certified it, although the defence may, with leave of the court, cross-examine the person who issued the certificate (section 50); that the giving of any document may be proved by oral evidence, affidavit or solemn declaration, even though the court may require the signatory to appear (section 52); that the continuity of possession of any exhibit tendered as evidence in a proceeding may be proved by the testimony, affidavit or solemn declaration of the person claiming to have had it in his possession (section 53); and that certified copies of records, books, electronic data or other documents seized may be presented as admissible evidence by the Minister's officer, the copied versions having the same probative force as the originals, unless the accused submits evidence to the contrary (section 54).

Subsection 55(1) establishes the power of the Governor in Council to make regulations. One of the objectives of Canada's drug policy was to monitor the legal trade in scheduled drugs for medical or scientific purposes. The CSDA significantly enhanced the Governor in Council's power to make regulations with respect to designated substances and precursors. The regulations made under the CSDA apply in particular to businesses, physicians and pharmacists. The Governor in Council may thus make regulations, with respect to the designated substances or precursors:

- ❖ Governing, controlling, limiting, authorizing the importation and exportation, production, packaging, sending, transportation, delivery, sale, administration, possession or obtaining of those substances or precursors;
- ❖ Issuing permits to businesses or persons permitting the aforementioned activities, defining the terms and conditions of payment and their revocation, and determining the qualifications required of permit holders;
- ❖ Controlling the methods of production, storing, packaging and restricting the advertising, if necessary, for the sale of those substances;
- ❖ Governing the books, records, electronic data or other documents that must be established by the businesses, physicians or pharmacists or any other permit holder engaged in the activities enumerated in the first point;
- ❖ Authorizing, if necessary, the communication of information obtained through investigations conducted by the inspectors of the Department of Health to provincial authorities in respect of a serious contravention of the regulations

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

concerning the activities defined in the first point so that they may take disciplinary measures;

- ❖ Exempting, on conditions set out in the regulations, any person or class of persons from the application of section 55.

Under subsection 55(2), the Governor in Council, on the recommendation of the Solicitor General of Canada, may make regulations that pertain to investigations and other law enforcement activities. This includes regulations exempting police officers, in certain circumstances, from the application of Part I of the Act (Offences and Penalties).

Under section 56, the Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of the act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Section 57 concerns the delegation of the powers of the Minister and the Solicitor General.

Section 58 provides that the provisions of the act and the regulations made under it prevail over any incompatible provisions of the *Food and Drugs Act* or its regulations.

Section 59 makes it an offence to make or assent to the making of a false or misleading statement in any book, record, return or other document that must be made under the act or regulations.

As mentioned, under section 60, the Governor in Council may amend any schedule to add or delete a controlled substance.

The specific case of cannabis

In the first version of the CSDA, cannabis was cited in the schedule containing the most dangerous drugs to which the most severe criminal penalties described above applied. To allay criticism, the government agreed to withdraw cannabis from Schedule I and created Schedules II, VII and VIII, which concern that drug exclusively. Schedule II defines cannabis as marijuana, cannabis resin (hashish) cannabinol, and so on. Schedule VII established at three kilograms of cannabis or hashish the maximum quantity for the imposition of a less severe penalty for trafficking or possession for the purpose of trafficking in that substance. Lastly, Schedule VIII provided that a person who had less than one gram of hashish or less than 30 grams of cannabis in his possession for his own personal use was liable to less severe criminal penalties than those provided for in Schedule II.

As a result, if a person is convicted of possession, possession for the purpose of trafficking or possession of a quantity greater than that defined in Schedules VII and VIII, the more severe penalties provided for in Part I for Schedule I or II substances apply. Otherwise, the CSDA defines new criminal penalties. As regards Schedule VIII, section 4 of the CSDA provides that a person charged with simple possession of cannabis may be prosecuted summarily and provides for a maximum term of

six months' imprisonment, a maximum fine of \$1,000 or both. Contrary to the majority recommendation made in the 1972 special report of the Le Dain Commission respecting the reduction of the penalty imposed for importing and exporting cannabis, life imprisonment still applies. Lastly, the maximum prison term of seven years provided for by the *Narcotic Control Act* for the offence of cultivation (production) of that drug remains unchanged under the CSDA.

CONCLUSIONS

Conclusions of Chapter 12	
	<ul style="list-style-type: none">➤ Early drug legislation was largely based largely on a moral panic, racist sentiment and a notorious absence of debate.➤ Drug legislation often contained particularly severe provisions, such as reverse onus and cruel and unusual sentences.➤ The work of the Le Dain Commission laid the foundation for a more rational approach to illegal drug policy by attempting to rely on research data.➤ The Le Dain Commission's work had no legislative outcome, except in 1996, in certain provisions of the Controlled Drugs and Substances Act, particularly with regard to cannabis.➤ No action was taken on the reform proposals introduced in the 1970s, particularly for the decriminalization of cannabis.➤ Thirty years after the Le Dain Commission, the legislation and its application have had no notable effect on the supply and demand of cannabis.➤ The present act Act takes no account of data from research on the comparative effects of various substances, particularly the effects of cannabis.

REPORT OF THE SPECIAL SENATE COMMITTEE ON ILLEGAL DRUGS: CANNABIS

CHAPTER 13

REGULATING THERAPEUTIC USE OF CANNABIS

As discussed in Chapter 9, cannabis has an extremely long history of therapeutic use, going back several thousands of years. It was often used for the same medical conditions it is used for today. With the development of the pharmaceutical industry in the last century, the medical community has gradually discontinued its use. Various factors may explain this. Developments in the pharmaceutical industry provided the medical community with more stable and better tested medication. The practice of medicine itself has changed and so has our conception of health. Then, at the turn of the 20th century, the plants from which opium, cocaine and cannabis are derived were banned by the international community, except for medical and scientific purposes. In the case of cannabis, no rigorous study had been done, until recently.

Further to the social rediscovery of cannabis and the identification of its molecular composition and chemical elements in the 1960s, renewed interest in the therapeutic applications of cannabis grew in the early 1970s. More people began using the plant for its therapeutic benefits and many demanded a relaxation of the prohibitionist rules governing cannabis.

Because its safety and effectiveness have yet to be reviewed in clinical trials, cannabis has not been approved for sale in Canada as a medical product.¹ Despite this lack of approval, many use cannabis for its therapeutic purposes without legal authorization. In addition, because of the many claims regarding its therapeutic benefit, a growing number of people have called for a less restrictive approach and are demanding access to cannabis for people who could benefit from its use.

This chapter reviews the events that prompted the recent enactment of the *Marihuana Medical Access Regulations*. One of the objectives of the regulations is to provide a compassionate framework of access to marijuana for seriously ill Canadians while research regarding its therapeutic application continues. Also discussed is the implementation of these regulations, which came into force on 30 July 2001.

¹ Two commercially available drugs related to cannabis have been approved for sale in Canada: Marinol, which contains chemically synthesized THC; and Cesamet, a synthetic cannabinoid. Both may be prescribed by physicians.

BACKGROUND TO THE RECENT REGULATIONS

Section 56 – Controlled Drugs and Substances Act

The *Controlled Drugs and Substances Act*² (CDSA) prohibits a series of activities relating to psychoactive substances, including: possession; cultivation; trafficking; possession for the purposes of trafficking; importation; and exportation. These activities are illegal unless authorized by regulations made under the CDSA. For example, the *Narcotic Control Regulations* regulate the legal distribution of narcotic drugs.³ In addition, before a drug may be marketed in Canada, it must be approved for sale under the *Food and Drugs Act*⁴ (FDA) and its regulations. The regulations under that Act set out controls dealing with, among others, the safety, efficacy and quality of therapeutic products. To market marijuana as a drug in Canada, a sponsor would have to file a “New Drug Submission” with the Therapeutic Products Programme of Health Canada. Submitted data would be evaluated to assess the potential benefits and risks of the drug before the drug would be approved for sale.

Other mechanisms authorize certain otherwise prohibited activities. Pursuant to section 56 of the CDSA, the Minister of Health is authorized to grant exemptions if, in his or her opinion, such an exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Thus, any person or class of persons may be exempted from the application of all or any of the provisions of the CDSA in these specified circumstances. These circumstances include both the cultivation and possession of marijuana, activities that are otherwise prohibited by the legislation.

In response to the growing demand for access to cannabis for therapeutic purposes and to Charter challenges in relation to therapeutic use, Health Canada published an Interim Guidance Document in May 1999. This document set out a process enabling Canadians to apply for an exemption to possess and cultivate marijuana for therapeutic purposes under the authority provided in section 56 of the CDSA. Applicants were required to demonstrate that the exemption was necessary for such purposes and required a statement from a physician in support of the application, along with details of their medical and drug therapy histories. Health Canada reviewed the applications on a case-by-case basis, taking into account the medical necessity of the applicant. The first exemption was issued in June 1999. As of 3 May 2002, 658 exemptions had been granted under the authority of section 56, and 501 were still active. With respect to the other 157 persons with exemptions, some are now authorized to possess the substance under the recently enacted *Marihuana Medical Access Regulations* and others may no longer need marijuana for therapeutic purposes. Under

² S.C. 1996, Chapter 19.

³ These drugs are set out in the schedule and include opium, codeine, morphine, heroin, cocaine, and cannabis.

⁴ R.S.C. 1985, Chapter F-27.

this process, persons with exemptions were required to limit their cultivation to the quantity specified in their exemption letter.⁵

In February 2000, as part of a commitment to public consultation in relation to the section 56 exemption program, a multi-stakeholder consultation workshop was held. The participants⁶ identified the following issues as priorities:

- ❖ Obtaining a legal source of marijuana for persons exempted under section 56;
- ❖ Exemptions for caregivers;
- ❖ Addressing the need for more information on the use of marijuana for medical purposes;
- ❖ Addressing concerns of law enforcement agencies;
- ❖ Improvement of the process and tools for section 56 applications; and
- ❖ Communications regarding the section 56 process and Health Canada's activities regarding marijuana for medical purposes.⁷

The information gathered at these consultations was later used for the development of the *Marihuana Medical Access Regulations*.

Charter challenges – therapeutic use of marijuana⁸

Charter challenges to prohibitions with respect to marijuana by those using the substance for therapeutic purposes have met with some success. In *Wakeford v. Canada* (1998),⁹ a person suffering from AIDS and using marijuana to fight nausea and loss of appetite, which were side-effects of the drugs he was taking to fight AIDS, sought a constitutional exemption from the prohibitions with respect to marijuana in the CDSA. The Ontario Court, General Division, found that by denying the individual the autonomy to choose how to treat his illness, the law infringed his rights to liberty and security of the person under the Charter. The Court indicated that the prohibition on marijuana was not arbitrary inasmuch as there is some risk of harm associated with its use.¹⁰ Thus, the Court found that in its general application, the law was consistent with

⁵ In June 1999, Health Canada released a report announcing a research plan for the use of marijuana for therapeutic purposes and stating that steps would be taken to establish a domestic source of research-grade marijuana. Both of these initiatives are discussed in more detail in subsequent sections of this chapter.

⁶ Participants included representatives from law enforcement, practicing physicians, research clinicians, National Association of Pharmacy Regulatory Authorities, Health Canada and others of unknown affiliation.

⁷ Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, p. 17.

⁸ This section is based largely on *Drug Prohibition and the Constitution*, a paper prepared for the Senate Special Committee on Illegal Drugs, by David Goetz, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 1 March 2001.

⁹ [1998] O.J. No. 3522 (Ont. Gen. Div.).

¹⁰ *Ibid.*, at paras. 49-50.

the principles of fundamental justice as set out in section 7 of the Charter. However, the law's impact on medical users raised additional considerations. As applied to these users, the blanket prohibition is over-broad and does not support the state's rationale for prohibition.

The Court held that it would be contrary to the principles of fundamental justice to prohibit the use of marijuana where it can be shown to be a significant medical treatment for a debilitating and deadly disease and where there was no procedural process for obtaining an exemption from prosecution.¹¹ However, the Court noted that such a process was provided for in section 56 of the CDSA. Therefore, the Court found that the law was in accordance with fundamental justice – even in respect of medical users – and denied Mr. Wakeford a constitutional exemption. It emphasized that, without a ministerial exemption process for medical users, the case would have been decided differently.¹² Later, Mr. Wakeford was granted an interim constitutional exemption with respect to the offences of possession and production/cultivation of marijuana on the basis of “fresh evidence” indicating that no real process had been established to deal with applications for exemptions under section 56 of the CDSA. Because the statutory exemption turned out to be “illusory,” the Court reopened the case and granted the exemption. It would remain in effect until the Minister of Health had made a decision on Mr. Wakeford's application for an exemption under section 56 of the CDSA.¹³

In *R. v. Parker* (2000),¹⁴ the Ontario Court of Appeal reached a similar conclusion with respect to the impact of the blanket prohibition on marijuana use on the “liberty and security of the person” interests of medical users. In *Parker*, the accused—who had been charged with cultivation and possession of marijuana—grew and used marijuana to control his epileptic seizures. The Court held that the criminal prohibition on the use of marijuana, vis-à-vis *bona fide* medical users, engaged their section 7 right to liberty because of the possibility of imprisonment. In addition, by depriving such individuals of the ability to choose marijuana as medication to alleviate the effects of a serious illness, the prohibition also infringed their rights to liberty and security of the person, independent of the potential for imprisonment. The Court in *Parker* further concluded that the blanket prohibition on marijuana possession did not accord with the principles of fundamental justice. The Court of Appeal made reference to the findings of the trial judge with respect to the medical conditions and symptoms for which cannabis has a therapeutic effect:

Based on the evidence adduced at trial, the trial judge found that the defence had established that smoking marihuana has a therapeutic effect in the treatment of nausea and vomiting particularly related

¹¹ *Ibid.*, at para. 54.

¹² *Ibid.*, at para. 66.

¹³ [1999] O.J. No. 1574, at paras. 11, 31 and 32.

¹⁴ 49 O.R. (3d) 481.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*to chemotherapy, intraocular pressure from glaucoma, muscle spasticity from spinal cord injuries or multiple sclerosis, migraine headaches, epileptic seizures and chronic pain.*¹⁵

Of significance to this chapter, the Court in *Parker* concluded that the exceptions and exemptions contemplated by the legislation that could cover approved medical use were contrary to the principles of fundamental justice. Firstly, although the legislation theoretically contemplated that a person could obtain marijuana with a doctor's prescription, the evidence in the case established that no pharmacist would fill such a prescription; the government would not look favourably on any physician who prescribed marijuana; and it was practically impossible to find a legal source of marijuana in Canada.¹⁶ Thus, this exception to the prohibition was held by the Court to be illusory.¹⁷

Secondly, with respect to ministerial exemptions under section 56 of the CDSA, the Court found this procedure to be inadequate and not in accordance with the principles of fundamental justice. The Court ruled that, under section 56, unfettered discretion was vested in the Minister of Health, an inappropriate basis for decisions relating to the security or liberty of the person in the context of access to medical treatment to alleviate the effects of serious illness.¹⁸ Key issues relating to the section 56 exemption process included: the broad discretion given to the Minister under the CDSA; transparency of the process; and a clear definition of medical necessity.

In the end, the Court concluded that the broad prohibition on possession of marijuana was contrary to section 7 of the Charter and did not constitute a reasonable and justified limit under section 1 of the Charter.¹⁹ The Court then declared the prohibition on the possession of marijuana to be unconstitutional and of no force and effect. However, the Court suspended the declaration of invalidity for one year in order to give Parliament the opportunity to amend the law to include adequate exemptions for medical use. In the interim, Mr. Parker was granted a personal exemption from the prohibition on possession of marijuana. The Court in *Parker* suggested its finding that the prohibition on possession of marijuana violated section 7 of the Charter would likely apply to the prohibition on cultivation as well.²⁰

Government reaction

In September 2000, while an appeal was still under consideration, the government announced its intention to establish a new regulatory approach, which would define the circumstances and the manner in which the use of marijuana for therapeutic purposes

¹⁵ *Ibid.*

¹⁶ *Ibid.*, at para. 155.

¹⁷ *Ibid.*, at para. 163.

¹⁸ *Ibid.*, at paras. 184-185 and 188.

¹⁹ *Ibid.*, at paras. 191-194.

²⁰ *Ibid.*, at para. 190.

would be authorized.²¹ A *Notice of Intent* was published on 6 January 2001 and meetings were held with key stakeholders as identified by Health Canada.²²

In April 2001, the government unveiled proposed regulations governing the possession and production of marijuana for therapeutic purposes. The proposed regulations were designed to address the key issues raised by the Ontario Court of Appeal in relation to the section 56 exemption process. There were two parts to the draft regulations: (1) authorization to possess and (2) licence to produce.

The 30-day regulatory consultation period, during which Health Canada received comments from 139 individuals and groups, resulted in the following changes being made to the proposed regulations: the application process would be managed by the individual applicant instead of by a medical practitioner; restrictions on growing locations would be relaxed and would no longer include a one-kilometre restriction on cultivation outdoors near schools and other places frequented by children; the formula to calculate the number of plants permitted under a licence to produce would be adjusted to reflect estimated indoor and outdoor growing yields and margins of error; and transitional provisions would be included to extend all current exemptions by six months with the objective of ensuring patients would be afforded ample opportunity to comply with the new regulations.²³

On 4 July 2001, the government announced that the regulations governing the possession and production of marijuana for therapeutic purposes would come into effect on 30 July 2001.

MARIHUANA MEDICAL ACCESS REGULATIONS

As stated above, there are two parts to the *Marihuana Medical Access Regulations* (MMAR): part 1, authorization to possess, and part 2, licence to produce. One of the objectives of the regulations is to provide a compassionate framework to allow access to marijuana for medical purposes.

The regulations establish a compassionate framework to allow the use of marijuana by people who are suffering from serious illnesses, where conventional treatments are inappropriate or are not providing

²¹ Health Canada, News Release, *Minister Rock announces intention to develop new approach for the use of marihuana for medical purposes*, 14 September 2000.

²² Key stakeholders included representatives from the Canadian Medical Association, the Canadian Pharmacists Association, the Canadian AIDS Society, the RCMP, Solicitor General Canada, Department of Justice, Correctional Service Canada and the Canadian Association of Chiefs of Police.

²³ Health Canada, Information, *Marijuana Medical Access Regulations – Amendments Resulting from Public Consultations*, July 2001.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*adequate relief of the symptoms related to the medical condition or its treatment, and where the use of marijuana is expected to have some medical benefit that outweighs the risk of its use.*²⁴

As will be reviewed in detail, the MMAR are intended to provide access to marijuana in special circumstances only: in the case of serious medical conditions where conventional treatment may not provide adequate symptomatic relief. Health Canada explains that this limitation is due to “*the health risks associated with the smoked form in particular, and due to the lack of evidence supporting the claimed health benefits.*”²⁵

Significantly, the application of the MMAR is limited to “Cannabis (marihuana)” as referred to in sub-item 1(2) of Schedule II of the CDSA. Thus, the regulations do not provide access to other cannabis-related products.

The key provisions of the MMAR are as follows.

Authorization to possess

Three distinct categories have been established in relation to authorization to possess dried marijuana, each with its own application requirements. In each case, the application is to be submitted by the patient, whose declaration must include information identifying the applicant and indicating that:

- ❖ The applicant is aware that no notice of compliance has been issued under the *Food and Drugs Act* concerning the safety and effectiveness of marijuana as a drug and that the applicant understands the significance of that fact; and
- ❖ The applicant has discussed the risks of using marijuana with a medical practitioner and consents to using it for the recommended medical purpose.

Category 1

- ❖ Eligibility: Applicants who suffer from a symptom associated with a medical condition for which the **prognosis is death within 12 months**.
- ❖ Conditions: A **medical practitioner** must provide a medical declaration indicating, among other things:
 - The applicant’s medical condition and the symptom that is associated with that condition or its treatment;
 - The applicant suffers from a terminal illness;
 - All conventional treatments for the symptom have been tried or considered;
 - The recommended use of marijuana would mitigate the symptom;
 - The benefits from the applicant’s recommended use of marijuana would outweigh any risks associated with that use;

²⁴ Health Canada, Information, *Medical Access to Marijuana – How the Regulations Work*, July 2001.

²⁵ Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, page 8.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- The medical practitioner is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug;
- The applicant’s recommended daily dosage and period of use.

Category 2

❖ Eligibility: Applicants who suffer from specific symptoms associated with some serious medical conditions, specially:

- **Multiple sclerosis:** severe pain and/or persistent muscle spasms;
- **Spinal cord injury:** severe pain and/or persistent muscle spasms;
- **Spinal cord disease:** severe pain and/or persistent muscle spasms;
- **Cancer:** severe pain, cachexia, anorexia, weight loss, and/or severe nausea;
- **AIDS/HIV infection:** severe pain, cachexia, anorexia, weight loss, and/or severe nausea;
- Severe forms of **arthritis:** severe pain; and
- **Epilepsy:** seizures.²⁶

	Severe Pain	Persistent Muscle Spasms	Cachexia	Anorexia	Weight Loss	Severe Nausea	Seizures
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>					
Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>					
Spinal Cord Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Cancer	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS, HIV infection	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Severe form of Arthritis	<input type="checkbox"/>						
Epilepsy							<input type="checkbox"/>

Source: Application for Authorization to Possess Dried Marihuana, Category 2 – Medical Specialist Form

- ❖ Conditions: Applicants must provide a declaration from a **medical specialist** to support their application, indicating, among other things:
- The applicant’s medical condition and the symptom that is associated with that condition or its treatment;
 - The specialist practises in an area of medicine that is relevant to the treatment of the applicant’s medical condition;

²⁶ These symptoms are listed in a Schedule to the MMAR and were selected based on the outcome or conclusions of scientific and medical reports, although seizures associated with epilepsy were added in view of the findings in the *Parker* decision. This list is intended to be reviewed on a regular basis and is to be amended as new information becomes available.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- All conventional treatments for the symptoms have been tried or considered and were found to be medically inappropriate for reasons outlined in the Regulations;
- The recommended use of marijuana would mitigate the symptom;
- The benefits from the applicant’s recommended use of marijuana would outweigh any risks associated with that use, including risks associated with long-term use of marijuana;
- The medical specialist is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug; and
- The applicant’s recommended daily dosage and period of use.

Category 3

- ❖ Eligibility: Applicants who have symptoms associated with a medical condition, **other than those described in Categories 1 and 2.**
- ❖ Conditions: Declarations from **two medical specialists** must accompany the application. The first declaration must indicate all information required under Category 2; all conventional treatments that have been tried or considered for the symptom; and the reasons, from those outlined in the Regulations, why the medical specialist considers that those treatments are medically inappropriate.

SYMPTOM(S)	TREATMENTS	REASONS – For each conventional treatment listed in the “Treatments” column, please provide the reasons why you consider that the treatment is medically inappropriate. (CHECK OFF THE APPROPRIATE BOX BELOW)							
		The treatment was ineffective.	The applicant has experienced an allergic reaction to the drug used as a treatment.	There is a risk that the applicant would experience cross-sensitivity to a drug of that class.	The applicant has experienced an adverse drug reaction to the drug used as a treatment.	There is a risk that the applicant would experience an adverse drug reaction based on a previous adverse drug reaction to a drug of the same class.	The drug used as a treatment has resulted in an undesirable interaction with another medication being used by the applicant, or there is a risk that this would occur.	The drug used as a treatment is contraindicated.	The drug under consideration as a treatment has a similar chemical structure and pharmacological activity to a drug that has been ineffective for the applicant.
In the column below, please list the name of symptom(s) associated with the medical condition or its treatment and that is (are) the basis for the application.	In the column below, for each symptom, please list the name of conventional treatments tried or considered.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source: Application for Authorization to Possess Dried Marijuana, Category 3 – First Medical Specialist Form

- ❖ The second declaration must indicate that, among other things: the specialist has reviewed the applicant’s medical file and the reasons why the conventional

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

treatments are considered to be medically inappropriate; the specialist has discussed the applicant's case with the first specialist and agrees that the recommended use of marijuana would mitigate the symptom, and the benefits of the applicant's recommended use of marijuana would outweigh any risks associated with that use, including the risks associated with long-term use of marijuana; and the second specialist is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug.

Dosage

The medical practitioner or specialist sets the daily dosage. If the recommended daily dosage is more than 5 grams per day, the medical practitioner or specialist must indicate that he or she has considered the risks associated with an elevated daily dosage of marijuana, including risks with respect to the effect on the applicant's cardiovascular, pulmonary and immune systems and psychomotor performance, as well as the potential for drug dependency; and that in his or her medical opinion, the benefits of the applicant's use of marijuana according to the recommended daily dosage would outweigh the risks associated with that dosage, including risks associated with the long-term use of marijuana.

Maximum quantity possessed

The authorization to possess specifies the amount that may be possessed at any given time is a 30-day treatment supply. As explained above, the medical practitioner or specialist sets the daily dosage used to determine the 30-day treatment supply.

Duration

Generally, authorizations to possess are valid for one year and may be renewed.

Licence to produce

There are currently two possible legal sources for holders of an authorization to possess: they can grow their own supply or they can designate someone else to grow it for them. Health Canada has stated that, in the future, they should also be able to obtain it from a licensed supplier.

Only holders of an authorization to possess (personal-use production licence) or someone who has been designated as their representative (designated-person production licence) are eligible to hold a licence to produce. A designated person cannot be remunerated for their activities.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Conditions for obtaining a licence to produce include the following:

- ❖ A person cannot be the holder of more than one licence to produce;
- ❖ One site may be used for the production of marijuana under a maximum of three separate licences;
- ❖ The holder of a licence to produce must maintain measures necessary to ensure the security of the product;
- ❖ The production of marijuana outdoors is not permitted if the production site is adjacent to a school, public playground, day care facility or other public place frequented mainly by persons under 18 years of age;
- ❖ A person is ineligible for a designated-person production licence, who has been found guilty of a designated drug offence in the previous 10 years.

The licence specifies the maximum number of plants that may be cultivated. The licence also deals with the maximum quantity of dried marijuana that may be kept in storage and, in the case of a designated representative, the transportation of marijuana. The maximum amount of marijuana that may be cultivated and stored at any time depends on the daily dosage that has been set by the medical practitioner or specialist, and whether plants are grown indoors or outside. The regulations also deal with inspection powers and record-keeping requirements.

Other provisions

There are also provisions dealing with matters such as: measures to ensure the security of the marijuana in the possession of an authorized person; the revocation of licences; the showing of documents to police officers; the referral to police of complaints received by inspectors; and the disclosure of information about a medical practitioner to provincial licensing authorities of medicine. Of note is a transitional provision extending section 56 exemptions for an extra six months after the date of their expiry.

Health Canada has established an ongoing review process to monitor the effectiveness and application of the MMAR and provide advice on future measures related to the manufacture, distribution and sale of marijuana for medical purposes. This process involves a series of activities intended to collect information and seek input on various aspects of the MMAR. A 15-member committee representing a number of different stakeholder groups is currently being established, with its first meeting planned in October 2002.

COMPASSIONATE ACCESS?

One of the objectives of the MMAR was to provide a compassionate framework for medical access to marijuana. In addition, one of the criteria used in choosing the current regulatory approach was that it “*must not unduly restrict the availability of marihuana to patients who may receive health benefits from its use.*”²⁷

While a process that authorizes the possession and production of marijuana has been established in Canada, this has not ensured that cannabis is suitably available to those in need. After careful review of the MMAR and thorough consideration of the evidence submitted to us, it is apparent that the MMAR have become a barrier to access. Rather than providing a compassionate framework, the regulations are unduly restricting the availability of cannabis to those who may receive health benefits from its use.

The following was stated in the Regulatory Impact Analysis Statement that accompanied the publication of the MMAR.

*Due to anticipated increased visibility and efficiency of the new regulatory scheme and increased awareness of the potential uses or medical benefits of marihuana, it can reasonably be expected that the numbers of applicants will **increase significantly**. (emphasis added)*

As reported to us by Health Canada, as of 3 May 2002, 658 exemptions had been granted under the authority of section 56, and 501 were still active. In terms of the MMAR, 498 applications were received and 255 had been authorized as of the same date. In addition, 164 personal production licences and 11 designated personal licences have been issued. The rest of the files are open and are incomplete, awaiting more information or undergoing review.²⁸

Thus, almost one year after the MMAR came into force, only 255 people have been authorized to possess marijuana for therapeutic purposes and only 498 applications have been received. These numbers are significantly lower than the number of exemptions that were granted under section 56 of the CDSA. Although 501 exemptions under section 56 are still active, it is clear that the number of applicants has not increased significantly as could “reasonably be expected” under the MMAR. In fact, the stated efficiency of the new regulatory scheme should be viewed with much scepticism. The low participation rate, in itself, should raise serious concerns among those sincerely aiming to provide compassionate access to cannabis for therapeutic purposes. In addition, the following sections will set out some of the specific problems

²⁷ Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, page 13.

²⁸ Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, page 32.

that must be addressed if the regulatory scheme is to be truly efficient and compassionate.

Eligibility

The current framework requires an applicant to obtain a declaration from a medical practitioner (or one or two specialists) indicating that the recommended use of marijuana would mitigate the applicant's symptom and that the benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use. The medical practitioner must also determine the applicant's recommended daily dosage and period of use. A medical practitioner is defined as someone who is authorized under the laws of a province to practise medicine.

It is clear to everyone that requiring medical practitioners to act as "gatekeepers" in the use of marijuana for therapeutic purposes has created a major impediment to access, or, as Health Canada states, "*there is a conundrum*". The Canadian Medical Association and many other professional medical organizations have refused to support the new federal application process because of issues of patient safety, dosages, and the legal liability of physicians prescribing cannabis.

This reluctance should not have come as a surprise to Health Canada. During the consultation process with regard to the proposed regulations, two medical associations and two provincial licensing authorities opposed the use of smoked marijuana for medical purposes. Their reasons included:

- The lack of scientific evidence supporting its use;
- The fact that marijuana is not an approved drug product;
- The view that the use of smoked marijuana is not an acceptable form of drug administration; and
- The view that the responsibility placed on doctors to support the use of marijuana for medical purposes may place them in conflict with professional conduct rules relating to the use of unapproved or "alternative" medicines.²⁹

The position taken by the Canadian Medical Protective Association (CMPA) is fairly reflective of the positions taken by other individuals and organizations in the medical community. The CMPA is a medical mutual defence organization with 60,000 members—about 95 per cent of the physicians practising in Canada. It has warned its members that they could expose themselves to liability or professional misconduct complaints if they prescribe marijuana without "detailed knowledge" of the drug's risks and benefits and the appropriate dosage. The following was stated in an information sheet sent to members:

Section 69 of the regulations allows a medical licensing authority to request from the federal health minister information regarding a specific medical practitioner, which may be provided if the minister has

²⁹ Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, p. 19.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

reasonable grounds to believe the medical practitioner has made a false statement under the regulations. This is a significant concern, as physicians may unknowingly make a false statement because they are being asked to attest to matters that may go beyond the scope of their expertise. As a result, the risk that physicians could be reported to their College is increased.

The fact that marijuana is not an approved drug product may lead some to conclude marijuana is an alternative medicine. This raises the important point as to whether the Colleges would consider physicians' involvement in the application for a licence to possess marijuana as requiring them to comply with the policy of that College concerning alternative or complementary medicines. The CMPA advises physicians to ascertain from their regulatory authority what their position is in this regard.

Given the consequences that may befall physicians with respect to their licensing body, or potential medico-legal liability, physicians will want to be very careful when determining whether to assist a patient in making an application under these regulations.³⁰

The CMPA has also stated that the information about the effectiveness of medical marijuana in each patient's case, the relative risks and benefits of the drug and what dosage would be appropriate is "simply is not available," making it nearly impossible for the vast majority of doctors to comply with requirements of the MMAR. It views the MMAR as placing "an unacceptable burden on member physicians" and states that, since "many physicians would not have the necessary knowledge about the effectiveness, risks or benefits of marijuana, we believe it is unreasonable to make physicians gatekeepers in this process."³¹ The CMPA advised its members as follows:

As you will see from the attached Information Sheet, now in the hands of our members, we have advised those physicians who are not or do not feel qualified to make those assessments to refrain from signing a declaration for a patient. We also advised our members to explain to their patients why they do not have the knowledge about marijuana, and to refer the patient to another physician, if known, with more experience in the medical use of marijuana.

Finally, recognizing that some physicians, out of compassion for their patients, may believe in good faith that their medical condition would benefit from marijuana, we have advised them to complete only Parts 1 and 2 of the form and to NOT complete Parts 3, 4 and 5, leaving Health Canada to decide whether to process an incomplete application.³²

Clearly, under these circumstances, patients will have difficulty finding a medical practitioner willing to complete the required declaration forms, and even more difficulty accessing the appropriate specialists. This situation has created an unacceptable barrier to access and one must conclude that physicians should not be the

³⁰ Canadian Medical Protective Association, *What To Do When Your Patients Apply For A Licence To Possess Marijuana For Medical Purposes*, October 2001.

³¹ Canadian Medical Protective Association, letter to the Honourable Allan Rock, Q.C., 8 November 2001.

³² *Ibid.*

“gatekeepers” under the MMAR, a responsibility that they themselves do not desire. Even Health Canada recognizes that there is a problem.

Without that scientific evidence, the doctors are in a legitimate quandary. For other therapeutic products, doctors rely on information that Health Canada either develops or analyzes through the drug review process. That is the basis for doctors’ understanding of the particular products. They do not have that analysis in this particular situation.

Through the marijuana medical access regulations, we have eliminated the criminality of possessing and growing for your own purposes. That is the regulatory regime that is in place. We are working with Prairie Plant Systems, as Ms Lynch has said, to develop a research source for this product that will be made available through legitimate clinical trials for patients.

Until such time as we can begin to get the results of the research and until the medical community can determine whether it will prescribe this in legitimate circumstances, there is a conundrum.³³

The involvement of physicians in the process is not questioned—what must be determined is their proper role with respect to use of cannabis for therapeutic purposes. Physicians are trained to provide a diagnosis of a person’s medical conditions and symptoms and to determine how to treat these conditions and symptoms medically. Most do not have, however, adequate knowledge of the therapeutic benefits of cannabis and are reluctant to associate themselves with this product for a variety of reasons, including its illegality. In our view, and as we have explained in detail in Chapter 9, a distinction must be made between an approved medicine per se and a substance that has, at the very least, potential therapeutic applications—although these may not have been “scientifically” confirmed to date. Chapter 9 enumerates the conditions and symptoms for which cannabis has potential therapeutic applications. Let us be clear: we do not view cannabis as a “miracle” substance that will treat or cure numerous medical conditions or symptoms. It is a substance, however, that is known to provide effective relief of certain medical conditions and symptoms, thus improving the quality of life of many individuals.

In these circumstances, the proper role of the physician should be to make a diagnosis of the patient’s medical conditions or symptoms. If the condition or symptom is one where cannabis has potential therapeutic applications, the patient would be authorized to use the therapeutic product of his or her choice, including cannabis. This would also mean eliminating the current requirement that all other “conventional treatments” have been tried or considered before the use of cannabis is authorized. There is no justification for making cannabis an option of “last resort.”

³³ Dann Nichols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, pages 37-38.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

The requirement for specialist involvement in the current scheme clearly can lead to long delays. To make matters worse, the stated positions of medical organizations would make it very difficult to get two specialists to make the required declarations. This creates another unwarranted barrier.

*The requirement to involve a medical specialist in the authorization of possession of medicinal cannabis is unjustified, unfounded, unrealistic and punitive. It negates timely access, and places an unjustified burden on both the patient and the Health Care system. Many patients already wait from nine months to a year to see a specialist. This means that those waiting for authorization to access medicinal cannabis may be on hold for upwards of a year. This is an inhumane wait to force upon those in dire medical need. In addition, it will unnecessarily exacerbate already extensive waiting lists for specialists, meaning those in genuine need of the specialists will unduly suffer.*³⁴

The conditions and symptoms for which cannabis use would be authorized are set out in Chapter 9. New conditions or symptoms would be added based on ongoing research.

We are aware that the *1961 Single Convention on Narcotic Drugs* would seem to require medical prescriptions for the supply or dispensation of drugs to individuals.³⁵ We make two comments:

- International conventions are generally subject to a country's constitutional provisions. As previously discussed, courts in Canada have found that depriving an individual of the ability to choose marijuana as medication to alleviate the effects of a serious illness does violate the rights protected under the *Canadian Charter of Rights and Freedoms* unless there is a statutory exemption scheme authorizing such use. The courts have indicated that, where a statutory exemption scheme turns out to be "illusory," a constitutional exemption will be granted. The stated positions of Canadian medical organizations may make the current MMAR exemption scheme turn out to be "illusory."
- It is better to look to the spirit rather than the letter of the Convention. While cannabis may not be an approved medicine per se, there is no doubting its potential therapeutic applications. Thus, the Government of Canada should advise the international community that we will not strictly adhere to this requirement and that we will be requesting appropriate amendments to the international conventions.

³⁴ B.C. Compassion Club Society, *BCCCS Response to Health Canada's Proposed Medical Marijuana Access Regulations*, 4 May 2001, page 4.

³⁵ *Single Convention on Narcotic Drugs, 1961*, Article 30.2.b.i.

Access to cannabis

Concerns regarding patients' ability to grow marijuana on their own or to find a person willing and able to do it for them were often raised. This problem is compounded by the condition in the MMAR that a person cannot be the holder of more than one licence to produce. Problems associated with the present scheme include a lack of experience in cultivation; products of unknown potency and quality; security risks related to cultivation of marijuana; etc.

Undoubtedly, patients must have access to safe and high-quality cannabis products. The current option of self-cultivation should remain open for those who prefer this avenue. In such cases, the patient would register directly with Health Canada. In cases where self-cultivation is not appropriate or feasible, access should be permitted through properly regulated **Dedicated Cannabis Distribution Centres**. These centres would be staffed by personnel with knowledge of the therapeutic use of cannabis, who could advise patients on the dosage, strain and potency best suited for their particular conditions. The failure to obtain a domestic source of research-grade marijuana, as had been planned, provides further justification for allowing distribution centres to dispense high-quality cannabis to eligible patients. In addition, we are convinced that the government should not be the only distributor of cannabis intended for therapeutic purposes. Currently, Compassion Clubs play a very important role in distributing cannabis to those who need it for therapeutic purposes. For example, the B.C. Compassion Club Society is a registered non-profit society that has been distributing cannabis for medical use since 1997. It employs a staff of 28 and serves a membership of approximately 1,600 people. Before registering a member, the club requires a confirmation of diagnosis and a recommendation for cannabis from a physician, naturopathic doctor or a psychiatrist. If a doctor will not sign a recommendation solely because he or she is uncomfortable with the legal status of cannabis, or has concerns about professional retribution, the club may register the patient without a doctor's recommendation, depending on the severity of the diagnosis. Similar Compassion Clubs exist elsewhere in Canada.³⁶

Access to a variety of strains of cannabis with varying levels of potency is crucial. For example, the B.C. Compassion Club Society currently stocks many varieties of cannabis products.

*Our daily menu usually has seven to ten varieties of cannabis, one or two varieties of hashish, cannabis tincture and baked goods. It is important that medicinal users have access to a variety of strains, as the effect of cannabis varies depending on which strain is being used and the method of ingestion. Our members are made aware of the differences and can then select the best strain of cannabis to most effectively treat their symptoms.*³⁷

³⁶ For example, the Vancouver Island Compassion Society currently has 235 members and the Club de compassion de Montréal has 130 members.

³⁷ Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 36

High-quality products would be ensured through proper testing. The importance of testing was raised as a key issue.

*It is absolutely crucial in the developments on which we are working – and that we would like to continue – to have strict guidelines in terms of moulds and mildews, pesticides, fungicides, heavy metals and the kinds of things – which can be very dangerous – that you find in non-organic cannabis. Even in organic cannabis, some of those elements of microbiology can be very harmful to people, especially for people with depleted immune systems. We can only develop such standards when the medical marijuana community has access to laboratories. I think that there are all kinds of standards that can be developed in terms of safety and cleanliness in growing and distribution.*³⁸

Despite what most would view as laudable motives—distributing cannabis to patients in order to alleviate their suffering—most of the existing clubs have faced or are facing difficulties with the justice system. Because they are operating in a grey area, those involved in these clubs are subject to prosecution and have in fact been prosecuted. For example, we heard from Philippe Lucas, director of the Vancouver Island Compassion Society (VICS), who indicated that he had been arrested and charged with possession for the purposes of trafficking because of his work with VICS. Mr. Lucas pleaded guilty to the charge but was recently granted an absolute discharge. Some of the comments made by the judge at sentencing are certainly relevant to this chapter. On the question of eligibility, the judge stated the following:

*This case must be viewed in a broad context, in which to date, the combination of federal regulations and College of Physicians trepidation has made it extremely difficult for applicants to obtain approval to use marijuana.*³⁹

He added the following with respect to access to marijuana:

Further, the federal government has so far been unable to ensure any legal supply of marijuana to those whom Health Canada thinks need it as a therapy. This is a particular hardship for those who cannot grow it.

*...the Crown cannot rely upon the argument that there is a lawful option for those in need of the drug when the evidence establishes that the drug is only theoretically available through legitimate sources.*⁴⁰

³⁸ *Ibid.*, page 44.

³⁹ *R. v. Lucas*, Provincial Court of British Columbia, Victoria, File No: 113701C, para. 47 (Honourable Judge Higinbotham).

⁴⁰ *Ibid.*, para. 47-48.

In conclusion the judge stated the following.

*I find that while there is no doubt that Mr. Lucas offended against the law by providing marijuana to others, his actions were intended to ameliorate the suffering of others. His conduct did ameliorate the suffering of others. By this Court's analysis, Mr. Lucas enhanced other peoples' lives at minimal or no risk to society, although he did it outside any legal framework. He provided that which the Government was unable to provide a safe and high quality supply of marijuana to those needing it for medicinal purposes. He did this openly, and with reasonable safeguards. The fact that he has stated he will continue this activity points to the sincerity of his principles, and points to our need as a society to get this thorny issue resolved quickly by either Parliament or the Supreme Court of Canada. If he re-offends, he will have to argue his case again, and may find a discharge difficult to obtain in the future. This court hopes that cooler heads will prevail pending the final resolution of issues regarding the medical and non-medical use of marijuana.*⁴¹

In Montreal, we heard how two volunteers of the *Club Compassion de Montréal* had been arrested only three months after they started operations. A decision is expected by the end of August 2002. Encouragingly, Hilary Black, founder and director of the B.C. Compassion Club Society, stated that the local police had generally been “wonderfully supportive of their work.” However, her next statement reveals readily apparent contradictions.

*Police who have come to the Compassion Club Society have told me what great work we are doing and have, on one occasion, protected a safe full of cannabis on our behalf. However, I have had a police gun held to my head for being at a growing facility. While I met with the federal health minister, Alan Rock, to give recommendations and information Health Canada had requested from us, the RCMP raided a greenhouse that was growing low cost, organic cannabis for the Compassion Club Society. While I am here before you, sharing our information as experts in the distribution of medicinal cannabis, my colleagues risk arrest, imprisonment, their ability to travel, to be employed, and their freedom to distribute cannabis to those in need. Prohibition is not protecting Canadians from the evils of cannabis; prohibition is destroying Canadians' lives.*⁴²

Because these organizations are presently operating in a grey area we would hope that those in charge of enforcement would use their discretion powers liberally and that cooler heads will prevail. Some of the statements made by Hilary Black led us to be optimistic in this area. Clearly, in other areas of the country, the political climate will have to change.

In order to create a transparent therapeutic distribution system, these centres should be licensed and properly regulated. The conditions of their operation should include a requirement that they be authorized only to distribute cannabis for therapeutic purposes to those who have been diagnosed as having an enumerated

⁴¹ *Ibid.*, para. 49

⁴² Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 41.

condition or symptom. In addition, the distribution centres would be required to keep suitable records and make periodic reports. The purpose of such information would be to keep Health Canada informed of the centres' members for registration purposes and also to provide valuable information for scientific research. Thus, the records would include information on a patient's medical condition and its evolution, the amounts consumed and the observed effects on the patient. The centres would also be required to ensure that security measures are in place and would be subject to inspections to ensure compliance with the regulations.

While added regulation will increase the costs of these distribution centres, this is essential to ensure proper controls over therapeutic use of medicinal cannabis. We insist that the costs of this regulatory scheme be kept to a minimum so as not to impede access to cannabis through inflated prices.

With respect to obtaining products, centres would agree to be supplied only by licensed producers. Such producers would be able to cultivate cannabis only for therapeutic purposes—since the separation of the therapeutic system from the recreational system is crucial. Licensed producers would be properly regulated—in particular, to ensure adequate safety measures are in place—and would be required to produce safe, high-quality products.

Products

Currently, the MMAR authorize possession of only dried marijuana, and not other cannabis products. We do not feel that this is justified and would recommend that the scheme be expanded to cover other cannabis derivatives .

Costs

We heard on several occasions that patients using cannabis for therapeutic purposes were often suffering from serious debilitating diseases, which negatively affected their financial situations. We recognize that drug coverage by insurance plans is generally a provincial responsibility. However, we believe that the purchase of marijuana for therapeutic purposes, and the purchase of equipment necessary for its cultivation, should be considered a medical expense for the purposes of the *Income Tax Act*.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

<i>Marihuana Medical Access Regulations</i>	Committee Proposals
<p>Eligibility</p> <ul style="list-style-type: none"> • The medical practitioner must not only confirm the applicant’s medical condition and the symptom that is associated with that condition or its treatment, but also confirm that the recommended use of marijuana would mitigate the symptom and that the benefits from the applicant’s recommended use of marijuana would outweigh any risks associated with that use • Requirement to consult one (category 2) or two (category 3) specialists for symptoms associated with medical conditions set out in category 2 and category 3 • Generally requires that all conventional treatments have been tried or considered • Three categories of eligibility 	<p>Eligibility</p> <ul style="list-style-type: none"> • The diagnosis of a medical doctor or other medical practitioner regulated by a provincial colleges of physicians and surgeons would suffice for the purpose of authorizing therapeutic use • Eliminate the requirement to consult one or two specialists • Eliminate the requirement that all conventional treatments have been tried or at least considered before cannabis may be used • Eliminate the three categories and enumerate the medical conditions or symptoms for which cannabis use would be permitted – updating the list on a continual basis based on commissioned research
<p>Access</p> <ul style="list-style-type: none"> • Patients are limited to growing their own supply or designating someone to grow it for them 	<p>Access</p> <ul style="list-style-type: none"> • Patients would be allowed to grow cannabis themselves or obtain it from dedicated distribution centres supplied by licensed producers
<p>Products</p> <ul style="list-style-type: none"> • Limited to cannabis (marijuana) 	<p>Products</p> <ul style="list-style-type: none"> • Include all cannabis-derived related products
<p>Dosage</p> <ul style="list-style-type: none"> • Set by medical practitioner 	<p>Dosage</p> <ul style="list-style-type: none"> • Would be determined by patient in association with the dedicated distribution centre

RESEARCH PLAN

Health Canada’s Office of Cannabis Medical Access is responsible for the administration of the MMAR. It also co-ordinates other initiatives related to cannabis, including research on the safety and effectiveness of marijuana used for therapeutic purposes and the establishment of a reliable Canadian source of research-grade marijuana.

As stated previously, Health Canada released a report in June 1999 announcing a research plan for the therapeutic use of marijuana. The document⁴³ laid out a five-year research plan for evaluating the risks and benefits of the use of marijuana for medical purposes. The plan included the following elements:

- ❖ a research agenda composed of projects to address the issues of safety and efficacy of smoked marijuana and cannabinoids;
- ❖ mechanisms for medical access to marijuana outside the projects (for example section 56 exemptions discussed previously in this chapter); and
- ❖ the development of a Canadian source of research-grade marijuana.

Scientific research

As part of the government's strategy to address the issue of medical marijuana, Health Canada decided to sponsor research activities to evaluate the safety and efficacy of smoked marijuana and of cannabinoids. Health Canada was concerned that the evidence of the therapeutic value of smoked marijuana was heavily anecdotal and that the scientific studies supporting the safety and efficacy of marijuana for therapeutic claims were inconclusive. Health Canada was also concerned about the health risks associated with the use of marijuana, especially in smoked form.

The strategy has been developed with advice from the Therapeutic Products Programme's (TPP) Expert Advisory Committee on New Active Substances, an external body of scientific and medical experts who provided advice to the TPP.

Currently, there is a partnership program between Health Canada and the Canadian Institutes of Health Research (CIHR), a granting agency. This is to ensure scientific validity of the studies. The Health Canada/CIHR Medical Marijuana Research Program (MMRP) has been established as a five-year research plan with estimated funding of up to \$7.5 million. The initial focus is on the smoked form of marijuana, although future initiatives are also to focus on non-smoked marijuana and cannabinoids.

We are aware of at least two studies that have been planned:

- ❖ In July 2001, Health Canada and the CIHR announced a contribution of \$235,000 to fund a pilot study at McGill, with about 32 patients, aimed at evaluating the effects of smoked marijuana for chronic neuropathic pain.
- ❖ In June 2001, Health Canada announced funding of \$840,000 to support a research project by the Community Research Initiative of Toronto (CRIT) on the efficacy of smoked marijuana in the treatment of wasting syndrome in those living with HIV/AIDS. At the time, it was entering the second phase of a three-part research project on smoked marijuana – The acute effects of smoked cannabis on appetite in persons living with HIV/AIDS (PHAs): A randomized, double-blind, placebo-controlled, crossover pilot study.

⁴³ Health Canada, Therapeutics Products Programme, *Research Plan for Marijuana for Medicinal Purposes : A Status Report*, 9 June 1999.

It should be noted, however, that neither of these projects is currently under way because they do not have access to marijuana.

In addition to pilot projects, Health Canada has announced that research-grade marijuana will be provided to eligible individuals who agree to provide health information for monitoring and research purposes. Health Canada will collect and analyse this information for research purposes. Once again, Health Canada has yet to provide marijuana to authorized users.

Health Canada has indicated that the knowledge gained from the overall research program will be used, in part, to amend the MMAR if necessary. For example, category 2 symptoms may need to be adjusted or the daily dosage may need to be more precisely determined. Health Canada also indicated that if no benefits were shown, the continued need of the MMAR would be in doubt.

Clearly, research on the therapeutic aspects of marijuana is essential. While Health Canada should be applauded for establishing a research plan, what is less commendable is the pace at which the research is progressing. As stated, the authorized pilot projects have yet to commence their research because Canada must rely on an American source for research-grade marijuana. This means that American institutions, in particular the National Institute on Drug Abuse, are entitled to review Canadian research protocols to determine whether or not they will deliver their marijuana products to Canadian researchers.

Our first source or our first attempt at sourcing the marijuana for research purposes was through NIDA, the National Institute on Drug Abuse in the States. They have seed and dried product. We are still negotiating with them to get some dry product.

In order to use their product, we have to have the protocols that the product will be used for approved by both the health department there and NIDA themselves. Once they have approved the actual scientific protocol, then it has to go to the DEA to see if they will allow the export.⁴⁴

While further research is essential, it does not suggest that therapeutic use is not justified in specified circumstances. The ongoing research should focus on confirming its justification and on identifying new medical conditions or symptoms for which cannabis has therapeutic value. Research to determine the value of cannabis as a medicine per se should also be a priority, as should finding alternative delivery systems that are as effective as smoked cannabis.

Before leaving the issue of research, mention should be made of the considerable expertise and knowledge currently residing in the Compassion Clubs, which have become established outside of the legal system. This source of valuable

44 Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, pp. 47-48.

information and expertise has not been acknowledged under Health Canada's current research plan. We feel strongly that the information they have must be gathered and analysed for research purposes. The validity of ongoing research using what some consider to be low-quality, low-potency cannabis imported from the National Institute on Drug Abuse or similar type of product that may be produced in Canada must also be called into question. Hilary Black, founder and co-director of the B.C. Compassion Club Society, stated the following.

*We created a research proposal with a team of research scientists from Vancouver. However, we were turned down because we refuse to facilitate a study using a placebo or low-quality, low-potency cannabis imported from the US National Institute on Drug Abuse. Any study attempting to prove the efficacy of cannabis as a medicine using such a low-potency herb, or unknown strains such as those currently being grown in Canada by Plant Prairie Systems, is destined to fail. There is no need to import cannabis for research, considering the high quality and huge quantity of cannabis being produced in Canada. The information we could gather is being requested by doctors, patients, pharmaceutical companies, Plant Prairie Systems and Health Canada, yet we are not financially empowered to facilitate this research.*⁴⁵

Research-grade marijuana

As was previously stated, another priority in Health Canada's research plan was the development of a Canadian source of research-grade marijuana. A request for proposal (RFP) was released on 5 May 2000 through Public Works and Government Services Canada. The purpose of the RFP was to establish a Canadian source of quality, standardized, affordable, research-grade marijuana for scientific research. Originally, the marijuana was to be made available only to qualified, approved scientists for research. A number of proposals were received by the closing date of 28 June 2000. The evaluation criteria included: financial status, qualifications of personnel, security requirements respecting personnel, etc. No experience in growing marijuana was required, although there was a requirement for experience in growing plant material for human consumption.

In December 2000, a contract was awarded to Prairie Plant Systems Inc. of Saskatoon (PPS) to provide Health Canada with a reliable source of affordable, quality, standardized marijuana for medical and research purposes. Health Canada also announced that until the domestic supply was established, it would submit requests to the U.S. National Institute of Drug Abuse to obtain research-grade marijuana for clinical trials being conducted in Canada on behalf of researchers.

PPS met the contract requirements for security and was given authorization to begin growing marijuana. The site chosen for the cultivation of research-grade marijuana in Canada was an abandoned mine in Flin Flon, Manitoba. While to some this appears comical, Health Canada justifies this decision because of the security this

45 Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, p. 10 :38-10 :39.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

location provides and the opportunity to control the temperature, the humidity and the growing conditions.

The first product was expected to be delivered to Health Canada by early 2002. Under the terms of the five-year, \$5.7 million contract that Prairie Plant Systems Inc. signed with Health Canada, the company would

- ❖ Set up and operate a marijuana growing, processing, fabrication and storage establishment;
- ❖ Conduct laboratory testing and quality control of marijuana throughout the product life cycle;
- ❖ Fabricate, package, label and store marijuana material;
- ❖ Distribute marijuana product to recipients authorized by Health Canada; and
- ❖ Conform to the requirements of the CDSA including stringent security and physical measures.

Health Canada also announced that this product would, in addition to use for research purposes, be made available to authorized Canadians using it for medical purposes who agree to provide information to Health Canada for monitoring and research purposes.

This spring, Health Canada revealed that the first crop could not be used for research purposes because of the varying quality. While they had hoped to obtain seeds from the National Institute on Drug Abuse, the seeds that were used were obtained from police seizures in Canada. This led to a collection of marijuana with different strains and characteristics. Health Canada states the importance of research-grade marijuana as follows:

*Going back to the comments we made earlier on why Health Canada is involved in the study of medical marijuana, it is to determine whether to develop the scientific evidence that is required to determine whether there is a benefit. In order to develop that scientific evidence, one must have a base product that meets research standards. It was not a question of whether Prairie Plant Systems did in fact grow marijuana; it was a question of whether the product they developed was consistent, research-grade standard such that it could be used in legitimate scientific research.*⁴⁶

While we are sympathetic to this argument, there would appear to be no justification for not supplying this product to those who have been authorized to do so under the CDSA, particularly since the safety of the product, in regard to pesticides, moulds, etc., should not be in question.

⁴⁶ Dann Nichols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, page 46.

CONCLUSIONS

We would like to emphasize that the changes we propose to the MMAR still ensure that therapeutic use is limited to cases of legitimate medical need and that distribution and production is done under governmental licence.

Conclusions of Chapter 13

- **The MMAR are not providing a compassionate framework for access to marijuana for therapeutic purposes and are unduly restricting the availability of marijuana to patients who may receive health benefits from its use.**
- **The refusal of the medical community to act as gatekeepers and the lack of access to legal sources of cannabis appear to make the current regulatory scheme an “illusory” legislative exemption and raises serious Charter implications.**
- **In almost one year, only 255 people have been authorized to possess marijuana for therapeutic purposes under the MMAR and only 498 applications have been received – this low participation rate is of concern.**
- **Changes are urgently needed with regard to who is eligible to use cannabis for therapeutic purposes and how such people gain access to cannabis.**
- **Research on the safety and efficacy of cannabis has not commenced in Canada because researchers are unable to obtain the product needed to conduct their trials.**
- **No attempt has been made in Health Canada’s current research plan to acknowledge the considerable expertise currently residing in the compassion clubs.**
- **The development of a Canadian source of research-grade marijuana has been a failure.**

CHAPTER 14

POLICE PRACTICES

Views on police priorities regarding enforcement of laws on illicit drugs are, at the very least, inconsistent, if not completely contradictory. Some believe that too much police time, effort and resources are spent in investigating illicit drug offences and, more specifically, possession offences – even more specifically, cannabis possession offences. Others—including the police themselves – claim that police priorities are already focused on traffickers and producers, and that possession charges are laid as a result of police presence to deal with other criminal activity. Thus, they maintain that the vast majority of cannabis possession charges are incidental to other police responsibilities.

This chapter will review the key organizations that are responsible for enforcing Canada's current illicit drugs legislation, the *Controlled Drugs and Substances Act* (CDSA). It will include a discussion of the powers they have been granted, and the investigative techniques used, in relation to illicit drug investigations. Finally, key police-related statistics will be explored. This information should help clarify some of the misconceptions related to enforcement of laws on illicit drugs.

ENFORCEMENT AGENCIES

Several organizations play a role in enforcing Canada's illicit drug legislation. This section will review three: the RCMP, the Canada Customs and Revenue Agency (CCRA), and provincial and municipal police forces. These key players co-operate with many other organizations when required, such as National Defence, Fisheries and Oceans, and the Canadian Coast Guard.

The RCMP

The RCMP's role and mandate is to enforce laws, prevent crime, and maintain peace, order and security. The RCMP is involved mainly in four components of Canada's Drug Strategy: enforcement and control; national co-ordination; international co-operation; and prevention programming.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

At the national level, the RCMP's drug enforcement responsibilities are primarily carried out by two groups:

- ❖ The Drug Enforcement Branch: with approximately 900 employees, this branch is responsible for drug enforcement in Canada through its head office in Ottawa and its divisional drug enforcement units located throughout the country. The Branch also provides rapid communication to members of the international drug enforcement community.
- ❖ Integrated Proceeds of Crime Initiative: with about 415 employees, this group is responsible for investigating persons for proceeds of crime and seizing assets obtained through criminal activities. With an estimated 90 per cent of seizures related to drugs, it is primarily a drug-related initiative. The 13 units are staffed with a mix of: federal, provincial, and municipal police; Justice counsel; customs officers; tax investigators; asset managers; and forensic accountants. Cases tend to be complex and lengthy.

These two services also receive assistance from other RCMP sections such as intelligence and other specialized investigation services, including electronic and physical surveillance. Their current priorities lie in the investigation and arrest of upper echelon criminal organizations, involved in the drug trade, and in the seizing of proceeds of crime. The RCMP has adopted an intelligence-driven approach and conducts project-oriented investigations—for example, focusing on organized crime. It gathers information that is fed through its intelligence process to identify the main threats across the country. National priorities are based on these threat assessments so that resources will be focussed on the areas of greatest risk to Canadians. National priorities are reassessed, modified and retargeted based on gathered intelligence. Within those national priorities – for example, outlaw motorcycle gangs – particular groups will be specifically targeted. This approach has resulted in cases that are complex and lengthy and consume significant resources. Many of these investigations can take many years to come to fruition.

When it appeared before the Committee in October 2001, the RCMP set out the following national priorities:

Our current strategic national priorities are outlaw motorcycle gangs, Asian-based organized crime, Italian-based organized crime, and Eastern European-based organized crime. These are national targets; they are not drug targets. These are the RCMP national targets. These groups are involved in all commodity areas. However, you will notice that all four groups are involved in illicit drugs¹

The RCMP works closely with other national and international enforcement agencies in its efforts to reduce the supply of drugs in Canada. In this function, it will

¹ R..G. Lesser, Chief Superintendent, RCMP, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 8, page 11.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

regularly participate in joint forces operations—which can be permanent working groups or temporary operations aimed at a specific target—to co-operatively investigate criminal activity and exchange intelligence. Liaison is maintained with provincial and municipal police departments, Interpol, the United Nations, the Organization of American States, National Defence, Fisheries and Oceans, Correctional Service of Canada, the Canadian Coast Guard, as well as Customs authorities and drug enforcement agencies worldwide, such as the Drug Enforcement Administration, FBI and U.S. Customs.

The RCMP is also involved in drug prevention and has established a Drug Awareness Service. With a budget of \$4 million and 31 employees, this Service is responsible for going into the community to educate students, parents, athletes, coaches, employees, employers and community groups. The RCMP—including all personnel and not only the 31 full-time employees—makes over 10,000 presentations per year. Programs include Drug Abuse Resistance Education (DARE)², the Aboriginal Shields Program, the Two-way Street: Parents, Kids and Drugs, and the Drugs and Sport Program.

In addition to its federal responsibilities, the RCMP is involved in local enforcement as part of the provincial and municipal policing responsibilities it performs under contract. Sgt. MacEachern, Drug Enforcement Coordinator in New Brunswick, provided the following explanation:

The RCMP has a contractual obligation to the Province of New Brunswick and, as such, we provide policing services to all rural areas of the province, a large number of the smaller service districts and small municipalities, and as well a significant number of larger municipalities. In addition, we have federal law enforcement units throughout the province, and for drug enforcement we have offices and suboffices in Bathurst, Moncton, Saint-Leonard, Saint John and Fredericton.

Simply put, our federal enforcement personnel dedicate themselves to larger scale investigations involving organized criminal groups at the provincial, interprovincial, national and international levels. Our provincial or contract detachments are tasked with targeting local or street level drug traffickers, but often, in the interests of addressing a significant local trafficking situation, our federal units combine resources with our detachments to pursue a specific goal.³

While enforcement statistics are discussed in greater detail in following sections of this chapter, it is interesting to note that, according to the following chart from the Auditor General's 2001 Report,⁴ the RCMP was responsible for approximately 24% of all charges under the *Controlled Drugs and Substances Act* in 1999, with only 4% of the charges relating to its federal policing services. In this chart, the number of persons

² DARE is discussed in greater detail in Chapter 17.

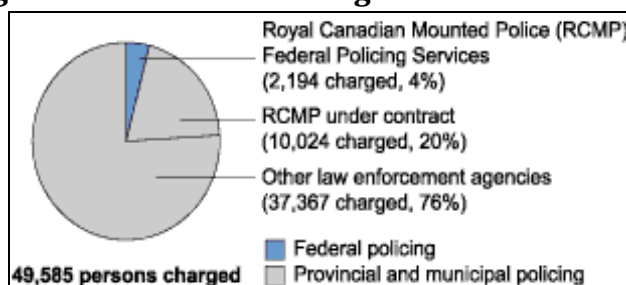
³ Presentation submitted to the Committee on 5 June 2002.

⁴ *Report of the Auditor General of Canada to the House of Commons, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role,"* p. 11.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

charged is according to the most serious offence in a given incident and means persons charged by police or persons against whom the police recommended charges be laid.

Charges under the Controlled Drugs and Substances Act in 1999



The Canada Customs and Revenue Agency⁵

The CCRA—currently with over 8000 employees—has always played a key role in drug enforcement in Canada and is responsible for intercepting drugs at the point of entry. This is a significant task because many of the illicit drugs found in Canada are smuggled across our borders – although this statement may be less accurate with respect to cannabis, because of local production.

The *Customs Act* grants customs officers certain powers. Section 98 authorizes an officer to search a person arriving in Canada if the officer suspects on reasonable grounds that the person has secreted on or about his person: anything in respect of which the Act has been or might be contravened; anything that would afford evidence with respect to a contravention of this Act; or any goods the importation or exportation of which is prohibited, controlled or regulated under the Act or any other Act of Parliament. In addition, section 99 authorizes examination of goods that have been imported into Canada.

The CCRA deals with several types of contraband, including firearms, alcohol, tobacco and drugs. Like that of the RCMP, its work is intelligence-based, using information gathered through its own extensive intelligence network and through other enforcement agencies (both nationally and internationally). Thus, its contraband and intelligence program works with national and international enforcement agencies to develop information, indicators and trends to help identify suspicious shipments and/or persons before they arrive at the border.

The enforcement programs are based on strategic planning, risk management, information gathering and dissemination, partnerships, and effective training of

⁵ This section relies to a great extent on the testimony of Mark Connolly, Director General, Contraband and Intelligence Services Directorate, Customs Branch, Canada Customs and Revenue Agency, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 8, pages 33-39.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

personnel. The Contraband and Intelligence Services Directorate—with illegal drugs as its first priority—is responsible for the design, development, and implementation of strategies with regard to anti-smuggling and intelligence programs. Due to increasing volume, the CCRA implemented the Customs Action Plan—modernizing customs processes and introducing programs based on risk management.

The CCRA contraband and intelligence program is made up of intelligence officers, analysts, and databases to support front-line customs inspectors in identifying high-risk persons and goods at our borders. These units are responsible for collecting and developing intelligence and disseminating it to the line officers across the country.

The CCRA maintains alliances with other customs administrations, national and international law enforcement agencies, and external stakeholders in connection with contraband, intelligence, strategic export and counter-terrorism programs. It has also built important partnerships with other law enforcement agencies in Canada, such as the RCMP and provincial and municipal police, and around the world with other customs administrations and law enforcement agencies such as the United States Customs Service, the Drug Enforcement Agency, the World Customs Organization, the Caribbean Customs Law Enforcement Council, and Interpol. The CCRA regularly participates in joint-force operations of both short- and long-term duration. For example, the Integrated Border Enforcement Teams (IBETS) is a multi-agency law enforcement initiative between Canada and the United States to address cross-border crimes. In addition, the CCRA and police pool resources on a daily basis with local, state and provincial enforcement agencies to combine expertise and intelligence. The CCRA is also part the Integrated Proceeds of Crime initiative discussed above.

Specific activities in relation to drug enforcement include:

- ❖ Use of highly sophisticated contraband detection equipment to conduct non-intrusive examinations to assist in the identification of narcotics – X-ray systems, including baggage, mobile truck and rolling cargo systems; ion scans used to detect trace amounts of narcotics on almost any surface; detector dog teams deployed across the country; contraband detection kits that include a number of useful tools such as probes and fibrescopes; and one submersible remote-operated vehicle used to detect narcotics and other contraband attached to the hull of ships, below the water level.
- ❖ Emphasis on training its customs inspectors in the area of contraband enforcement.
- ❖ Use of several enforcement systems and databases, both internal and external, which allow customs officers and inspectors to identify the level of risk of travellers, carriers and/or drivers.
- ❖ Deployment of dedicated enforcement personnel to enhance intelligence and interdiction in the regions. Regional Intelligence Officers work with local police authorities, targeters, investigators and customs officers to identify high-risk movement across the border. Flexible Response Teams consist of highly trained customs officers who have been placed across Canada to perform monitoring and

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

compliance verification activities, as well as sampling stints on travellers chosen on a random basis. Regional Intelligence Analysts analyze large seizures to identify links to organized crime; they also conduct threat assessments based on trends, and help identify future risk.

The CCRA estimates that it is responsible for approximately 50% of all drug seizures in Canada.

Provincial and municipal police

Provincial and municipal police forces handle the majority of drug cases in Canada. They are involved primarily in enforcing illicit drug legislation at the street level. In addition, members of these forces are often involved in joint operations with the RCMP and/or the CCRA and other enforcement agencies. For example, the Committee was informed of joint operations currently being run with the RCMP—and in certain cases other enforcement agencies—and the Toronto Police Service, the Vancouver Police Department and the Regina Police Service.

COSTS ⁶

The Committee had requested certain details from police forces such as the proportion of time officers spend on drug-related cases, the number of officers assigned to drug enforcement, etc. In most cases, we either received no response to these questions or very general broad statements. Either the police forces were not willing to share this information or police work does not lend itself to these types of calculations and no one knows how much is spent on drug enforcement. In either case, the lack of data makes it extremely difficult to estimate how much of police budgets is allocated to drug-related matters and to analyze whether or not public funds are efficiently allocated.

Estimating the cost of drug enforcement is a fairly complex exercise. Questions raised include: Which items should be included? Which items should be left out because of a lack of data? How should each cost element be measured? Are such costs truly avoidable? How are items to be costed? Finally, what is the effect of these factors on the quality of the results?

⁶ This section relies to some extent on *The Costs of Drug Abuse and Drug Policy*, a paper prepared for the Special Senate Committee on Illegal Drugs by Antony G. Jackson, Economics Division, Parliamentary Research Branch, Library of Parliament, 22 April 2002.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

The Canadian Centre on Substance Abuse (CCSA) undertook the latest major study of the costs of drug abuse in Canada.⁷ This study was published in 1996 and relates to 1992 data. Law enforcement costs were estimated as:

Police	\$208.3M
Courts	\$59.2M
Corrections (including probation)	\$123.8M
Customs and Excise	\$9.0M
<i>Total law enforcement costs</i>	\$400.3M

Police costs consisted of the costs for specialized law agencies such as the (then) RCMP Narcotics Division, plus that fraction of the general costs of operations that could be attributed to dealing with illicit drug crimes. Such crimes included both direct violations of the drug laws and also that proportion of general crimes that could reasonably be attributed to illicit drugs.

Data existed on the proportion of homicide and assault cases in which the perpetrator was under the influence of illicit drugs. The CCSA study estimated the proportion of those cases where the assault or homicide could be causally attributed to the drug intoxication of the perpetrator. Putting these two together, it estimated that 8% of violent crimes were attributable to illicit drugs in Canada. No such figure was estimated for property crimes.

The measure of police output was the offence. To estimate policing costs, total policing expenditures as reported by Statistics Canada were multiplied by the percentage of offences that were estimated to be drug-related. The CCSA study concluded that in 1992, 2.4% of all offences were attributable to illicit drug use.

Policing costs of enforcing federal drug laws	\$168.4M
Policing costs of 8% of violent crimes	\$39.9M
<i>Total policing costs</i>	\$208.3M

The Customs and Excise figure excluded programs financed under the Drug Strategy.

While we are unable to conduct an in-depth study of enforcement of laws on illicit drugs costs in relation to the RCMP, the CCRA and provincial and municipal police, we can assert with certainty that the current costs of enforcement of laws on illicit drugs are significantly higher than the approximately \$210 million estimated in 1992.

The Auditor General's 2001 report estimated that the RCMP alone spent approximately \$164 million in 1999 on enforcement of laws on illicit drugs.⁸ This

⁷ Single, E., et al., (1996) *The Costs of Substance Abuse in Canada: A Cost Estimation Study*, Ottawa: Canadian Centre on Substance Abuse.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

estimate was based on detailed expenditure data gathered by the federal drug enforcement program. The amount included costs directly related to drug enforcement as well as costs in related areas such as proceeds of crime and customs and excise initiatives.

The \$164 million applies **only** to RCMP federal policing services, however, and not to the policing services rendered by the RCMP under contract to a province or municipality, which account for the largest share of the force's budget. We were told that, at present, it was not possible to ascertain the costs related to the enforcement of laws on illicit drugs for the latter functions.

In the case of contract policing, enforcement of drug laws is rendered in conjunction with a number of other services as, typically, the officers under contract are performing uniform duty, that is, general policing duties in communities. It is therefore difficult to determine what portion of their time is spent doing which activity. This difficulty is enhanced when the drug offence is incidental to another crime, which is often the case.

One must consider that a large portion of the cost of any police service is the pay and benefits extended to its members. In order to accurately determine the cost of drug enforcement in contract policing, the amount of time devoted to the effort must be measured.

While this is done for members of the RCMP employed in the federal services, the present system applied to contract policing is incapable of collecting this information. An effort is being made to develop a new system that could possibly capture this information. However, given the breadth of day-to-day contract policing duties, it is a clear challenge to separate out, in a meaningful way, drug-related activity.

...I should like to speak now to the cost borne by provincial and municipal police forces. We have recently begun a process to determine what information exists on enforcement costs and where the gaps lie. Last month, at the most recent meeting of the National Coordinating Committee on Organized Crime, which I chair, our department distributed a questionnaire to collect existing information on the cost of enforcement in the provinces and territories. The questionnaire has since been distributed to police forces across the country through the Canadian Association of Police Boards. We are very interested in analyzing the results once we have received them.⁹

This Committee is obviously also very interested in these results, since they would provide the most accurate information available to date. As previously explained, we found it extremely difficult, if not impossible, to obtain any specific details on cost breakdowns for drug-related activities for provincial and municipal police forces. While Chief Fantino of the Toronto Police Service indicated that “probably one-third of our

⁸ *Report of the Auditor General of Canada to the House of Commons, 2001, Chapter 11, “Illicit Drugs: The Federal Government’s Role,” page 17.*

⁹ Paul E. Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch, Department of the Solicitor General, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, pages 9-10.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

resources are sucked right up in some form or another relating to drug work,”¹⁰ this type of statement is insufficient to permit concrete conclusions with respect to policing costs. What we did hear was that drug investigations—in particular those targeting trafficking networks—can be very resource-intensive for police forces.

*It is a large pull on resources, due to the nature of the work. The work is complex and, as you point out, it involves surveillance. It will sometimes involve wiretap surveillance as well. It requires a network of people who work in a clandestine fashion. It takes the police a long time to assemble credible evidence to reveal the network, make the connections, and then to correlate all of that for the court. It is a very resource-intensive aspect of policing, therefore, it is very expensive to the police department.*¹¹

It is not clear, however, whether the same rationale with respect to costs applies in the case of cannabis possession.

Cannabis use is, except as it is incidental to an encounter with a police officer, not a target of police investigation at this time, at least not in this community. We do not go out and seek people who are simply using cannabis. We do encounter them, however, as we go about our business in many other circumstances. We encounter them as one part of the drug investigation into trafficking, so we see the users there and some charges arise. We see them in domestic disputes. We see users in drinking establishment investigations and sometimes in traffic-infracton situations. Their presence is incidental to the investigation.

*As far as targeting cannabis trafficking and cannabis cultivation, that is a mainstream of the drug investigations. The money from cannabis cultivation and cannabis trafficking does flow into other aspects of crime. In some communities it is most definitely formal, organized crime; in other communities it is groups of affiliated criminals who are involved for profit only. We direct our activity to those areas.*¹²

With respect to customs-related costs, the CCRA indicated that of its \$410 million budget for 2001-2002, it can be estimated that \$75 million is dedicated to the interdiction of illegal drugs, in areas such as: Flexible Response Teams; district-targeting units; the container examination program; the marine centre of expertise; regional intelligence analysts; and regional intelligence officers. In addition, costs were associated with contraband detection technology that includes: X-rays; ion-mobility spectrometers; and the Detector Dog service. The CCRA did indicate that the officers involved in contraband detection are not dedicated solely to drug enforcement but to contraband enforcement in general—although illicit drug interdiction was their first priority. The

¹⁰ Chief Julian Fantino, Toronto Police Service, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 5, page 11.

¹¹ Chief Cal Johnston, Regina Police Service, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 16, page 31.

¹² *Ibid.*, page 33.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

Auditor General's 2001 report had estimated the CCRA's enforcement expenditures at between \$14 and \$36 million for illicit drug interdiction.¹³

The numbers indicated below have been selected from the following sources:

- ❖ RCMP (federal policing services) – Auditor General's 2001 report and testimony before the Committee;
- ❖ Provincial and municipal forces and RCMP (under contract) – by multiplying the estimated total policing expenditures for municipal and provincial policing of \$5.0 billion (in 1997-1998, expenditures totalled \$4.8 billion – excluding RCMP federal policing services expenditures)¹⁴ by 3.5% (the percentage that illicit drug offences represented of all CDSA and *Criminal Code* offences in 2001: 91,920 CDSA offences and 2,534,319 *Criminal Code* offences = 2,626,239 total CDSA and *Criminal Code* offences)¹⁵; and
- ❖ CCRA – based on an estimate between figures provided in the Auditor General's 2001 report (\$14 to \$36 million) and the CCRA's testimony before the committee (\$75 million).

While this is a crude and unscientific method of calculation and does not take into account a series of factors that would certainly lead to adjustments, it does provide some basis for comparison.

RCMP (Federal Services)	\$164 million
Provincial and municipal policing	\$175 million
CCRA	\$50 million
Total \$389 million	

As indicated above, given the fact that drug investigations are extremely resource-intensive, drug enforcement may be assumed to represent much more than 3.5% of policing budgets. Chief Fantino of the Toronto Police Service indicated that it was probably closer to 33% of his budget. Even if a conservative number such as 15% were used, the figure for provincial and municipal policing costs would increase to \$750 million. **This would mean that almost \$1 billion is being spent on drug enforcement in Canada every year.** Clearly, not all costs would be recoverable, even under a legalized system. For example, already overburdened police forces would surely

¹³ *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role," page 16.

¹⁴ Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Justice Spending in Canada, Catalogue no. 85-002-XIE, Vol. 19, No. 12, pages 4-6.

¹⁵ Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, page 14.

redirect resources to other priorities. However, significant savings could reasonably be expected, if the cannabis laws were relaxed.

*...the actual savings in law enforcement costs attributable to changing prohibition of possession are hard to estimate. The difficulty occurs in part because cannabis arrests have decreased in recent years in Vancouver reflecting the overall tendency to relax enforcement for simple possession. Nevertheless, **reduced law enforcement activities would have substantial savings if the law was repealed or changed.**¹⁶ (emphasis added)*

POLICE POWERS¹⁷

There are those who argue that police have been granted powers that are far too extensive in relation to drug enforcement and that in this fight against drugs, society has come to tolerate a battery of investigative techniques—wiretapping, strip-searches, the use of paid informants, entrapment, etc—which are offensive to our basic notions of civil liberty. As will be discussed in more detail, the nature of drug offences renders them difficult to enforce. This results in police agencies requesting and using a variety of unusual methods of enforcement. While there is a long history of special police powers in relation to drug enforcement, this chapter will focus primarily on modern police powers.

No one questions the fact that police require powers for the maintenance of law and order in our society. In investigating criminal offences, the police may use less intrusive investigative techniques such as observation and interrogation. In other cases, they may be required to use more intrusive methods such as electronic surveillance and reverse sting operations. While such methods are not limited to drug enforcement and may be used in other criminal matters, they are certainly used much more extensively in drug investigations.

These powers must be constrained, however, so as to protect individuals from excessive police activity. As stated by La Forest J.: “*The restraints imposed on government to pry into the lives of the citizen go to the essence of a democratic state.*”¹⁸ In determining whether police conduct is acceptable, conflicting interests generally have to be weighed. First, there are the individual’s interests, including the interest of being free from state intrusion. Second, there are the state’s interests, including that of protecting society

¹⁶ Kash Heed, Vice Drugs Section, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 62.

¹⁷ This section is in essence a summary of *Police Powers and Drug-Related Offences*, a paper prepared for the Special Senate Committee on Illegal Drugs by Gérald Lafrenière, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 6 March 2001.

¹⁸ *R. v. Dyment*, (1988) 45 C.C.C. (3d) 244 at p. 254 (S.C.C.).

from crime. Because these interests generally conflict, it can sometimes be difficult to agree on where the line should be drawn in relation to police conduct.

The courts have recognized that, as crimes become more sophisticated, police must be able to use more sophisticated investigative techniques to detect their commission. In addition, with respect to drug-related offences and other consensual types of offences,¹⁹ it is acknowledged that routine investigative techniques are often insufficient because of the difficulty in detecting these activities. Generally, because there is no “victim,” no one is there to complain or report the offence to police. Both Parliament and the courts appear to agree that additional police powers may be warranted in these circumstances. It is believed that police need to be proactive, rather than reactive, as is generally the case for other non-consensual offences. An example of this viewpoint is expressed in the following statement by former Chief Justice Laskin of the Supreme Court of Canada:

Methods of detection of offences and of suspected offences and offenders necessarily differ according to the class of crime. Where, for example, violence or breaking, entering and theft are concerned, there will generally be external evidence of an offence upon which the police can act in tracking down the offenders; the victim or his family or the property owner, as the case may be, may be expected to call in the police and provide some clues for the police to pursue. When “consensual” crimes are committed, involving willing persons, as is the case in prostitution, illegal gambling and drug offences, ordinary methods of detection will not generally do. The participants, be they deemed victims or not, do not usually complain or seek police aid; this is what they wish to avoid. The police, if they are to respond to the public disapprobation of such offences as reflected in existing law, must take some initiatives.²⁰

The Le Dain Commission had also recognized the special nature of drug offences.

The peculiar nature of drug crimes—the fact that the people involved in them are consenting and co-operative parties, and there is rarely, if ever, a victim who has reason to complain, as in crimes against persons and property – makes enforcement of the drug laws very difficult. The police are rarely assisted by complainants. For the most part they have to make their own cases. Moreover, the activity involved in non-medical drug use is relatively easy to conceal. It can be carried on, by agreement of the parties involved, in places which are not easily observed by the police. Further, the substances and equipment involved are relatively easy to conceal or dispose of.

All of these difficulties have given rise to the development of unusual methods of enforcement.²¹

¹⁹ Other consensual offences include gambling and prostitution.

²⁰ *R. v. Kirzner* (1977) 38 C.C.C. (2d) 131 (S.C.C.) at page 135.

²¹ Commission of Inquiry into the Non-medical Use of Drugs (1972) *Cannabis*, A Report, Ottawa, page 239.

Searches and seizures

Special powers of search and seizure have long been part of drug law enforcement practices. For example, before they were eliminated in 1985, writs of assistance generally gave peace officers the power to search without first having to obtain a warrant. Such powers were found in previous versions of the *Customs Act*, the *Excise Act*, the *Food and Drugs Act* and the *Narcotic Control Act*. Before its repeal in 1985, section 10(1) of the *Narcotic Control Act* allowed peace officers acting under “*the authority of a writ of assistance or a warrant*” to enter and search a dwelling-house “at any time,” so long as the peace officer had a reasonable belief that there was a narcotic in the house “*by means of or in respect of which*” an offence under the Act had been committed. Section 8 of the Charter eventually put an end to writs of assistance.

Today, the CDSA establishes a comprehensive search and seizure scheme for drug-related offences. Although these provisions are similar to the search and seizure provisions of the *Criminal Code*, police have some additional powers under the illicit drug legislation. Section 11(1) allows a justice to issue a search warrant if he or she is satisfied by information on oath that there are reasonable grounds to believe that specific items are in a place. These items are:

- ❖ A controlled substance or precursor in respect of which the CDSA has been contravened;
- ❖ Anything in which a controlled substance or precursor referred to in the previous paragraph is contained or concealed;
- ❖ Offence-related property; or
- ❖ Anything that will afford evidence in respect of an offence under the CDSA.

A warrant may be obtained even though there is no reason to believe that there are illicit drugs in the place being searched, so long as there are grounds respecting the presence of one of the other three types of items.

The CDSA authorizes a search “**at any time.**” Thus, there is no requirement to obtain authorization to search at night, as in the case of a search under the *Criminal Code*.

Another special power is found in subsection 11(5), which allows the police to **conduct searches of the person** in certain circumstances. This power is not found in the *Criminal Code*, although the police do have power of search incidental to arrest under common law. The CDSA gives the police, in the process of executing a search warrant, the power to search a person for a controlled substance or other specified items. This can be done only if the officer has reasonable grounds to believe that the person found in the place set out in the warrant has in his or her possession a controlled substance or other specified items set out in the warrant. Thus, this provision authorizes the police to conduct a search of the person even if no arrest is made, but only for specified items and only if the police have reasonable belief of certain facts.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

Subsection (7) allows the police to conduct a search described in subsections (1), (5) or (6) without a warrant “*if the conditions for obtaining a warrant exist but by reason of exigent circumstances it would be impractical to obtain a warrant.*” As will be discussed later, warrantless searches are presumed to be unreasonable, but the courts have allowed for exceptions. The rules have been summarized as follows:

A warrantless search has been justified where, based on the circumstances of the search, it was not feasible to obtain the warrant; for example, where a vehicle, airplane or other conveyance having the ability to change location is the subject of the search. The onus in such cases is on the Crown to establish that the obtaining of a warrant in the circumstances of the specific case would impede the effectiveness of the enforcement of the law.

Where there is no common law search power regarding searches in “exigent circumstances”, the courts have held that it is necessary for the enabling legislation to specifically refer to a warrantless search power in certain circumstances, for example, exigent circumstances. Such legislative provisions should narrowly define the type of investigation which would permit the use of a warrantless search.²²

Although exigent circumstances may be created by the presence of drugs in a vehicle, whether a warrantless search of a person’s home in exigent circumstances will be found to be constitutional is still in doubt.²³ The courts will require some public interest sufficiently compelling to override the privacy interests attaching to the home. One example of such a compelling interest is the preservation of human life or safety.²⁴

The legislation also allows: a police officer to seize things not specified in the warrant if the officer believes on reasonable grounds that they are items mentioned in subsection (1);²⁵ and the power to seize anything that the officer believes on reasonable grounds has been obtained by or used in the commission of an offence (not limited to drug offences) or will afford evidence in respect of an offence.²⁶

The CDSA also deals with the use of force. Section 12 allows a police officer who is executing a warrant to “enlist such assistance as the officer deems necessary” and “*use as much force as is necessary in the circumstances.*” It should be noted that the search provisions in the *Criminal Code* do not specify that force may be used, although this is set out in other sections of the *Criminal Code*.

Things seized under the CDSA can be classified as either offence-related property (for example, money and automobiles) or controlled substances (“drugs”), with specific rules regarding detention and forfeiture for each category. The legislation also provides for the search, seizure, detention and forfeiture of proceeds of crime in relation to

²² Brucker, T. (2002) *The Practical Guide to the Controlled Drugs and Substances Act*, Third Edition, Carswell, page 101.

²³ In *R. v. Feeney*, the Supreme Court of Canada refused to deal with the issue because, according to the Court, exigent circumstances did not exist when the arrest was made.

²⁴ *R. v. Godoy*, (1999) 131 C.C.C. (3d) 129 (S.C.C.).

²⁵ See *Controlled Drugs and Substances Act*, section 11(6).

²⁶ See *Controlled Drugs and Substances Act*, section 11(8).

drug-related offences by incorporating the proceeds of crime provisions of the *Criminal Code*.

Section 8 of the Charter—warrantless searches

Section 8 of the Charter provides that everyone has the right to be secure against unreasonable search and seizure. Court decisions have dealt with the question of whether searches are reasonable in various situations and with the ancillary question of whether evidence obtained during the searches can be adduced at trial. A search will generally be reasonable if it is authorized by law, the law itself is reasonable, and the search is carried out in a reasonable manner.

Section 8 protects the public's reasonable expectation of privacy from state intrusions. Thus, where there is no reasonable expectation of privacy, section 8 does not apply. In addition, a diminished expectation of privacy (for example, in prisons or at border crossings) will lower the standard of reasonableness (for example, excusing the absence of a warrant or reducing the standard required for justifying the search). A person's home is where there would be the greatest expectation of privacy and thus a greater degree of constitutional protection.

Although the Charter does not specifically require that police obtain a search warrant to conduct a search, the Supreme Court of Canada in *Hunter v. Southam Inc.* has established a presumption that a warrantless search is unreasonable.²⁷ The general rule for a valid search is that the police will require prior authorization to conduct the search (for example, by obtaining a search warrant) and reasonable and probable grounds to justify it. This is to provide a safeguard against unjustified state intrusion.

This is the general rule; however, there are exceptions. It is recognized that a prior authorization is not always feasible. With respect to these exceptions, the courts require some authority, in statute or at common law, to conduct warrantless searches. The existence of such authority is not enough, however, because the courts will also review this authority to ensure that it is reasonable. In defining what is reasonable, the courts have established that warrantless searches should generally be limited “to situations in which exigent circumstances render obtaining a warrant impracticable.”²⁸ In *R. v. Grant*, the Court stated:

*To sum up on this point, s. 10 may validly authorize a search or seizure without warrant in exigent circumstances which render it impracticable to obtain a warrant. Exigent circumstances will generally be held to exist if there is an imminent danger of the loss, removal, destruction or disappearance of the evidence if the search or seizure is delayed. While the fact that the evidence sought is believed to be present on a motor vehicle, water vessel, aircraft or other fast moving vehicle will often create exigent circumstances, no blanket exception exists for such conveyances.*²⁹

²⁷ *Hunter (Director of Investigation & Research) v. Southam Inc.* (1984) 14 C.C.C. (3d) 97 (S.C.C.).

²⁸ *R. v. Grant* (1993) 84 C.C.C. (3d) 173 (S.C.C.) at p. 188.

²⁹ *Ibid.*, page 189.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

While every case will be reviewed on its merits, the greater the degree of urgency the police can demonstrate in the circumstances, the more inclined a court will be to find the warrantless search reasonable.

Searches of the person

Apart from a few specific provisions, such as the one found in the CDSA, federal criminal law does not provide authorization for a search of the person. The common law does, however, allow a search of the person incidental to a lawful arrest. This common law power is an exception to the general rule that a search requires prior authorization to be reasonable. This is a very important exception, because most searches of the person are done pursuant to this power. As explained earlier, the CDSA does allow a police officer who is executing a search warrant under that Act to search people who are present, under certain conditions.

A person may be searched under the common law power only for the purpose of locating further evidence relating to the charge upon which he or she has been arrested or to locate a weapon or some article that may assist him or her to escape or commit violence. Although the power to search incidental to an arrest is fairly broad, there is no automatic unrestricted right to search incidental to an arrest.

Manner in which search conducted

Courts have shown a willingness to scrutinize the manner in which a search of the person is conducted. For example, in *Collins*, a British Columbia case, the accused was sitting in a bar that was said to be frequented by heroin users and traffickers. The accused was seized by two police officers; while one of them used a choke-hold that rendered her semi-conscious, the other forced open her mouth. While this was happening, three caps of heroin dropped out of the accused's right hand. The Court held that the officers in this case had not had reasonable and probable grounds to believe that narcotics were in the accused's mouth and that therefore the search was unlawful. The Court went further and determined that to admit the evidence would bring the administration of justice into disrepute, for it would condone and allow the continuation of unacceptable conduct by the police. This decision was affirmed on appeal by the Supreme Court of Canada. This does not mean that a choke-hold will always be considered unreasonable. The following was stated in *R. v. Garcia-Guiterrez*.³⁰ "a choke-hold was used to prevent the evidence from being swallowed and a punch to the solar plexus to force the suspect to cough it up. Subject to a strongly worded dissenting opinion, the majority of the B.C. Court of Appeal held that the choke-hold to preserve evidence was acceptable in the circumstances."³¹

Searches of the person authorized by statute and the common law generally provide no indication as to the scope of the search that can be carried out. As discussed above, one of the requirements of a reasonable search is that it be executed in a

³⁰ (1991) 65 C.C.C. (3d) 15 (B.C.C.A).

³¹ Fontana, J.A. (1997) *The Law of Search and Seizure in Canada*, Fourth Edition, Butterworths, page 396.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

reasonable manner. With respect to searches of the person, the level of intrusion may render the search unreasonable.

When discussing body searches in border areas, the Supreme Court of Canada distinguished between three categories of searches:

It is, I think, of importance that the cases and the literature seem to recognize three distinct types of border search. First is the routine of questioning which every traveller undergoes at a port of entry, accompanied in some cases by a search of baggage and perhaps a pat or frisk of outer clothing. No stigma is attached to being one of the thousands of travellers who are daily routinely checked in that manner upon entry to Canada and no constitutional issues are raised. It would be absurd to suggest that a person in such circumstances is detained in a constitutional sense and therefore entitled to be advised of his or her right to counsel. The second type of border search is the strip or skin search of the nature of that to which the present appellant was subjected, conducted in a private room, after a secondary examination and with the permission of a customs officer in authority. The third and most highly intrusive type of search is that sometimes referred to as the body cavity search, in which customs officers have recourse to medical doctors, to X-rays, to emetics, and to other highly invasive means.³²

In the *Simmons* case, Dickson C.J.C. went on to add that the different types of searches raise different issues and entirely different constitutional issues “for it is obvious that the greater the intrusion, the greater must be the justification and the greater the degree of constitutional protection.”³³ This approach was confirmed in the 1999 Supreme Court of Canada decision in *Monney* (discussed below). In both cases, the constitutionality of the third category of searches was left open, while the first two categories were held to be reasonable under section 8 even if based only on suspicion. It should be noted that these cases were decided in the context of border searches.

The Supreme Court of Canada indicated the following with respect to frisk searches in the context of a search incidental to arrest:

A “frisk” search incidental to a lawful arrest reconciles the public’s interest in the effective and safe enforcement of the law on the one hand, and on the other its interest in ensuring the freedom and dignity of individuals. The minimal intrusion involved in the search is necessary to ensure that criminal justice is properly administered.³⁴

Thus, when a search of the person is justified, a frisk search will generally be held to be reasonable because it is the least intrusive means available to conduct one.

Strip searches were considered in *R. v. Flintoff*.³⁵ A police officer arrested the accused at the scene of an accident for impaired driving. The accused was strip-searched before the breath tests, pursuant to a general police policy requiring all police

³² *R. v. Simmons*, (1988) 45 C.C.C. (3d) 296 (S.C.C.).

³³ *Ibid.*

³⁴ *Cloutier* (1990) 53 C.C.C. (3d) 257 (SCC) at pages 277-278.

³⁵ (1998) 126 C.C.C. (3d) 321 (Ont. C.A.).

officers to strip-search every person brought into the station in custody, regardless of the circumstances of the case or the individual. The Court held that the search was unreasonable and in violation of section 8 of the Charter. The Court stated that the strip search was not justified in law and was not incidental to an arrest. It found the breach was “outrageous” and “flagrant” and that it would shock the public. According to the Court, strip-searching “is one of the most intrusive manners of searching” and “one of the most extreme exercises of police power.” Although the police can search incidental to an arrest, “the degree of intrusion must be reasonable and in pursuit of a valid objective such as safety.”

The recent Supreme Court of Canada decision in *R. v. Golden*³⁶ reviews issues surrounding searches incidental to arrest and the manner in which such a search may be conducted. Mr. Golden was arrested following what police believed were drug transactions in a restaurant. He was taken to a stairwell where the police pulled down his pants and underwear and noticed a clear plastic wrap containing a white substance in the anal area. The police tried to retrieve it but the accused resisted. He was escorted back into the restaurant and patrons were told to leave. The accused was forced to lean over a table and his pants and underwear were lowered. He continued to resist police attempts to retrieve the plastic wrap and accidentally defecated—which did not dislodge the plastic wrap. The police retrieved a pair of rubber dishwashing gloves and removed the package while the accused was face-down on the floor. The accused was strip-searched again at the police station. The Supreme Court made the following statement regarding strip searches:

While the respondent and the interveners for the Crown sought to downplay the intrusiveness of strip searches, in our view it is unquestionable that they represent a significant invasion of privacy and are often a humiliating, degrading and traumatic experience for individuals subject to them. Clearly, the negative effects of a strip search can be minimized by the way in which they are carried out, but even the most sensitively conducted strip search is highly intrusive. Furthermore, we believe it is important to note the submissions of the ACLC and the ALST that African Canadians and Aboriginal people are overrepresented in the criminal justice system and are therefore likely to represent a disproportionate number of those who are arrested by police and subjected to personal searches, including strip searches... As a result, it is necessary to develop an appropriate framework governing strip searches in order to prevent unnecessary and unjustified strip searches before they occur.³⁷

In *Golden*, the Supreme Court of Canada found that the Crown had failed to prove that the strip search of the appellant was carried out in a reasonable manner. It was of the view that the evidence fell far short of establishing that a situation of exigency existed so as to warrant a strip search outside of the police station, particularly with the station two minutes away. Thus, the Court concluded that this was not a case involving an urgent and necessary need to conduct a strip search “in the field” for the purpose of preserving evidence.

³⁶ 2001 SCC 83.

³⁷ *Ibid.*, para. 83.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

The Supreme Court also cautioned against the use of force in conducting a search:

*We particularly disagree with the suggestion that an arrested person's non-cooperation and resistance necessarily entitles police to engage in behaviour that disregards or compromises his or her physical and psychological integrity and safety. If the general approach articulated in this case is not followed, such that the search is unreasonable, there is no requirement that anyone cooperate with the violation of his or her Charter rights. Any application of force or violence must be both necessary and proportional in the specific circumstances. In this case, the appellant's refusal to relinquish the evidence does not justify or mitigate the fact that he was strip searched in a public place, and in a manner that showed considerable disregard for his dignity and his physical integrity, despite the absence of reasonable and probable grounds or exigent circumstances.*³⁸

The importance of *Golden* is that the Supreme Court adopted a “framework for the police in deciding how best to conduct a strip search incident to arrest in compliance with the Charter.” It set out the following questions:

1. *Can the strip search be conducted at the police station and, if not, why not?*
2. *Will the strip search be conducted in a manner that ensures the health and safety of all involved?*
3. *Will the strip search be authorized by a police officer acting in a supervisory capacity?*
4. *Has it been ensured that the police officer(s) carrying out the strip search are of the same gender as the individual being searched?*
5. *Will the number of police officers involved in the search be no more than is reasonably necessary in the circumstances?*
6. *What is the minimum of force necessary to conduct the strip search?*
7. *Will the strip search be carried out in a private area such that no one other than the individuals engaged in the search can observe the search?*
8. *Will the strip search be conducted as quickly as possible and in a way that ensures that the person is not completely undressed at any one time?*
9. *Will the strip search involve only a visual inspection of the arrestee's genital and anal areas without any physical contact?*
10. *If the visual inspection reveals the presence of a weapon or evidence in a body cavity (not including the mouth), will the detainee be given the option of removing the object himself or of having the object removed by a trained medical professional?*
11. *Will a proper record be kept of the reasons for and the manner in which the strip search was conducted?*

Because of the nature of drug-related offences and the fact that the substance is more easily concealed, it would appear that more intrusive searches may be allowed. The courts are certainly aware of the tactics used by offenders to conceal drugs and may be more willing to allow police conduct that would otherwise be unreasonable. It is clear from the decisions, however, that the more intrusive the search, the greater must be the justification and greater the constitutional protection.

³⁸ *Ibid.*, para. 116.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

Schools

In *R. v. M. (M.R.)*,³⁹ in a majority decision, the Supreme Court of Canada has held that a student's reasonable expectation of privacy in the school environment is "significantly diminished" because school authorities are responsible for "providing a safe environment and maintaining order and discipline in the school." In the case of searches by school authorities (not the police), there is no requirement for a warrant, and the standard is reasonable belief. The school authority must not, however, be an agent of the police. The Court added that students must know "that this may sometimes require searches of students and their personal effects and the seizure of prohibited items." In the result, the Court held that the seizure of marijuana from a student searched during a school dance did not infringe his rights under section 8 of the Charter. While setting out the parameters for a reasonable warrantless search in such circumstances, it must be noted that the majority decision expressly limited its findings to the elementary or secondary school milieu, with "no consideration" having been given to a college or university setting.

Borders

Searches conducted by customs officers at the border are an example of reduced constitutional protections where the courts find that there is a lower expectation of privacy based on the context. In such cases, the standards established in *Hunter* may not apply.

Section 98 of the *Customs Act*⁴⁰ allows an officer to search a person who has just arrived in Canada within a reasonable time of the person's arrival, or a person who is about to leave, if the officer suspects on reasonable grounds that the person has hidden illegal items on his or her person. The Supreme Court of Canada has interpreted this standard as one of reasonable suspicion and not the higher standard of reasonable grounds.⁴¹ A person about to be searched can request to be taken before a senior officer who will make a determination as to whether the search shall proceed.⁴²

In *R. v. Simmons*,⁴³ the accused was required to submit to a strip search as the result of a customs officer's belief that she was carrying contraband. The Supreme Court's decision acknowledged Canada's right as a sovereign state to control both who and what crosses its boundaries. Even though the search power did not meet the standards that it had set out in *Hunter* (for example, prior authorization and reasonable grounds), the Court stated:

³⁹ [1998] 3 S.C.R. 393.

⁴⁰ S.C. 1986 c. 1.

⁴¹ *R. v. Monney*, (1999) 133 C.C.C. 129 (S.C.C.).

⁴² The *Customs Act* also contains many other provisions dealing with powers of customs officers. These are not discussed.

⁴³ (1988) 45 C.C.C. 296 (S.C.C.).

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

I accept the proposition advanced by the Crown that the degree of personal privacy reasonably expected at customs is lower than in most other situations. People do not expect to be able to cross international borders free from scrutiny. It is commonly accepted that sovereign states have the right to control both who and what enters their boundaries. For the general welfare of the nation the state is expected to perform this role. Without the ability to establish that all persons who seek to cross its borders and their goods are legally entitled to enter the country, the state would be precluded from performing this crucially important function. Consequently, travellers seeking to cross national boundaries fully expect to be subject to a screening process. This process will typically require the production of proper identification and travel documentation and involve a search process beginning with completion of a declaration of all goods being brought into the country. Physical searches of luggage and of the person are accepted aspects of the search process where there are grounds for suspecting that a person has made a false declaration and is transporting prohibited goods.

In my view, routine questioning by customs officers, searches of luggage, frisk or pat searches, and the requirement to remove in private such articles of clothing as will permit investigation of suspicious bodily bulges permitted by the framers of ss. 143 and 144 of the Customs Act, are not unreasonable within the meaning of s. 8. Under the Customs Act searches of the person are not routine but are performed only after customs officers have formed reasonable grounds for supposing that a person has contraband secreted about his or her body. The decision to search is subject to review at the request of the person to be searched. Though in some senses personal searches may be embarrassing, they are conducted in private search rooms by officers of the same sex. In these conditions, requiring a person to remove pieces of clothing until such time as the presence or absence of concealed goods can be ascertained is not so highly invasive of an individual's bodily integrity to be considered unreasonable under s. 8 of the Charter.

I also emphasize that, according to the sections in question: (i) before any person can be searched the officer or person so searching must have reasonable cause to suppose that the person searched has goods subject to entry at the customs, or prohibited goods, secreted about his or her person, and (ii) before any person can be searched, the person may require the officer to take him or her before a police magistrate or justice of the peace or before the collector or chief officer at the port or place who shall, if he or she sees no reasonable cause for search, discharge the person.

In light of the existing problems in controlling illicit narcotics trafficking and the important government interest in enforcing our customs laws, and in light of the lower expectation of privacy one has at any border crossing, I am of the opinion that ss. 143 and 144 of the Customs Act are not inconsistent with s. 8 of the Charter.⁴⁴

It is noteworthy for our purposes that the Court mentioned the problems of controlling illicit narcotics trafficking as a factor in determining that the search was reasonable under section 8 of the Charter.

The fact that those travelling through customs have a lower reasonable expectation of privacy does not, however, diminish the obligation on state authorities to adhere to the Charter, even if the grounds prompting the search are reasonable and drugs are found as a result. Before any search, the inspectors must clearly explain to the subject his/her rights under the Charter – especially the prior right to consult a lawyer –

⁴⁴ *Ibid.*, at pages 320-321.

and the right to have the search request reviewed before complying with it, as provided in the *Customs Act*. In *Simmons*, the subject remained ignorant of her legal position because she had not properly been informed of her rights. As a result, the Supreme Court of Canada found that the search was unreasonable; even so, the evidence was not excluded because the customs officers had acted in good faith.

The Supreme Court of Canada has determined that section 98 of the *Customs Act*, authorizing searches for contraband “secreted on or about” the person, applies to contraband that a traveller has ingested. In *R. v. Monney*,⁴⁵ the Court concluded that a customs officer who has reasonable grounds to suspect that contraband has been ingested is authorized by the Act to detain the traveller in a “drug loo facility” until that suspicion can be confirmed or dispelled. Although such action amounts to a search for the purposes of section 8 of the Charter, the Court confirmed that “*the degree of personal privacy reasonably expected at customs is lower than in most other situations*” and that the search in question was “*reasonable for the purposes.*”

The Court did indicate that the different levels of intrusion raise different constitutional issues (for example, by potentially requiring a higher standard than reasonable suspicion). The Court stated: “*the potential degree of state interference with an individual’s bodily integrity for searches in the third category requires a high threshold of constitutional justification.*”⁴⁶

It is clear that the courts apply a lower standard of constitutional protection for searches at the border than elsewhere. As stated in *Monney*, “*decisions of this Court relating to the reasonableness of a search for the purposes of s. 8 in general are not necessarily relevant in assessing the constitutionality of a search conducted by customs officers at Canada’s border.*”⁴⁷

Electronic surveillance

Because of the consensual nature of drug offences, police often resort to special investigative techniques to detect these crimes, including the use of electronic surveillance. The Supreme Court of Canada has stated that electronic surveillance constitutes a search for the purposes of section 8 of the Charter, and its decisions in this area have had a significant impact on the *Criminal Code* provisions dealing with such techniques. Because electronic surveillance is more invasive of privacy than actions under regular search warrants, more procedural safeguards are provided in the legislation. Although surreptitious interception is often used for drug offences, it can also be used for many other serious offences under the *Code* and other federal legislation.⁴⁸ The Solicitor General’s 1998 report entitled *Annual Report on the Use of Electronic Surveillance* states the following with respect to the importance of electronic surveillance as an investigative tool:

⁴⁵ (1999) 133 C.C.C. 129 (S.C.C.).

⁴⁶ *Ibid.*, at page 152.

⁴⁷ *Ibid.*, at page 151.

⁴⁸ See *Criminal Code* section 183.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

Electronic surveillance plays a crucial role in the battle against organized crime, especially with respect to the offence of drug trafficking. In curtailing the importation and distribution of illicit drugs in Canada, law enforcement agencies rely heavily upon the interception of private communications. Section III of this report demonstrates that the majority of authorizations granted by the courts allow for the use of electronic surveillance in relation to trafficking in a controlled substance. As in previous years, many of these authorizations were related to criminal conspiracies, crimes which are difficult for the police to detect, investigate and solve.

...The use of electronic surveillance has led to a number of seizures of large quantities of drugs in Canada. These seizures reduce the amount of drugs available in streets and neighbourhoods, and assist in the prevention of crimes associated with drug abuse. Without this crucial tool, the ability of the law enforcement community to prevent crimes and ensuing social harm would be seriously hindered.

Although it is clear that electronic surveillance is an effective investigative tool, it is also clear that it constitutes a dramatic infringement of the right to privacy. The Supreme Court of Canada stated the following:

*The very efficacy of electronic surveillance is such that it has the potential, if left unregulated, to annihilate any expectation that our communications will remain private. A society which exposes us, at the whim of the state, to the risk of having a permanent electronic recording made of our words every time we opened our mouths might be superbly equipped to fight crime, but would be one in which privacy no longer had any meaning. As Douglas J., dissenting in *United States v. White*, supra, put it, at p. 756: "Electronic surveillance is the greatest leveller of human privacy ever known." If the state may arbitrarily record and transmit our private communications, it is no longer possible to strike an appropriate balance between the right of the individual to be left alone and the right of the state to intrude on privacy in the furtherance of its goals, notably the need to investigate and combat crime.*

This is not to deny that it is of vital importance that law enforcement agencies be able to employ electronic surveillance in their investigation of crime. Electronic surveillance plays an indispensable role in the detection of sophisticated criminal enterprises. Its utility in the investigation of drug related crimes, for example, has been proven time and again. But, for the reasons I have touched on, it is unacceptable in a free society that the agencies of the state be free to use this technology at their sole discretion. The threat this would pose to privacy is wholly unacceptable.⁴⁹

Because electronic surveillance is more invasive of privacy than are actions permitted under regular search warrants, more procedural safeguards are provided in the legislation. Similar rules apply to video surveillance.

The Supreme Court of Canada decisions rendered on 25 January 1990 in the *Duarte* and *Wiggins* cases had a significant impact on policing methods, particularly undercover investigations involving drug and morality offences. In *Duarte*,⁵⁰ the Court affirmed that electronic surveillance constitutes a search and seizure within the meaning of section 8. This only occurs, however, where a reasonable expectation of privacy

⁴⁹ *R. v. Duarte*, (1990) 53 C.C.C. (3d) 1 (S.C.C.) at page 11.

⁵⁰ (1990) 53 C.C.C. (3d) 1 (S.C.C.).

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

exists. The Court said that unauthorized electronic surveillance and interception “*of private communications by an instrumentality of the state with the consent of the originator or intended recipient thereof, without prior judicial authorization, does infringe the rights and freedoms guaranteed by section 8.*” Until then, it had been legal for the police to intercept such communications, as long as one of the parties to the conversation consented. It is now necessary for a judge to authorize such interception in the same way as interception of an entirely private conversation (“wiretapping”) where neither party has given prior consent. The Court also required that there be reasonable and probable grounds, established on oath, to believe that there is evidence of an offence in the place to be searched. Suspicion would not satisfy this requirement.

In *Duarte*, the Supreme Court of Canada said that “the primary value served by section 8 is privacy,” which it defined as “*the right of the individual to determine when, how, and to what extent he or she will release personal information.*” Accordingly, “*one can scarcely imagine a state activity more dangerous to individual privacy than electronic surveillance and to which, in consequence, the protection accorded by s. 8 should be more directly aimed.*” The Court took the position that it could no longer allow the police an “unfettered discretion ... to record and transmit our words” without prior judicial authorization because this widespread police practice represented an “*insidious danger*” to the “*very hallmark of a free society,*” namely, the “*freedom not to be compelled to share our confidences with others.*” In *Wiggins*,⁵¹ the use of “body pack” microphones by police was also found to be unconstitutional, for the reasons expressed in *Duarte*. The *Duarte* decision demonstrates that even if conduct is authorized by legislation, this does not mean that it is reasonable under section 8. The *Code* has since been amended to provide for prior authorization of consent interceptions.

With respect to surreptitious interceptions, a judge must ensure that: (1) the best interests of the administration of justice would be served; and (2) other investigative procedures (a) have been tried and have failed; or (b) are unlikely to succeed; or (c) the situation is urgent. In 2000, the Supreme Court of Canada in *R. v. Araujo*⁵² interpreted the second requirement set out in the legislation. The Court indicated that the standard for branch (b) was not one of “efficiency” but rather “necessity.” The test is: There must be, practically speaking, no other reasonable alternative method of investigation, in the circumstances of the particular criminal inquiry.

Section 24

Section 24(1) of the Charter provides a course of action for accused persons whose Charter rights have been infringed or denied. Under it, they can apply to a “court of competent jurisdiction” for the “appropriate and just” remedy. Section 24(2) allows a court to exclude evidence obtained in a manner that infringed or denied Charter rights, if admitting it into evidence “*would bring the administration of justice into*

⁵¹ [1990] 1 S.C.R. 30.

⁵² (2000) S.C.C. 65.

disrepute.” The three primary factors to be considered are: (a) does the admission of the evidence affect the fairness of the trial; (b) how serious was the Charter breach; and (c) what would be the effect on the system’s repute of excluding the evidence.

Some have criticized the way these factors are applied to drug-related offences. For example, Don Stuart stated the following:

The impression left by these recent Supreme Court and Ontario Court of Appeal rulings, especially in drug cases, is that these Courts seem generally determined not to exclude real evidence found in violation of section 8. These Courts tend to ratchet up the rhetoric respecting the third Collins factor about the seriousness of the offence and the effect on the repute of the system if the exclusion of reliable evidence were to result in acquittals. If this is the major reason for admitting the evidence, it points to an irony and inconsistency with the Stillman approach, in that the seriousness of the offence and reliability are not relevant factors when evidence is characterized as going to trial fairness. Canadian criminal trials under the Charter are no longer exclusively concerned with determining guilt or innocence and it betrays respect for the Charter to argue a return to the pre-Charter days where police conduct was not a material consideration. Particular abhorrence of drug offences may well have coloured consideration of the second Collins factor so that seriousness of the violation is unduly de-emphasised. The Courts, as guardians of the Charter, should be above the war against drugs. This one category of offences does not require special and reduced Charter standards.⁵³

The decision of whether the evidence should be excluded can be important; if courts are reluctant to exclude evidence, they may be sending conflicting messages to the police. Although their conduct will have been found to breach a person’s Charter rights, there may be little incentive for the police to adhere to the limits imposed by the courts if the evidence is not excluded.

Entrapment and illegal activity

Entrapment and illegal police activity are both based on the doctrine of abuse of process.

Entrapment

In some cases, police forces use informers (including paid informers) or undercover police agents to obtain information about criminal offences. With consensual offences such as those related to drugs, infiltrating a group and acting as a consensual participant is often the only way for the police to obtain evidence of an offence. They are generally there to observe the suspect and, in some instances, may afford the suspect an opportunity to commit an offence. The police must ensure that the actions of the informer or the undercover agent do not go too far. When police actions are excessive, the accused may attempt to rely on the doctrine of entrapment. Although police tactics intended to provide a person with the opportunity to commit

⁵³ Stuart, D. (1999) “The Unfortunate Dilution of Section 8 Protection,” *Queens Law Journal*, Volume 25, Number 1, page 68.

an offence and illegal police activities are not limited to drug offences, it is fair to state that these tactics are probably much more prevalent in investigations of these types of offences.

The leading case in Canada on entrapment is the Supreme Court of Canada's decision in *R. v. Mack*.⁵⁴ Lamer J., as he then was, delivered the unanimous judgement of the Supreme Court of Canada. He explained that entrapment is not a substantive defence (such as necessity or duress) and indicated that the rationale for this defence is not a lack of culpability in the accused (because the essential elements of the offence will generally be present). Rather, the rationale is based on the need for the Court "to preserve the purity of the administration of justice" and to prevent an abuse of the judicial process. Thus, entrapment is based on the common law doctrine of abuse of process. According to Lamer J., entrapment occurs when the conduct of the police exceeds acceptable limits. This is the case in the following circumstances:

- ❖ The authorities provide a person with an opportunity to commit an offence without acting on a reasonable suspicion that this person is already engaged in criminal activity or pursuant to a *bona fide* inquiry; or
- ❖ Having a reasonable suspicion or acting in the course of a *bona fide* inquiry, the police go beyond providing an opportunity and induce the commission of an offence.

To establish entrapment, the accused is required to demonstrate only that one of the two branches of the test has been met. If successful, the remedy is a stay of proceedings.

According to the guidelines set out by the Supreme Court of Canada, the police are required to have a reasonable suspicion that the accused is already engaged in criminal activity, or must be acting pursuant to a *bona fide* inquiry. The rationale for requiring reasonable suspicion is "*because of the risk that the police will attract people who would not otherwise have any involvement in a crime and because it is not a proper use of the police power to simply go out and test the virtue of people on a random basis.*"⁵⁵

In determining whether police conduct goes further than providing an opportunity, a court will assess the following non-exhaustive list of factors:

- ❖ The type of crime being investigated and the availability of other techniques for the police detection of its commission;
- ❖ Whether an average person, with both strengths and weaknesses, in the position of the accused would be induced into the commission of a crime;
- ❖ The persistence and number of attempts made by the police before the accused agreed to commit the offence;

⁵⁴ (1988) 44 C.C.C. (3d) 513 (S.C.C.).

⁵⁵ *Ibid.*, at page 560.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

- ❖ The type of inducement used by the police, including deceit, fraud, trickery or reward;
- ❖ The timing of the police conduct, in particular whether the police instigated the offence or become involved in ongoing criminal activity;
- ❖ Whether the police conduct involves an exploitation of human characteristics such as the emotions of compassion, sympathy and friendship;
- ❖ Whether the police appear to have exploited a particular vulnerability of a person such as a mental handicap or a substance addiction;
- ❖ The proportionality between the police involvement, as compared to that of the accused, including an assessment of the degree of harm caused or risked by the police, as compared to the accused, and the commission of any illegal acts by the police themselves;
- ❖ The existence of any threats, implied or express, made to the accused by the police or their agents; and
- ❖ Whether the police conduct is directed at undermining other constitutional values.⁵⁶

The Supreme Court of Canada stated that the claim of entrapment is a very serious allegation against the state, and that the state must be given substantial room to develop techniques which assist in its fight against crime in society. It is only when the police and their agents engage in conduct which offends basic values of the community that the doctrine of entrapment should apply. The Court indicated that a stay should be entered only in the “*clearest of cases*.”⁵⁷

In *Mack*, the Supreme Court of Canada stated that with respect to the crime of drug trafficking, the state must be given substantial leeway. This offence “*is not one which lends itself to the traditional devices of police investigation*.” The Court added that it is a “*crime of enormous social consequence which causes a great deal of harm in society generally*.” The Court concluded “*this factor alone is very critical*.”⁵⁸

Although the Supreme Court of Canada stated in *Mack* that random virtue-testing will not be permitted because there is a risk of attracting innocent individuals into the commission of an offence, it does make an exception to the requirement to have reasonable suspicion with respect to the individual in the case of a *bona fide* investigation related to an area where it is reasonably suspected that criminal activity is taking place.

It is clear that such an exception can apply to known locations of drug trafficking. An example of this can be seen in *R. v. Barnes*.⁵⁹ The accused was charged with a number of offences, including trafficking in cannabis. An undercover police officer had approached the accused and his friend because they generally fitted the description of persons who may possess and sell drugs. After a short conversation, the accused agreed

⁵⁶ *Ibid.*, at page 560.

⁵⁷ *Ibid.*, at page 567.

⁵⁸ *Ibid.*, at page 69.

⁵⁹ (1991) 66 C.C.C. (3d) 1 (S.C.C.).

to sell hashish to the undercover agent. The place where the arrest took place (a six-block pedestrian mall) was a well-known area where trafficking occurred, and the police were conducting what are known as “buy-and-bust” transactions. The accused relied on the defence of entrapment.

The Supreme Court of Canada reiterated the circumstances when entrapment occurs. Because in this case the police did not have reasonable suspicion of the accused’s involvement in unlawful drug-related activity, its conduct would amount to entrapment unless it was part of a *bona fide* inquiry. Thus, although the basic rule is that the police may only present the opportunity to commit an offence to a person for whom they have a reasonable suspicion that they are already engaged in criminal activity, there is an exception where the police conduct is part of a *bona fide* investigation directed in an area where it is reasonably suspected that criminal activity is occurring. If the location is defined with “*sufficient precision*,” the police may present any person associated with the area with the opportunity to commit the particular offence. In these circumstances, the police conduct would not be considered to be random virtue-testing.

In summary, the key issue with respect to entrapment is whether the police had reasonable grounds or suspicions to target an individual or were acting pursuant to a *bona fide* inquiry. In addition, even if the first branch of the test is satisfied, one must consider whether the police conduct went beyond providing an opportunity by determining whether the tactics used by the police were designed to induce an average person into the commission of an offence. It is important to note, however, that with respect to entrapment the “*fact situations can vary enormously, which is why, although the general principles are beginning to emerge, their application is not always easy and can lead to disagreement.*”⁶⁰ The courts have indicated that each case must be determined on its own facts, making it difficult to provide more precise rules regarding police conduct.

Illegal activities

As has been discussed, as criminal offenders become more sophisticated, the police have adopted new investigative tools in an attempt to keep pace (including cases where police officers have breached the law while in the performance of their duties). This occurs in drug investigations, for example, when police conduct buy-and-bust operations and reverse sting operations. The use of illegal police activity to combat crime raises the issue of whether such conduct leads to an abuse of process such that a stay of proceedings will be granted. The Supreme Court of Canada has stated that illegal police activity does not automatically amount to an abuse of process. The legality of police actions is but a factor to be considered, “albeit an important one.” Although the issue of illegal police activity is important, it has less of an impact on the

⁶⁰ Mewett, A.W. and S. Nakatsuru, (2000) *An Introduction to the Criminal Process in Canada*, Fourth Edition, Carswell, page 180.

enforcement of drug legislation. The reason is that the drug legislation provides police immunity for activities such as buy-and-bust operations and reverse sting operations.⁶¹

The leading case with respect to illegal police activities is *R. v. Campbell*.⁶² The police in this case had conducted a reverse sting operation in which undercover officers portrayed themselves as large-scale hashish vendors. The accused argued that the police conduct was illegal because they had committed the offence of trafficking themselves (the CDSA and the exemption it provides for such police conduct having not yet been passed). They added that this amounted to an abuse of process.

According to the Supreme Court of Canada, the police are not immune from criminal liability for acts committed in the course of an investigation, unless this is authorized by legislation. The Court added that the issue should be left to Parliament: “*If some form of public interest immunity is to be extended to the police to assist in the ‘war on drugs,’ it should be left to Parliament to delineate the nature and scope of the immunity and the circumstances in which it is available...*”⁶³ Where alleged illegal police activity is authorized within the legislative scheme, there is no abuse of process issue. The Supreme Court of Canada added, however, that illegal police activity does not automatically amount to an abuse of process. The legality of police actions is but a factor to be considered, “albeit an important one.”

Although this decision may have had a significant impact on general law enforcement in Canada, the impact was less severe in the case of drug enforcement. This is because drug legislation was amended to allow police officers to conduct the type of activities that were at issue in *Campbell*.

The CDSA proscribes various activities such as possession, trafficking and manufacturing of drugs, while allowing various regulatory exceptions, for example the importation by licensed dealers and the sale by pharmacists. The Act also allows for the making of regulations dealing with enforcement matters such as exempting police officers from application of the Act on such terms and conditions as specified in the regulations. In addition, the Act allows for the making of regulations “*that pertain to investigations and other law enforcement activities conducted under this Act by a member of a police force and other persons acting under the direction and control of a member.*” Thus, the regulations provide a legal framework for specialized enforcement techniques (including buy-and-bust, and sting operations) and set out the parameters for such activities. The police rely on these regulations for protection against prosecution.

Section 3 of the *Narcotic Control Regulations* authorizes members of police forces to possess narcotics where such “*possession is for the purposes of and in connection with such employment.*” In addition, the CDSA (*Police Enforcement*) *Regulations* exempt police officers from the offences of trafficking, importation or exportation and production. The regulations set out the eligibility requirements for the exemption. Different rules apply

⁶¹ Illegal activities by a police officer also raise the issue of whether the police officer may be liable to prosecution. The issue is beyond the scope of this paper.

⁶² (1999) 133 C.C.C. (3d) 257 (S.C.C.).

⁶³ *Ibid.*, at page 282.

depending on the source of the drugs. At all times, the individual must be an active member of a police force and must be acting in the course of his or her responsibilities for the purposes of the particular investigation.

Thus, special immunity for police officers is set out in the CDSA. Canadian criminal legislation has recently been amended to provide a general exemption from criminal liability for police officers. The legislation provides police with protection from criminal liability for certain otherwise illegal acts committed during the course of a *bona fide* investigation or other law enforcement duties, as long as certain conditions are met.⁶⁴

Conclusion

Clearly, Parliament and the courts have recognized that, as criminals become more sophisticated, the police must be given more sophisticated tools to fight them. In addition, they generally view the illegal drug trade as a serious challenge. Courts often mention the sinister nature of the drug trade and the impact it has on society in rendering their decisions. They may be influenced by these concerns in determining where to draw the line with respect to police conduct. They recognize the difficult job police have and are often willing to grant them “considerable latitude.” An example of this attitude is the following statement by the Supreme Court of Canada with respect to the selling of drugs: “*It is a crime that has devastating individual and social consequences. It is, as well, often and tragically coupled with the use of firearms. This crime is a blight on society and every effort must be undertaken to eradicate it.*”⁶⁵ In another case, the following was stated: “... *this Court must also consider the societal interest in law enforcement, especially with regard to the illicit drug trade. This pernicious scourge in our society permits sophisticated criminals to profit by inflicting suffering on others.*”⁶⁶ However, the police have not been given “carte blanche” to do what they want to solve a crime. Their activities are scrutinized so as to ensure that their conduct does not shock the community and in any way detract from the fairness of an accused’s trial.

STATISTICS

The following sections will review key criminal statistics related to enforcement of illicit drug legislation. This information must be carefully interpreted. It is generally thought that police-reported crime statistics are much more a reflection of police activity than actual societal changes, particularly in the case of consensual type offences.

⁶⁴ SC 2001, Chapter 32.

⁶⁵ *R. v. Silveira*, (1995) 97 C.C.C. (3d) 450 at page 496.

⁶⁶ *R. v. Grant*, (1993) 84 C.C.C. (7d) 173.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

As in many other drug related areas, Canadian statistics are fairly weak—for example, other than fairly basic information, it is very difficult if not impossible to identify some of the essential characteristics of individuals entering the criminal justice system.

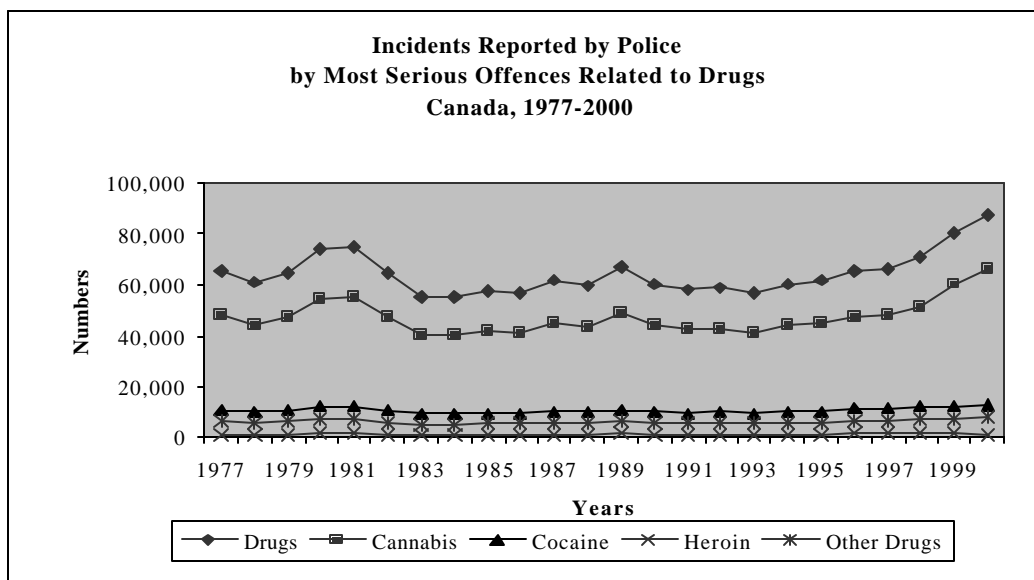
Reported incidents⁶⁷

Reported incidents are incidents that come to the attention of the police and are captured and forwarded to the Canadian Centre for Justice Statistics according to a nationally approved set of common crime categories and definitions. Thus the actual number of drug offences would be much higher, since it can be assumed that most drug offences do not come to the attention of police. As with other consensual types of offence, it is impossible to determine accurately the amount of illegal activity. In addition, the survey counts only the most serious offence committed in each criminal incident, which consequently underestimates the total number of drug-related incidents, particularly offences with less severe penalties. The number of reported incidents should also not be confused with the number of charges that are laid by the police. Because police have wide discretion in whether to lay a charge, it is clear that the number of charges will be lower than the total reported incidents.

The figure below shows trends in the number of incidents reported by police according to the most serious crime. It reveals that, from 1983 to 1995, incidents related to drug offences were relatively stable, hovering around 60,000 per year. However, from 1995 to 2000, there was an increase of approximately 50%, with the number of reported incidents reaching nearly 88,000. In 2001, the number reached 91,920, an increase of 3.3% in relation to the previous year.

⁶⁷ The Canadian Centre for Justice Statistics warns that crime statistics may be influenced by many factors, including: reporting by the public to the police; reporting by the police to the Canadian Centre for Justice Statistics; the impact of new initiatives such as changes in legislation, police or enforcement practices; and social, economic and demographic changes.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS



Most of the increase in recent years can be attributed to cannabis-related offences. In 2001, these increased by 5.5% in relation to the previous year. These offences account for the majority of all drug-related offences in Canada. In 2001, cannabis-related offences accounted for 71,624 of reported incidents, **almost 77% of all drug-related incidents**. Of those 71,624 offences, 70% were for possession, 16% for trafficking, 13% for cultivation, and 1% for importation.⁶⁸ This means that **approximately 54% of all reported drug-related offences are for the possession of cannabis**. The following are reported incident rates per 100,000 people for offences related to cannabis, cocaine and all drugs.

Selected drug offences per 100,000, Canada 1994-2001

	1994	1995	1996	1997	1998	1999	2000	2001
Cannabis	138	148	157	160	168	197	215	227.22
- possession	97	103	110	108	115	130	147	
Cocaine	42	38	37	38	40	39	42	39.4
Total all drugs	207	208	217	222	235	263	286	295.7

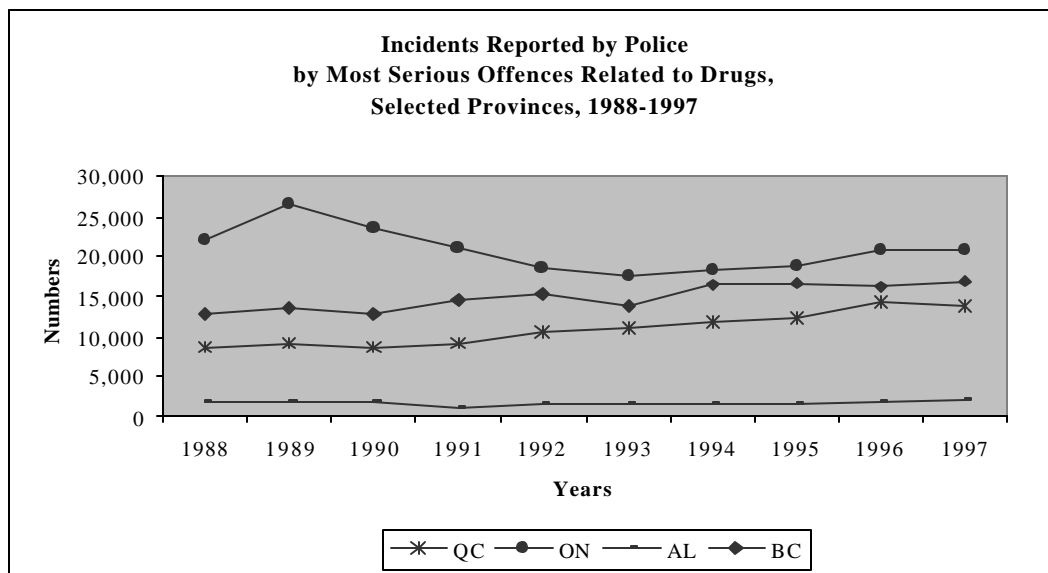
From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5; for cocaine-related offences, -31.5; for heroin-related offences, -36.1; and for other drugs, +15.0. **This means that, based on the**

⁶⁸ Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, Catalogue no. 85-002-XIE Vol. 22, no. 6, page 11.

same population, reported cannabis-related offences have almost doubled in the last decade.

In recent years, the cultivation of cannabis, particularly in British Columbia, has raised concerns. This type of offence has also seen a significant increase over the past decade: from a rate of 7 incidents per 100,000 people in 1990 to 29 in 2001.⁶⁹ A recent report indicates that in British Columbia, the number of growing operations is increasing by an average of 36% per year and average size is increasing at a rate of 40% per year. The report adds that the vast majority of cases coming to the attention of the police in British Columbia do so as a result of public complaints, meaning that the increase in cases is not due to increased proactive police enforcement.⁷⁰

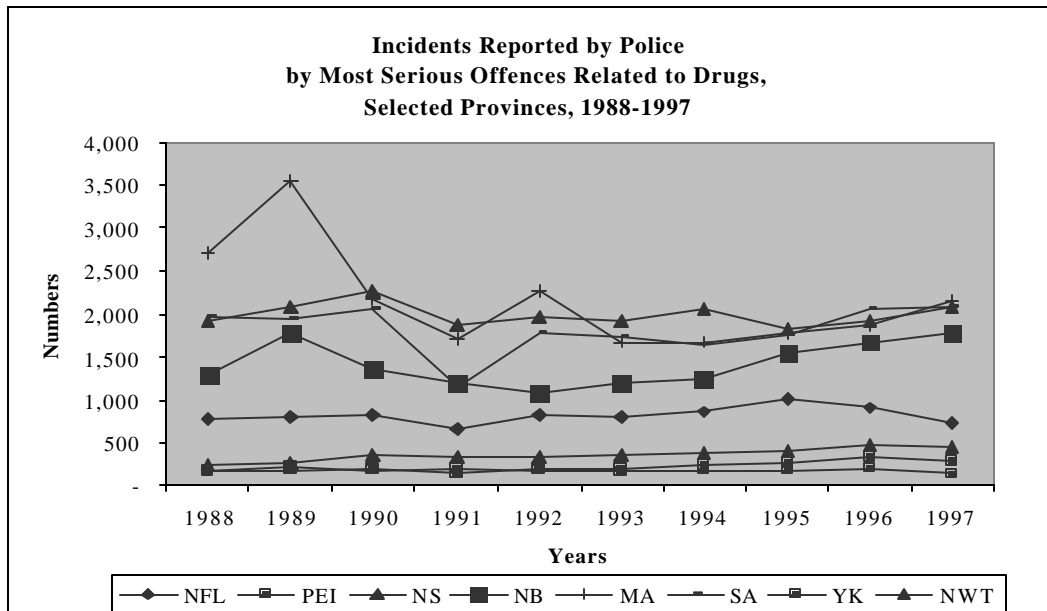
The two figures that follow provide information on the location of reported incidents from 1988 to 1997. Not surprisingly, the most populated provinces are at the top, with Ontario in the lead followed by British Columbia, Quebec and Alberta.



⁶⁹ *Ibid.*

⁷⁰ Plecas, D., et. alii., (2002) *Marihuana Growing Operations in British Columbia – An Empirical Survey (1997-2000)*, Department of Criminology and Criminal Justice – University College of the Fraser Valley and International Centre for Criminal Law Reform and Criminal Justice Policy.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS



A better indication of the level of crime in a province, however, is a calculation based on rates per 100,000 population. British Columbia has historically had the highest provincial rate of drug crime in the country.⁷¹ For example, in 2001, the rate was 563.5 incidents per 100,000, almost double the national figure of 295.7. The rates for the other provinces and territories are as follows: Newfoundland and Labrador-173.1; Prince Edward Island-192.0; Nova Scotia-218.3; New Brunswick-346.9; Quebec-262.1; Ontario-256.1; Manitoba-215.9; Saskatchewan-278.4; Alberta-235.3; Yukon - 478.5; Northwest Territories-597.2; and Nunavut-806.1. It is obvious that the level of drug-related crime varies considerably from one province and territory to another.

Charges

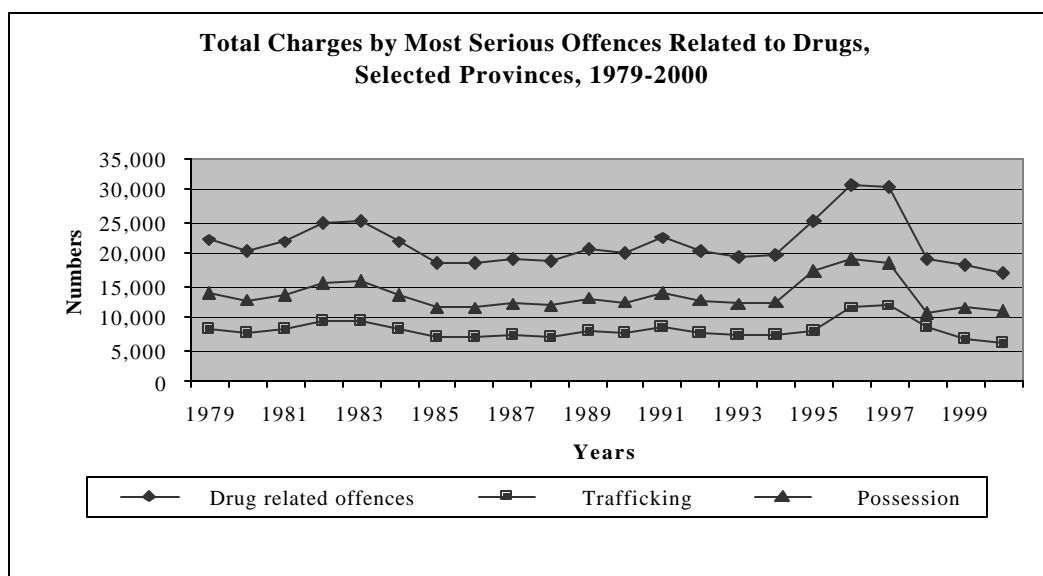
From the available data presented in the following figure, it would seem that trafficking and possession charges for drug-related offences have declined noticeably since 1997. It should be remembered that the number of reported incidents (discussed previously) is not equivalent to the number of charges that are laid by the police. In some cases, the police will report a drug incident to Statistics Canada but will decide not to charge the offender. The wide discretion given to police can lead to serious concerns regarding the enforcement of the legislation. These concerns are discussed later in this chapter. The reader should be aware that this figure does not include data

⁷¹ It should be noted that in 1997 the rate in both Yukon and Northwest Territories was even higher than in British Columbia.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

from three provinces (New Brunswick, Manitoba and British Columbia) and from one territory (Nunavut). In addition, data from certain courts in Quebec are not included.⁷²

Because data from three provinces are not included—in particular, British Columbia—the actual number of drug charges in Canada was actually much higher than the figure suggests. As was previously explained, British Columbia has, in the past, consistently reported the highest rate of drug crime.



Statistics from 1997 show, however, that with respect to charging drug offenders, British Columbia is more lenient than other provinces:

Among provinces and territories, police departments in British Columbia reported the lowest charge rate (47%) for drug offences. Only 35% of cannabis incidents and 36% of “other drug” incidents resulted in charges, compared to 79% and 81% for all the other provinces combined.⁷³

For example, Superintendent Ward Clapham of the Richmond RCMP indicated that, for possession of marijuana under 30 grams, only 40 people were charged out of 700 reported cases in the year 2000; and in 2001, only 30 people were charged out of 605 reported cases. Once again, it is clear that the enforcement of the legislation varies considerably from one area of the country to another.

With respect to cannabis offences in 2001, the male population was much more likely to be charged with an offence. For both youths (12 to 17) and adults, 88% of the

⁷² Also, the data prior to 1995 are based on approximations made from the average distribution of charges during the period covering the years 1995 to 2000.

⁷³ Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Illicit Drugs and Crime in Canada, Catalogue no. 85-002-XIE, Vol. 19, No. 1, page 5. In this case, “other drugs” means: 1) illegal drugs other than cannabis, cocaine or heroin, and 2) controlled drugs.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

people charged with cannabis offences are male.⁷⁴ In addition, while adults are much more likely to be charged than youths, 18% of cannabis-related charges relate to youths.⁷⁵

While the previous figure seems to indicate that there were fewer than 20,000 drug-related charges in 1999, the Auditor General's 2001 report indicates that during that year, just under 50,000 people were charged with drug offences under the CDSA (in cases where the most serious offence was drug-related). One of the drawbacks of recording offence statistics according to the most serious offence is that this leads to severe underreporting of offences, particularly offences with less severe penalties. In the hierarchy of criminal offences (of which there are 152), marijuana offences are ranked as follows: importation or exportation- 44; trafficking of more than 3,000 grams-46; production-52; trafficking of 3,000 grams or less-59; possession of more than 30 grams-120; and possession of 30 grams or less--121.

Of the approximately 50,000 drug-related charges laid in 1999, cannabis was involved in 70% of the charges. **In 43% of the drug-related cases (21,381), the charge was for possession of cannabis.** Overall, 54% of the drug offences were for possession. Since the number of reported incidents has continued to climb, one can only assume that today even more people are being charged with drug offences, particularly cannabis offences.

With over 34,000 charges per year for cannabis-related offences and with over 21,000 charges per year for possession of cannabis, can one conclude that police are actively seeking out cannabis possession offences? After reviewing the evidence, we do not believe this to be the case. Nonetheless, over 21,000 people per year enter the criminal justice system in cases where their most serious offence was that of possession of cannabis. It bears repeating that these statistics are based on the most serious offence in a given incident.

Several reasons were advanced to explain the high number of possession offences. Those enforcing the CDSA stated that they do not actively seek out such offences, but rather they are discovered in the normal course of their duties. This was repeated time and time again. While we do not doubt the sincerity of these statements, in certain cases—as will be discussed below—police tactics can be questioned. In addition, we were told that while the offence of trafficking, if it occurs over a period of time, is recorded as one offence—the continuing offence rule—this rule does not apply to possession offences.

Concerns

While there may be valid reasons for the high incidence of possession charges, many have raised serious concerns with respect to the discretion used by the police in

⁷⁴ Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, Catalogue no. 85-002-XIE, Vol. 22, No. 6, page 19.

⁷⁵ *Ibid.*

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

regard to drug-related possession charges – in particular, cannabis possession cases. As mentioned earlier, the number of reported incidents and the charge rate vary considerably from province to province.

The uneven application of the drug legislation in the various provinces, even within the same province, raises serious concerns. Mr. Kash Heed from the Vancouver Police Department indicated that small-scale possession of any drug in Vancouver is virtually unenforced by the police department unless there are aggravating circumstances. Their focus is on those who profit—traffickers and producers. He added that the number of prosecutions in British Columbia for cannabis possession is quite small in comparison to other provinces. He concluded that total prohibition had “resulted in costly enforcement, alienation of groups of people, discriminatory enforcement, little deterrence in supply, and minimal deterrence of use.” Heed added that, even in British Columbia there are discrepancies—centres outside of Vancouver having higher rates of prosecution for possession of cannabis than does the City of Vancouver.

We have estimated that approximately 2.5 million people in Canada used cannabis in the last year. In 1999, 21,381 people were charged with the possession of cannabis. This means that only 0.85% of cannabis users were actually charged with possession. It is also important to remember that of the number of people who used cannabis in the last year, many would have used it more than once. As a result, the actual chance of being charged for possession of cannabis in relation to the actual number of offences is in all likelihood much lower than 1%. This certainly raises concerns regarding fairness. In addition, both the effectiveness of the legislation and any deterrent effect it may have are seriously in doubt.

So what are the potential consequences of uneven enforcement of the legislation and unfettered discretion as to whether or not to proceed with laying a charge? Marie-Andrée Bertrand, referring to a paper prepared by Nicolas Carrier⁷⁶ stated the following:

A recent qualitative study of members of the Montreal Urban Community Police Department underscores the ambivalence and confusions of frontline police officers and their varied reactions to the “drug problem.” The extent of the problem is perceived quite differently depending on the officers in question and the neighbourhoods they patrol. In the minds of some, particularly in the case of young drug users and “exchangers”, although “the law is the law” and must undoubtedly be enforced, drug possession and use do not really concern the police. The prohibition is simply not enforceable. It is impossible to determine cases of possession in the absence of search and seizure powers, except “on a hunch” or in arresting suspects for other “crimes”. Once possession cases and drug deals in public places are discovered either by accident or in the course of investigating other offences, police officers react in various ways depending on their professional aspirations. Those seeking promotion and specialization (who want to join the drug or victimless crimes squads) pass the information along to the appropriate

⁷⁶ Carrier, N. (2000) *Discours de patrouilleurs montréalais sur la détection de l'infraction de possession de drogues prohibées*. Mémoire de maîtrise. École de criminologie, Université de Montréal.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

*divisions. Patrolmen who intend to remain patrolmen close their eyes or question suspects to obtain trafficking information in exchange for promises of immunity, or else take substances abusers to treatment services, call the parents of a minor, etc.*⁷⁷

The uneven application of the legislation is one of our greatest concerns, for a variety of reasons. First, there is the danger that this can lead to discriminatory enforcement, where certain people are more likely to be charged than others because of their personal characteristics. While current national statistics do not allow such an analysis, there is some evidence that the law is applied discriminatorily.

The Carrier paper discussed above was the result of interviews with 21 Montreal area patrol officers. It discusses the difficulties of detecting possession offences due to the lack of a “victim,” the discreetness of the offences and the constitutional limits on unwarranted searches. The paper explains that a police officer’s actions depend on several factors, such as how serious the officer perceives the drug problem to be and what are the officer’s career aspirations—those wanting promotions respond more proactively to drug offences than those wishing to remain as patrol officers, who tend to be more reactive. Police are generally frustrated by the limits imposed on searches.

So how do they go about detecting possession offences? The officers indicated that most possession offences are detected when a person is stopped for another criminal matter—the arrest allowing an officer to conduct a search of the person. On rare occasions, officers detected the offence when a person openly flouted the law.

Of note, officers also indicated that certain people attracted their attention and some indicated that there are “signs” which lead them to believe that people are in possession of illegal substances. With respect to people in cars, the following factors were mentioned: the appearance of passengers in a vehicle; the vehicle’s model and value; the person’s driving habits; and a computer check of the licence plate indicating that the owner had a criminal record. Officers are allowed to stop people to ensure they have the proper documentation, and this may lead to the discovery of an offence that would result in a search. With respect to pedestrians, the following factors were mentioned: the person is known as a drug user; physical appearance; the person’s activities; associating with other “suspects”; and association with dwellings suspected for trafficking. Certain officers indicated that questioning such suspects can lead to an arrest—for example, an outstanding warrant of arrest—and a search. Officers also indicated that on occasion they selectively applied municipal by-laws and other provincial legislation in order to obtain a person’s name, after which the person can be investigated. If a person refuses to give his or her name, the person may be arrested and searched. Officers also indicated they had used techniques to “go fishing.” While the evidence would not be admissible in court, in certain circumstances it allowed the

⁷⁷ Voir aussi la discussion qu’en fait M. Guy Ati-Dion lors de son témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2001, fascicule 8, pages 73-74.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

officer to obtain information from the person in exchange for “not laying a charge,” or allowed the officer to seize the illegal substance.

While this study is of limited scope, it does provide an indication of how police discretion in enforcing drug legislation may lead to discrimination based on factors such as a person’s appearance.

Another concern is the danger of alienating certain groups of society. Those targeted by enforcement may lose respect for police and the criminal justice system in general. Inconsistent legal responses are likely to create an atmosphere that brings the administration of justice into disrepute. As Parliamentarians, we find this unacceptable.

Finally, there is the basic issue of fairness and justice. No one seems able to explain why some people are charged and others are not. It is not surprising that this legislation faces such fierce criticism.

Customs Act - fines

In general, when one thinks of drug enforcement, one thinks of charges laid by police under the CDSA and seizures made by them. Other legislation can be applied in certain circumstances, however. For example, the *Customs Act* allows for the seizure of prohibited goods and also of vehicles used in contravention of that act. In this case, a civil "penalty" may be imposed against the importer, because a Customs officer may return the vehicle to the importer only upon payment of the assessed monetary penalty. The penalty is based on the quantity of drugs found.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

Amount	Marihuana	Hashish	Hashish oil	Controlled drugs	Hallucinogens	Cocaine Opiates
*\$220	over 8 grams not over 15 grams	over 2 grams not over 4 grams	over 1 gram or less	over 10 pills not over 20 pills	over 1 dosage not over 4 dosages	1 gram or less \$400
\$440	over 15 grams not over 30 grams	over 4 grams not over 8 grams	over 1 gram not over 2 grams	over 20 pills not over 40 pills	over 4 dosages not over 8 dosages	
\$550	over 30 grams not over 60 grams	over 8 grams not over 16 grams	over 2 grams not over 4 grams	over 40 pills not over 60 pills	over 8 dosages not over 12 dosages	
\$660	over 60 grams not over 100 grams	over 16 grams not over 24 grams	over 4 grams not over 6 grams	over 60 pills not over 80 pills	over 12 dosages not over 16 dosages	
\$770	over 100 grams not over 150 grams	over 24 grams not over 32 grams	over 6 grams not over 8 grams	over 80 pills not over 110 pills	over 16 dosages not over 20 dosages	
\$880	over 150 grams not over 200 grams	over 32 grams not over 40 grams	Over 8 grams not over 10 grams	over 110 pills not over 140 pills	over 20 dosages not over 24 dosages	
\$990	over 200 grams not over 250 grams	over 40 grams not over 46 grams	Over 10 grams not over 12 grams	over 140 pills not over 160 pills	over 24 dosages not over 28 dosages	
\$1100	over 250 grams not over 300 grams	over 46 grams not over 56 grams	Over 12 grams not over 14 grams	over 160 pills not over 180 pills	over 28 dosages not over 32 dosages	

For amounts in excess of the above stated sums:

over 300 grams: \$4 for each additional gram	over 56 grams: \$20 for each additional gram	over 14 grams: \$70 for each additional gram	over 180 pills: \$8 for each additional pill	over 32 dosages: \$40 for each additional dosage	over 1 gram: \$400 for each gram
--	--	--	--	--	----------------------------------

The CCRA will also arrest the importer, under the authority of the *Customs Act*, for smuggling goods into Canada, that are prohibited, restricted or controlled by the Act or by any other Act of Parliament (for example, the CDSA). Once the CCRA has seized the drugs and made an arrest, the responsible police force is contacted and will decide whether or not to proceed and lay charges. As will be discussed later, in some cases, the CCRA has entered into Criminal Charge Agreements with police forces. The Crown Attorney will then decide whether or not to prosecute, based on case-by-case specifics.

Under section 6 of the CDSA importing drugs, except as authorized under the regulations, is an offence regardless of quantity. Therefore, in the case of importing, there is no "threshold" in the CDSA below which a lesser sentence or fine can be imposed. However, if the amount imported is of a quantity normal for personal use, rather than resale, the Crown may choose to prosecute for possession rather than importing.

The CCRA in Windsor has a Criminal Charge Agreement with the Windsor RCMP which sets out guidelines for criminal prosecution for border seizures. The amounts are to be used only as a guide, but generally a person will not be charged by the RCMP for importation of less than 50 grams of marijuana, less than 20 grams of

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

hashish or less than 15 grams of hash oil. In these cases, enforcement will be done under the *Customs Act*. From 1996 to 2001, almost 99% of the 4,055 marijuana seizures in the Southern Ontario region were for less than 50 grams.

SEIZURES

The following table provides information on seizures made by the RCMP, CCRA, Sûreté du Québec, Ontario Provincial Police and the municipal police forces of Montreal, Laval and Toronto.

Drugs Seized in Canada: 1993–2001

	1993	1994	1995	1996	1997	1998	1999	2000	2001
heroin	153	85	128	83	95	105	88	168	74
cocaine	2,731	7,915	1,544	3,110	2,090	2,604	1,116	1,851	1,783
ecstasy				1,221	10,222	68,496	400,000	2,069,709	1,871,627
marihuana (kg)	7,314	6,472	5,500	17,234	50,624	29,598	23,829	21,703	28,746
marihuana (plants)	238,601	288,578	295,999	675,863	689,239	1,025,808	954,781	1,102,198	1,367,321
hashish	56,721	36,614	21,504	25,155	6,118	15,924	6,477	21,973	6,677
liquid hashish	669	659	663	805	824	852	434	1,240	397

(Weights in kilograms; Ecstasy in dosage units)

According to Professor Steve Pudney, Public Sector Economics Research Centre, Department of Economics, Leicester University, “seizure data provide the most direct information on availability of drugs even though drugs seized are not contributing to the available supply.”⁷⁸ If one looks at RCMP drug seizure trends, however, it becomes obvious that the data must be used cautiously, because the number of interceptions or the amount seized in one year is not necessarily a true indicator of an increase or decrease in the drug situation. Rather, it is an indication of the impact of active and passive policing.

Seizures are likely to be passive in the sense that there is a more or less constant seizure rate achieved by routine monitoring and investigation. The greater the amount of drugs entering the market, the greater the background level of seizures, on a purely statistical basis. Passive seizures are thus a positive

⁷⁸ Appendix B. ‘Referee’s Comments.’ In Bramley-Harker (2001) *Sizing the UK market for illicit drugs*. London: Home Office. RDS Occasional Paper no 74.

*indicator of the size of the market. However, drug policing also has active aspects. Investigations based on criminal intelligence often lead to the closing down of pipelines of supply and the removal of significant quantities of the product from the domestic market. Seizures of this type are negatively related to market size in the sense that a large seizure, rather than being an indicator of supply growth, is a cause of supply contraction. When these two aspects are present, it is difficult to draw any clear conclusion about supply from information on seizures.*⁷⁹

While passive seizures may indeed be a positive indicator of the size of the drug market, one must remember that passive seizures may also be somewhat inaccurate, because Canada's vast borders and coastline make it difficult for Canadian officials to make consistent interceptions and seizures each year. Importers continually find new ways of avoiding authorities by means of different ports of entry, as well as larger, infrequent shipments or vice versa.

Despite these problems with seizure data, the trends indicate that the seizures of cannabis, both in kilos and plants, have seen a fairly significant increase in the last few years, particularly when compared to seizures relating to cocaine and heroin.

What is clear from the seizure data is that police have, in recent years, placed increased emphasis on marijuana cultivation offences. In 1993, police seized fewer than 250,000 marijuana plants, while seizures in 2001 totalled more than 1,350,000 plants. This would seem to suggest an increase in cultivation in Canada and also a shift in police priorities to cultivation offences.

CONCLUSIONS

Conclusions of Chapter 14	
	<ul style="list-style-type: none">➤ Annual costs for drug enforcement in Canada can be estimated at between \$700 million and \$1 billion.➤ Reduced law enforcement activities resulting from amendments to the drug legislation on cannabis could produce either substantial savings or significant reallocations of funds by police forces to other priorities.➤ Due to the consensual nature of drug offences, police have been granted substantial enforcement powers and have adopted highly intrusive investigative techniques; these powers are not unlimited, however, and are subject to review by Canadian courts.➤ Over 90,000 drug-related incidents are reported annually by police; more than three-quarters of these incidents relate to cannabis and over 50% of all drug-

⁷⁹ *Ibid.*

- related incidents involve possession of cannabis.
- From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5—thus, the rate of reported cannabis-related offences has almost doubled in the last decade.
 - Reported incidents related to the cultivation of cannabis have seen a dramatic increase in the last decade.
 - Reported incident rates vary widely from province to province.
 - Cannabis was involved in 70% of the approximately 50,000 charges in 1999. In 43% of cases (21,381), the charge was for possession of cannabis.
 - Charge rates for drug offences vary significantly from province to province.
 - The uneven application of the law is of great concern and may lead to discriminatory enforcement, alienation of certain groups within society, and creation of an atmosphere of disrespect for the law; in general, it raises the issue of fairness and justice.
 - Seizure statistics would seem to confirm an increase in cannabis cultivation in Canada and also a shift in police priorities regarding this offence.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS : CANNABIS

CHAPTER 15

THE CRIMINAL JUSTICE SYSTEM

The previous chapter examined how people first come into contact with the criminal justice system through the enforcement of criminal legislation. Several questions remain, however. What happens once a person has been charged with a drug offence? Who is responsible for prosecuting drug cases? What type of punishment do people receive? Who ends up with a criminal record? Have there been any challenges to the constitutional validity of drug legislation? These issues and others related to the criminal justice system are reviewed in this chapter.

PROSECUTION

The Federal Prosecution Service (FPS) is the lead prosecution agency with respect to drug offences in Canada. Its mandate is to prosecute offences in every province and territory under a variety of federal statutes, including the CDSA. Its work consists mostly of drug prosecutions.

Under the CDSA, provinces can exercise jurisdiction to prosecute if a drug proceeding was commenced at the instance of the provincial government. Presently, only two provinces—Quebec, and to a lesser extent New Brunswick—have exercised this jurisdiction. Thus, in Quebec, the FPS prosecutes only offences that have been investigated by the RCMP. In the rest of Canada – apart from New Brunswick – the service prosecutes drug offences that have been investigated by a provincial or municipal police force or the RCMP.

The FPS has 300 full-time in-house lawyers in 13 offices across the country and approximately 750 standing agents from the private sector, who conduct drug prosecutions on behalf of the Attorney General of Canada. Generally, the police investigate an offence and lay a charge, which is followed by a prosecution. In certain provinces – such as British Columbia, Quebec and New Brunswick—the police are required to seek Crown approval before laying a charge.

While complex cases still represent a fairly small percentage of cases prosecuted by the FPS, they are becoming more common and are already very time consuming for prosecutors.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

...Most cases are of low or medium complexity; however, the complexity of cases is increasing and complex cases are becoming more common. Currently, it is estimated that complex cases make up 7 percent of the caseload but use 60 percent of prosecutors' time. Complex organized crime cases require the involvement of Justice at an early stage because of the legal issues associated with the collection, organization, and admissibility of evidence.¹

The total cost of drug-related prosecutions conducted by the FPS is approximately \$57 million per year—\$35 million for in-house counsels and \$22 million for standing agents. The FPS estimates that for the year 2000-2001, the cost of prosecuting cannabis possession was approximately \$5 million, or roughly 10% of the total budget of \$57 million.²

COURTS

During our deliberations, we were not given much detail on the costs to the provincial court system of drug-related prosecutions. The 1996 study by CCSA already presented in a previous chapter³ estimated court costs for 1992 at approximately \$60 million. One would assume that, with nearly 50,000 people currently charged per year for drug offences, and with the increased complexity of these cases, court administration costs would be significantly higher than the amount estimated in 1992.

The Auditor General estimated that in 1999 Canadian criminal courts heard 34,000 drug cases that involved more than 400,000 court appearances.⁴ Other court-related costs are the considerable resources spent on legal aid. While we did not receive information on how much of these costs should be allocated to drug-related offences, we do know that in 1996/1997, \$860 million was spent on court administration costs, and that in 1997/1998, \$455 million was spent on legal aid.⁵

Drug treatment courts

Drug courts originated in the USA in the late 1980s as one of the measures in the “war on drugs”. The arrangement essentially involves permitting the judge hearing a

¹ *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, “Illicit Drugs: The Federal Government’s Role”, page 12.

² Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section, Department of Justice, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 54.

³ Single, E. et. al., (1996) *op. cit.*

⁴ *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, “Illicit Drugs: The Federal Government’s Role”, page 4.

⁵ Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Justice Spending in Canada, Catalogue no. 85-002-XIE Vol. 19, no. 12, pages 7-9.

case involving narcotics to order treatment measures instead of any other form of sentence. There are now approximately 2,000 drug courts in the USA and they have apparently dealt with about 200,000 individuals. The primary task of these courts is to deal with offenders whose offences did not involve violence and who have a history of drug use (including alcohol). Two approaches are taken: one is applied before sentencing and the other after sentencing. In the former case, the charges are suspended and in the latter case it is the sentence of probation or imprisonment that is suspended. Responses include intensive judicial supervision, long-term clinical treatment, frequent random urine tests, and related services (housing, employment, etc.). Various assessments of the system claim that the benefits include a reduction in drug use and delinquency as well as a reduction in the costs to the criminal justice system (it costs approximately US \$2,000 to deal with a delinquent in the drug court system as compared with between US \$20,000 and \$50,000 for a criminal conviction combined with a prison sentence).⁶

Drug courts have also been established in Australia (1999), Ireland (1998) and England (1998).

The Committee visited Canada's first drug treatment court (DTC) during its travels to Toronto. Established in 1998 as a pilot project with funding support from the National Strategy on Community Safety and Crime Prevention, this initiative brought together many players including Justice Canada, Solicitor General Canada, FPS, the Ontario government, the provincial court, the Centre for Addiction and Mental Health (CAMH), the Toronto Police Service, the City of Toronto Public Health Department and a range of community-based service organizations. The pilot project is currently funded to December 2004.

A second drug treatment court pilot project was established in Vancouver in December 2001. It also uses an inter-sectoral model and is intended to ensure intensive case management and linking of participants to community resources and skills development programs, as required. While the Toronto DTC uses the Centre for Addiction and Mental Health as its treatment provider, treatment providers in Vancouver tend to be more locally based.

Drug treatment courts are specifically designed to supervise cases of drug-dependent offenders and are based on knowledge that incarceration alone does not lead to a reduction in drug use and related criminal activity. Typically, the criminal justice system does not address substance abuse problems or the root causes of these problems – which may include unemployment, homelessness, physical and sexual child abuse histories, family discord and a range of mental and physical health problems. DTCs are based on research that demonstrates that offenders with substance abuse problems commit fewer crimes when they are enrolled in treatment programs.

⁶ See, *inter alia*, the document prepared by the Canadian Centre on Substance Abuse (2000) *Drug treatment courts: Substance abuse intervention within the justice system*. Ottawa: author.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Another underlying assumption is that through therapeutic jurisprudence approaches such as drug courts, which are intended to provide rehabilitative and reintegration outcomes for drug-addicted offenders, the criminal justice system, in partnership with treatment providers and community services, can act as a change agent in altering the course of the addict's life.⁷

The Toronto DTC provides court-supervised treatment for people who have a dependency on cocaine and/or opiates. Non-violent drug-dependent offenders charged with possession of, or trafficking in, small amounts of crack/cocaine or heroin, or with prostitution-related offences, are eligible for the program. In all cases, the offender is screened and assessed by a treatment provider. Admission is voluntary but must be approved by the Crown. Factors considered include other current criminal charges, the potential for risk to the community and the seriousness and circumstances of the offence. Two tracks have been established. In general, the first track is for those with limited or no criminal record and a charge of simple possession. They are eligible to enter the DTC prior to plea—once the program is completed, the charge is stayed or withdrawn. The second track is for those with more serious criminal records or a trafficking charge. They are required to plead guilty—once phase I of the program is completed, the offender receives a non-custodial sentence and is placed on probation (phase II). Failure to complete phase I results in the offender being expelled and sentenced.

The system is based on close collaboration between the Court and treatment systems. The offenders attend court sessions on a regular basis—the court sits twice a week—where the judge, in consultation with the DTC treatment team, reviews their progress. The DTC team includes the DTC judge, crown prosecutor, duty counsel, a representative of probation services, court staff, community/court liaison staff and treatment staff. Decisions are made regarding future treatment and judicial involvement. Continued compliance is encouraged through a system of graduated incentives and sanctions—this is accomplished by releasing the offender on bail with appropriate conditions that must be satisfied. Relapses are anticipated as part of the recovery process and do not automatically lead to expulsion. Honesty and accountability are important, however. Failure to meet other conditions, such as attendance in court or providing a urine sample, can result in a range of sanctions, including revocation of bail for up to five days.

The offender is involved in a structured outpatient program geared to his or her specific needs. Treatment lasts approximately one year, during which the offender works closely with a case manager. Treatment includes: group and individual counselling, ongoing case management, regular and random drug screening, and addiction medicine services – including methadone maintenance where appropriate. Treatment staff also collaborate closely with community resources and agencies to meet

⁷ Patricia Begin, Director, Research and Evaluation, National Crime Prevention Centre, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 57.

the needs of participants. To complete the program, the offender must not have used crack/cocaine and/or heroin for an extended period of time and must also demonstrate a fundamental life-style change involving improved interpersonal skill development, stable and appropriate housing, and educational and vocational success.

The DTC initiative seems very encouraging although it is clear that evaluations will have to be conducted to ensure that these programs are effective. We were told that there are very few existing comprehensive, well-designed evaluations of drug treatment courts but that results of more comprehensive evaluation should be ready in 2002-2003. Problems to date include the following: most of the evaluations or research have taken place within very limited time frames; there has been no significant follow up to look at whether there has been re-use or abuse of drugs and criminal recidivism; and there has been a lack of adequate comparison groups from which to draw conclusions about the impact and effects of the program. Also discussed were differences from American drug courts, where mandatory minimum sentences and harsher penalties in general are a significant incentive for American participants to remain with the program.⁸ Patricia Begin, Director of Research and Evaluation at the National Crime Prevention Centre, provided the following preliminary details of the Toronto DTC:

Briefly, the Toronto evaluation is using a quasi-experimental design. The comparison group is composed of those clients who were assessed as eligible to enter the program and made the decision not to participate in the drug treatment court, but rather go through the traditional criminal justice processing.

Between April 1999, when the evaluation data started to be collected, and October 5, 2001, there were 284 clients involved in the drug treatment court. Eighty-three per cent, or 234, are the experimental group, and 17 per cent constitute the comparison group of 50 clients.

In the experimental group, 16.7 per cent are still in the program; 13.7 or 14 per cent have graduated, which is 32 graduates; and 62 per cent have been expelled. The overall retention is 31 per cent.

One of the things the research has illuminated is that for those drug treatment court clients who make it past the three-month period, the retention rate rises to 50 per cent. The court is attempting, through the data, to better understand the characteristics of those clients who are deemed to be eligible but do not make it, and who are expelled or withdraw in the first three months.

...The evaluation has found that the comparison group is more likely than the experimental group to be younger, unemployed, have an income source from illegal activity, more criminal convictions, have been incarcerated more often and been charged with a new offence since admission to the drug treatment court. In many respects, the comparison group is at much higher risk than the experimental group. Lower reoffending rates for those receiving the drug treatment court program and related services may be related to their level of risk. We would like to explore further whether it is participation in the program, or lower risk and motivation to change one's life that is accounting for these differences.

⁸ *Ibid.*, page 8.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

The evaluation data that we have to date has told us the following: The drug treatment court in Toronto is able to engage and retain offenders. Those who stay in the program tend to complete it and graduate, and the limited follow-up data that has been collected so far would indicate that they do have lower recidivism rates and reduced drug use.

There is also a reduction in drug use and criminal activity while offenders are in the program. There tend to be lower re-arrest rates for the experimental group compared with the expelled or the comparison group. One of the evaluation challenges over the next couple of years will be to try to identify a better matched group of offenders in order to define the outcomes, impacts and effects of the drug treatment court experience on some of the key outcome measures, which have to do with drug use, criminal activity, re-insertion in a pro-social way into the community, family stability and things of that nature.⁹

We look forward to the results of more comprehensive evaluations. Of note, the cost of incarceration in Ontario is approximately \$45,000 per year while treatment costs related to drug courts are estimated at \$4,500 per year. Clearly, increased use of DTCs could lead to substantial savings to the criminal justice system while at the same time showing promising results in reducing substance abuse problems.

DISPOSITION AND SENTENCING

While the quality of criminal justice statistics has been discussed in other chapters, the weakness in these numbers is particularly evident with respect to the disposition and sentencing of drug-related offences. This issue was also raised in the Auditor General's report for 2001.

There are weaknesses in some aspects of law enforcement statistics. First, there are no national statistics on illicit drug convictions and sentencing. For example, British Columbia, Manitoba, New Brunswick, and Nunavut do not provide adult criminal court data to Statistics Canada. The use of statistics requires good analysis and interpretation to understand underlying trends and causes. Because Canada does not have national data, it cannot monitor important trends such as sentence lengths, emergence of new drugs, and regional differences...

A second weakness is that the statistics on drug convictions and sentencing, which are reported according to the categories under the Controlled Drugs and Substances Act, are limited in detail. While the national statistics on police charges break down the number of drug charges by both type of substance (for example, heroin, cocaine, and cannabis) and act (for example, possession, trafficking, importation, and cultivation), the statistics on convictions are broken down into only two categories - possession and trafficking. The Inter-American Drug Abuse Control Commission's 1999-2000 report on Canada's

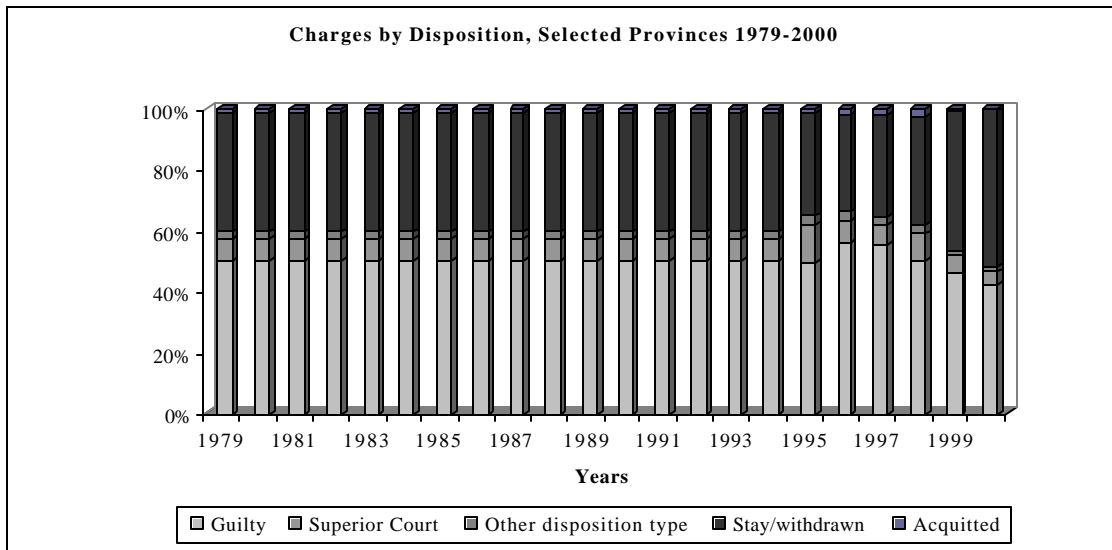
⁹ *Ibid.*, pages 58-60.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*progress in drug control stated that improvements were needed in the justice system's statistics on drug offences.*¹⁰

Despite these weaknesses, data relating to the disposition and sentencing of drug-related offences will be reviewed.

The following figure details the outcome of those charged with drug offences in selected provinces. It would appear that, from 1995 to 2000, there was a fairly significant increase in the percentage of cases in which the charges against the accused were either stayed or withdrawn. Not surprisingly, the percentage of people being found guilty of drug offences once they had been charged was lower. It is important to note, however, that this figure does not include data from three of the provinces (New Brunswick, Manitoba and British Columbia) and from one of the Territories (Nunavut); nor does it include data from certain courts in Quebec. Also, the data prior to 1995 are based on approximations of the average distribution of charges during the period covering the years 1995 to 2000.



For the year 1996-1997, 64% of persons convicted of drug trafficking were sentenced to imprisonment. The median sentence was four months. Probation was imposed as the most serious sentence in 24% of these cases and fines, in 9%.¹¹

¹⁰ *Report of the Auditor General of Canada to the House of Commons, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 15.*

¹¹ *Statistic Canada, Canadian Centre for Justice Statistics, Juristat, Illicit Drugs and Crime in Canada, February 1999, page 7.*

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

With respect to possession, a fine was imposed in 63% of the cases, with a median amount of \$200. A fine was imposed as the most serious sentence in 55% of cases, probation in 22% and imprisonment in 13%.¹²

We were informed that the FPS is attempting to identify and implement alternatives to prosecution where appropriate. For example, “diversion” – whereby first-time offenders who have been charged with simple possession of cannabis are diverted out of the formal criminal justice system – was mentioned. Also discussed were the drug treatment court pilot projects in Toronto and Vancouver, whereby addicted offenders are referred to a fairly rigorous court-monitored treatment program. In addition, we were told about the recent implementation of the “deferred prosecution pilot project,” in which prosecutors post a peace bond for offenders who have been charged with possession of cannabis in Manitoba. In these cases, the charges would be stayed, and as long as the offender is not back before the court system within a period of one year, the matter would be discontinued. Other “diversion” programs across Canada were mentioned.¹³

While Canada’s disposition and sentencing data are incomplete, a few studies of limited scope suggest what is happening in Canada. A document prepared by the *Comité permanent de lutte à la toxicomanie* reviews police and judicial practices based on Quebec statistics from 1985 to 1998.¹⁴ The report found that practices varied from one region to another in Canada and also from one region to another in Quebec. It notes that while there is a trend towards greater use of diversion in cannabis possession cases, it is far from being a standard practice. Diversion was used more often in the case of minors and, in their case, is on the rise (20.6 % in 1990, 48.2 % in 1995, 55.9 % in 1996 and 63 % in 1997). Once again, this varies considerably from one region to another.

Of those charged with cannabis possession, approximately 80% were adults and mostly male (roughly 90%). The report noted that penalties were not severe, particularly where it involved only one offence. For adults, the majority of the penalties imposed by the courts were fines and probation, and very rarely imprisonment. For minors, the most common penalty was community work or probation; detention was rarely imposed. Data from Montreal in 1998 indicate that incarceration for cannabis possession was less likely (13.8 % of all sentences) than for other substances, and that such penalties were shorter (50% were for 1 day and none was for more than 10 days). In addition, fines were smaller (average fines for cannabis were \$186 while they were \$277 for cocaine).

¹² *Ibid.*

¹³ Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section, Department of Justice, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, pages 54-55.

¹⁴ Comité permanent de lutte à la toxicomanie, *La déjudiciarisation de la possession simple de cannabis*, June 1999, pages 11-13.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Patricia Erickson, a researcher from the Centre for Addiction and Mental Health, provided information on cannabis criminals based on three studies conducted in Toronto in 1974, 1981, and 1998. The studies indicate that cannabis criminals were overwhelmingly young men (about 90% were male and more than half were aged 21 years or less). Of the sample group, 80% were employed or in school and about half lived with parents. Most offenders were charged with only one count of simple possession and the amounts involved were small. In over 75% of the cases, charges were based on possession of less than 14 grams of cannabis. Of the whole sample interviewed in 1998, 50% had 1 gram or less of cannabis as the basis for their cannabis possession charges.

With respect to sentencing, in the first two studies, an absolute or conditional discharge was ordered in a large proportion of the cases. In 1998, 43% were diverted and the rest were awaiting disposition. It was indicated that penalties seemed to be given out randomly and that there “*was no correlation between sentence received and the type of person they were, or the case characteristics, charge and amount of drug.*”¹⁵

Also discussed was the issue of deterrence. The first study noted that 92% were still users one year later (in the later studies, about 80% intended to use cannabis or were still using it). In addition, the studies noted that the severity of the penalty was not relevant in deciding whether to use it in the future. The factor that best predicted an end to use after the user was arrested was simply the quantity the offender had used in the past—the less used the more likely the user was to stop. There was also no evidence of general deterrence, although it was indicated that this is much more difficult to measure.

While diversion programs are certainly an improvement on the traditional justice system response, it would seem that these programs are being developed on an ad hoc basis and are not consistently available across the country. Thus, while some offenders may benefit, others are left to face the traditional criminal justice system. In addition, it is not clear whether the admission criteria are similar under the various diversion initiatives. This would suggest an uneven application of the criminal law with respect to offenders who have committed the same offence, with the disposition of a case based not on the offence itself but rather on where it was committed.

CORRECTIONS

¹⁵ Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, page 90.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

Correctional Service Canada (CSC) is responsible for offenders serving sentences over two years, including individuals convicted of serious drug offences. CSC estimates that:

- nearly 70% of federal offenders have problems with alcohol and/or drugs;
- more than half used drugs or alcohol when they committed their current offence; and
- approximately 20% of incarcerated offenders have been convicted of drug-related offences.

With such numbers, it is obvious that substance abuse should be a high priority for CSC. This raises two issues: (1) how to address the supply of drugs in federal institutions; and (2) how best to provide treatment and rehabilitation for offenders with substance abuse problems.

With respect to security measures, CSC conducts searches, does urinalyses and works with police to share intelligence about drug issues. In addition, ion scanners have recently been set up in every institution to help detect the introduction of drugs. There are also plans to have a drug detection dog in every institution. Despite all these security measures, it would be difficult for CSC to argue that it is successfully keeping psychoactive substances out of prisons. The national results from a random urinalysis sample program in 2000-2001 found that 12% of samples tested positive for at least one intoxicant.¹⁶ In addition, a recent study in Quebec penitentiaries shows that 29% of inmates admit to illicit drug use, the majority of them taking cannabis.

Imprisonment does not necessarily address the problem. A study that we conducted recently in Canadian penitentiaries in Quebec showed that inmates are taking drugs there too. We asked inmates to tell us about their drug use habits over the past three months of imprisonment. All the inmates were men. Sixteen per cent of them told us that they had consumed alcohol, whereas 29 per cent said that they had taken illicit drugs. In the majority of cases, these inmates were taking cannabis, whereas on the outside, the same inmates used to take cocaine. This is a significant change. Why were these people consuming cannabis, which is more readily detectable by its smell and by the traces it leaves in urine? Cannabis is detectable for 15 days after it was consumed, whereas cocaine can only be detected for 48 hours afterwards. Inmates want to escape. Cocaine is a stimulant which brings the inmate back to reality and this is not the desired effect. These people want to escape. Tranquillizing substances are the favourite. Sometimes they take benzodiazepine. However, they are easily able to get their hands on cannabis.¹⁷

CSC provides substance abuse and treatment programs to offenders with drug problems. A range of programs is available to help offenders break the cycle of

¹⁶ Paul E. Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch, Department of the Solicitor General, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 10.

¹⁷ Serge Brochu, Professor, University of Montréal, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 12, pages 23-24.

addiction and safely reintegrate back into the community. Programs include the Offender Substance Abuse Prevention Program, the CHOICES Program and the Substance Abuse Program for Long-Term Offenders. CSC has also introduced Intensive Support Units, which include added searching and testing to support offender efforts to change substance abuse behaviour. The Auditor General estimates that 53% of offenders participate in substance abuse programs while serving their sentences.¹⁸

With respect to harm reduction, CSC provides methadone treatment to some opiate-addicted injection drug users and also makes bleach available in prisons to sterilize needles. CSC also has other initiatives to prevent the spread of infectious diseases, such as immunization for Hepatitis B. In early 2002, CSC announced an expanded methadone treatment program for federal prisoners addicted to heroin and other opiates.

CSC's Addictions Research Centre (ARC) opened in Montague, Prince Edward Island, in May 2001. The mandate of the ARC is to conduct applied research to assist the CSC in understanding issues surrounding substance abuse and to develop programs that assist offenders in breaking their drug dependency. It is the only research centre established by a correctional organization to specifically address the challenges of addictions. With a staff of 20, it currently focuses on four areas: program development – which is currently focused on culturally sensitive programs for women and Aboriginal offenders; program research – in areas such as community intervention, methadone maintenance, intensive support units and fetal alcohol syndrome; assessment and monitoring – to measure trends over time to evaluate the success of interventions; and knowledge dissemination.

Obviously, CSC's largest cost is related to incarceration. The Auditor General estimated that in 1999, CSC spent \$169 million to deal with illicit drugs: \$154 million to deal with offenders serving sentences in whole or in part for drug-related offences; \$8 million on substance abuse programs (including alcohol); \$4 million for treatment programs (e.g., methadone); \$3 million on urinalysis testing. The cost of other security measures to control supply in institutions were unknown.¹⁹ Of the current population of approximately 13,000 federal inmates, roughly 7,000 participate in substance abuse programs while serving their sentences. About \$1,150 is spent per participating offender on substance abuse programs.

As of 31 December 2000, 5,779 convicted drug offenders were under federal jurisdiction (either serving their sentence: (1) in a federal institution or (2) on conditional release). Of these, 3,890 were serving sentences for trafficking, 621 for

¹⁸ *Report of the Auditor General of Canada to the House of Commons, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 13.*

¹⁹ *Report of the Auditor General of Canada to the House of Commons, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 16.*

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

importation, 225 for cultivation and 2,221 for possession.²⁰ Inmates serving in federal institutions are those who have been sentenced to imprisonment for two years or more.

Of those same 5,779 convicted drug offenders serving their sentences as of 31 December 2000, 2,548 were in federal correctional institutions: 1,613 for trafficking, 113 for importation, 82 for cultivation and 1,318 for possession.²¹ In addition, 3,231 were on conditional release: 2,312 for trafficking, 508 for importation, 145 for cultivation and 946 for possession.²²

In the five-year period from 1995 to 2000, the total federal drug offender population increased by almost 9%. Most of the growth involved those on conditional release, as this population increased by 19% over this period. At the same time, the number of those serving their sentence in institutions decreased by 2%.²³

At the end of 2000, the average time served by drug offenders in federal custody was 2.2 years. With respect to conditional release, the average time served was 3.7 years. While this figure is lower than the average for non-drug offences, it is interesting to note that the average time served in custody for possession offences was 2.52 years, while it was 1.89 years for trafficking, 1.48 years for importation and 0.88 years for cultivation. For those on conditional release, the average time served for importation was 4.6 years, while it was 3.6 years for possession, 3.5 years for trafficking and 2.2 years for cultivation.²⁴ CSC indicated the reason that offenders appeared to be serving longer sentences for possession offences than for other drug-related offences such as trafficking is that they may also be serving time for other more serious offences, a situation making comparisons extremely difficult.

The following figure provides details of the number of admissions by region in federal correctional institutions in relation to drug offences for the year 2000, and the number of inmates incarcerated in different regions of the country as of 31 December 2000.

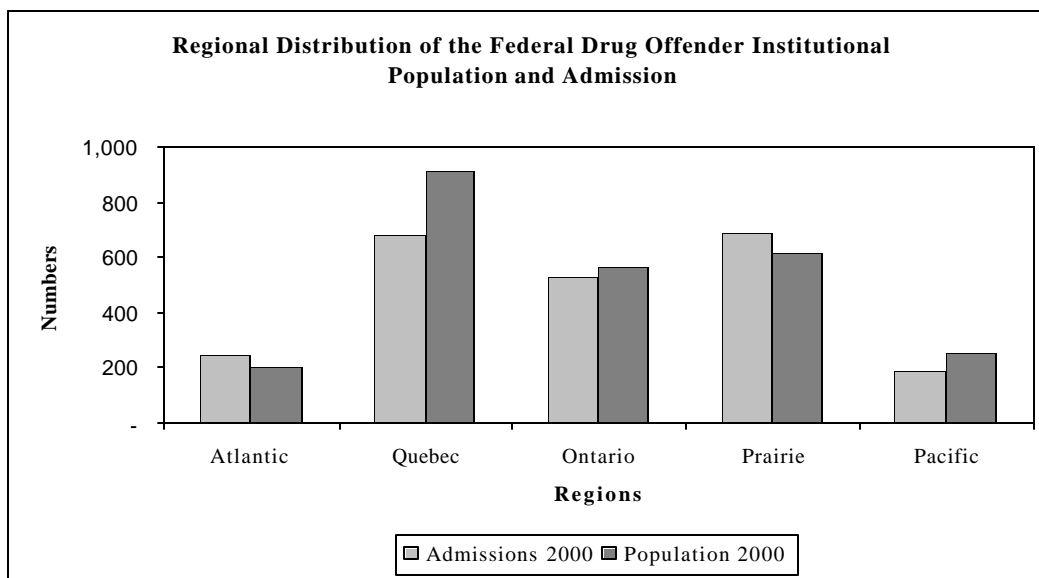
²⁰ Correctional Service Canada, *Forum on Corrections Research*, Volume 13, no. 3, September 2001, page 25. Please note that possession for the purpose of trafficking is included in the trafficking numbers.

²¹ *Ibid.* It should be noted that some offenders might be represented in more than one drug offence category.

²² *Ibid.* It should be noted that some offenders might be represented in more than one drug offence category.

²³ *Ibid.*

²⁴ Correctional Service Canada, *Forum on Corrections Research*, Profiling the drug offender populations in Canadian federal corrections, September 2001, Volume 13, Number 3, page 26.



CRIMINAL RECORD

So what are the consequences of a criminal conviction? There are pre-disposition costs related to the criminal justice system such as legal fees, time off from work, etc. Often, the liberty of the offender is compromised by virtue of having to go to the police station. There are also the emotional costs of worrying about having been charged with a criminal offence. Even if the charge is later withdrawn, offenders have experienced costs.²⁵

Sanctions imposed in court are another obvious cost to the offender. They could include probation, a fine or some other sentence. Finally, there are also post-conviction costs. For example, a criminal conviction can have a negative impact on a person's employment opportunities and can be an impediment to travel to other countries. The general stigma of criminalization affects all offenders. Those offenders receiving harsher sentences generally feel unfairly treated, a feeling that can lead to a lack of respect for the administration of justice.²⁶

²⁵ Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, pages 82-90.

²⁶ *Ibid.*,

Allan Young made the following statement

I get two to three calls a week from otherwise law-abiding citizens who are pot smokers who have been fired from their jobs or have been denied entry into the United States or access to their children or government employment. These people have been treated like common criminals. This is the biggest problem with the marijuana prohibition: If you treat someone who is otherwise law-abiding as a common criminal, they will start to disrespect people like Chief Fantino and the other people who really do try to serve and protect our interests.²⁷

With respect to the costs of cannabis prohibition, Dr. Patricia Erickson indicated that we do have choices.

It is evident in U.S. drug policy that, the people for whom drug use is a moral issue, the cost is unimportant. The costs are irrelevant to them. What is relevant is making sure that the use of drugs is seen as wrong. In Canada, however, we have always been more balanced and more evidence-based. That is a good distinction from the U.S. Canadians are at least able to measure and discuss the costs of policy and consider alternatives. We are not willing to pay any price.²⁸

A criminal conviction can also be an important factor in future dealings with the criminal justice system. For example, a person's prior conviction: may influence a police officer to lay a charge in cases where he or she might otherwise have used their discretion not to lay a charge; may influence a crown prosecutor to proceed by indictment rather than by summary conviction; may be used in limited circumstances in subsequent criminal proceedings; and may lead a judge to impose a more severe sentence. These are not trivial matters for those who have been convicted of a drug-related offence—in particular, the offence of possession of cannabis.

What happens in the case of a conditional or an absolute discharge? Section 730 of the *Criminal Code* indicates that such a person is deemed not to have been convicted of the offence. However, such a person would in likelihood have to answer yes if he or she were asked whether they had ever been arrested for, found guilty of, or pleaded guilty to a criminal offence.

A conviction does not necessarily mean that a person has a “criminal record,” that is, a record in the Canadian Police Information Centre (CPIC) System. This computerized information system for law enforcement use provides information on crimes and criminals. The Identification Data Bank—one of four CPIC data banks—contains the Criminal Record Synopsis File in which records are entered based on information contained on criminal fingerprint forms. This file contains tombstone data respecting the file—such as status of the record, subject description, subject history

²⁷ Alan Young, Associate Professor, Osgoode Hall Law School, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 5, page 27.

²⁸ Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, page 99.

(record, offence type) and subject aliases – and the complete Criminal Record is available to all CPIC terminal agencies upon request.

In the case of adult offenders, the Criminal Record file will be destroyed the earlier of either three years after their death and the date the individual reaches 80 years of age (although this will not apply in certain circumstances, such as where the individual has been charged with an offence within the previous 10 years). Absolute and conditional discharges will be removed to an archive as follows: absolute discharge on or after 24 July 1992 upon the expiration of one year from the date of sentencing (it is archived for five years and then destroyed); and conditional discharge on or after 24 July 1992 upon the expiration of three years from the date of sentencing (it is archived for five years and then destroyed). Discharges prior to 24 July 1992 will be destroyed on written request. Where a pardon is granted, the information about this offence is removed from CPIC to secured storage, separate and apart from all other criminal records (it is destroyed following the guidelines set out above for regular criminal record files). In the case of a charge not resulting in a conviction, the accused may make a request to the police agency that handled the case to have the information removed from local police files and RCMP records. The RCMP will return a person's fingerprints and remove the offence information from CPIC, only on the request of the police agency that handled the case. Special rules apply to young offenders.

As explained previously, even though a person does not have a "criminal record," it does not mean that the person has not been convicted of a criminal offence. While the presence of a criminal record is more likely to lead to negative consequences for the individual, many of the issues raised above also apply to those who have been convicted of a criminal offence but who do not have a "criminal record." Depending on the circumstances and on the way the question is formulated, the lack of a criminal record is irrelevant.

Because the offence of possession of less than 30 grams of marijuana is currently a summary conviction offence, a person should not be fingerprinted following arrest. Because fingerprints are the basis for a "criminal record," no such record will be entered in CPIC based only on this offence. However, before 1996, people had a criminal record, and it has been indicated that by the early 1990s, over 500,000 Canadians had a criminal record for cannabis possession.²⁹

Because of the complexity of this issue, one wonders whether people who have been convicted of an offence, notwithstanding the sentence imposed or whether they have received a pardon, know their legal rights. For example, most people would probably have difficulty answering certain criminal-related questions found on employment application forms.

²⁹ Patricia Erickson and Benedikt Fisher, Canadian Cannabis Policy: The Impact of Criminalization, the Current Reality and Future Police Option, paper presented at the International Symposium on Cannabis Policy, Criminal Law and Human Rights, Bremen, Germany, October 5-7, 1995.

COURT CHALLENGES³⁰

Not surprisingly, the cases that have challenged the substantive validity of drug prohibition laws under the Charter have so far specifically dealt with marijuana, rather than with harder drugs, such as cocaine and heroin. Cases dealing with the right to use cannabis for medical purposes have been discussed in Chapter 13. This section will review cases where a right to non-therapeutic (or recreational) drug use is claimed. Although the medical cases have met with greater success, Charter challenges to marijuana prohibition by recreational users have been taken more seriously by the courts than they were a few years ago.

So far, Canada's legislative prohibition on marijuana – as it relates to non-therapeutic use – has been consistently upheld by the courts. However, the court's reasons have become more elaborate and more extensive in recent cases than in earlier cases. Undoubtedly, this reflects, at least in part, a change in judicial perceptions of the scope of section 7 of the Charter.

No cases could be found which dealt with challenges to the ban on marijuana or other drugs under the *Canadian Bill of Rights*. Undoubtedly, this can at least in part be explained by the courts' approach to the Bill of Rights generally, and to the "due process" clause specifically. The courts took a rather cautious approach to applying the Bill of Rights which, being an ordinary statute, was not taken to "reflect a clear constitutional mandate to make judicial decisions having the effect of limiting or qualifying the traditional sovereignty of Parliament."³¹ Moreover, the prevailing view of the "due process of law" standard was that it was restricted to procedural fairness, and the "liberty" interest was undoubtedly assumed to refer only to freedom from physical restraint.

The earliest case concerning a Charter challenge to the offence of possession of an illegal narcotic—in this case, marijuana—was the Quebec Superior Court judgement in *R. v. Lepage* (8 May 1989, unreported).³² However, this case was unreported and a copy of the decision could not be found, so the reasons for the decision, including the provisions of the Charter under which the decision was made, are not available.

The British Columbia Supreme Court decision of *R. v. Cholette* (1993)³³ was the first case located that dealt squarely with a section 7 challenge to the ban on the use of marijuana. In this case, the accused claimed that the ban violated his right to security of the person under section 7. The accused cited the benefits which he derived from using marijuana and questioned the motivation of the government's original decision to ban

³⁰ This section relies to a great extent on *Drug Prohibition and the Constitution*, a paper prepared for the Special Senate Committee on Illegal Drugs by David Goetz, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 1 March 2001.

³¹ *R. v. Therens*, [1985] 1 S.C.R. 613, at page 639, per Le Dain J.

³² Bruce A. MacFarlane, Robert J. Frater and Chantal Proulx, *Drug Offences in Canada*, Aurora, Ont.: Canada Law Book, 1996 (rev. November 2000) (loose-leaf), pages 4-27.

³³ [1993] B.C.J. No. 2616.

marijuana in 1923 (on the basis that it reflected anti-Asian bias and stereotyping), and its continued retention of the ban, on the grounds that there is no evidence of any significant harmful effect to society. Justice Dorgan rejected the accused's argument and concluded that the accused had failed to demonstrate that the ban on marijuana "interferes in any real way with the right of access to medical treatment for a condition representing a danger to the life or health of the accused..."³⁴

Four months after the *Cholette* case, similar arguments were being weighed by the Quebec Court of Appeal in *R. v. Hamon* (1993).³⁵ This time, the accused relied on the broader conception of the liberty interest advanced by Wilson J. in *Morgentaler* arguing that the decision to use marijuana was a fundamental personal decision. He further claimed that, as marijuana is not really harmful to society – or, at least, no more harmful than tobacco or alcohol – the ban is arbitrary and irrational, and thus contrary to the principles of fundamental justice. Justice Beauregard, for the court, was prepared to assume that an arbitrary criminal prohibition would be contrary to the principles of fundamental justice.³⁶ However, the Court concluded that the ban was not arbitrary and accepted the expert evidence adduced by the government to the effect that cannabis use did have harmful effects on individual users and society.³⁷ Moreover, the court rejected the suggestion that there was anything unjust in the government's decision to treat cannabis differently from tobacco or alcohol.³⁸ Leave to appeal this decision to the Supreme Court of Canada was refused.

In the 1997 case of *R. v. Hunter*,³⁹ Justice Drake of the British Columbia Supreme Court addressed a challenge to the prohibitions on marijuana and psilocybin under various Charter provisions. With respect to the accused's arguments that the prohibitions violated his section 7 liberty and security of the person interests, Justice Drake summarily dismissed them, stating simply that "*the two statutes contain reasonable prohibitions against certain conduct, and these are not unduly broad in their application*" and referring with approval to the Quebec Court of Appeal decision in *Hamon*.⁴⁰

In the preceding cases involving challenges to the ban on marijuana (and psilocybin, in the case of *Hunter*) under section 7 of the Charter, the courts dismissed the arguments with little detailed reasoning. However, in two provincial courts of appeal decisions released in 2000, similar arguments were the subject of more extensive analysis.

The first of these two cases was *R. v. Malmo-Levine* (and its companion case of *Regina v. Caine*),⁴¹ a decision of the British Columbia Court of Appeal released on

³⁴ *Ibid.*, at para. 9.

³⁵ 20 C.R.R. (2d) 181, [1993] A.Q. no. 1656.

³⁶ *Ibid.*, at p. 183 C.R.R. and para. 14, [1993] A.Q.

³⁷ *Ibid.*, at p. 183-84 C.R.R. and paras. 17-20, [1993] A.Q.

³⁸ *Ibid.*, at p. 185 C.R.R. and paras. 22-26, [1993] A.Q.

³⁹ [1997] B.C.J. No. 1315.

⁴⁰ *Ibid.*, at para. 15.

⁴¹ [2000] B.C.J. No. 1095.

2 June 2000. In this case, a majority of the court upheld the criminal prohibition on simple possession of marijuana as being in conformity with section 7 of the Charter.

First, the Court decided that the accused's section 7 liberty interest was engaged by the fact that the penalty for the offence provided for possible imprisonment; and that it was therefore unnecessary to decide whether personal recreational use of marijuana was independently protected as an element of "liberty."⁴²

Justice Braidwood, for the majority, then turned to the task of identifying and defining the principles of fundamental justice applicable in the case. After considering relevant common law and constitutional jurisprudence, scholarly legal and philosophical writings (in particular, those of John Stuart Mill), and law reform commission reports, the Court accepted the accused's argument that the principles of fundamental justice as set out in section 7 of the Charter include a precept referred to as the "harm principle," pursuant to which a person ought not to be imprisoned unless there is a potential that his or her activities will otherwise cause harm to others.⁴³ Moreover, this principle requires that the degree of harm involved "must be neither insignificant nor trivial."⁴⁴

Recognition of the "harm principle" as a principle of fundamental justice is consistent with the assumption made by the Quebec Court of Appeal in *Hamon*, that a prohibition that was arbitrary and irrational would be contrary to section 7 of the Charter.

As in *Hamon*, the majority of the Court in *Malmo-Levine* found that the prohibition was not arbitrary. Justice Braidwood, for the majority of the Court, held that the criminal prohibition on possession of marijuana satisfied the harm principle. The majority concluded that Parliament had a "reasonable basis" to ban marijuana based on the following findings concerning the health risks associated with its use:

- ❖ Impairment of ability to drive, fly, or operate complex machinery—in this regard, users represent a risk of harm to others in society as well as to themselves (however, the number of accidents attributable to marijuana use cannot be said to be significant).
- ❖ Risk that the person will become a "chronic" user. Approximately 5% of marijuana users are chronic users; and it is impossible to tell in advance who is likely to become a chronic user. There is a risk that marijuana use, and with it the total number of chronic users, would increase if it were legalized.
- ❖ Increased health risks to "vulnerable persons" such as young adolescents.
- ❖ Risk of added costs to the health care and welfare system with increased use of marijuana (although, at current rates of use, such costs would be "negligible" compared with those associated with tobacco or alcohol use).⁴⁵

⁴² *Ibid.*, at para. 69.

⁴³ *Ibid.*, para. 134.

⁴⁴ *Ibid.*, para. 138.

⁴⁵ *Ibid.*, para. 142.

Justice Braidwood then proceeded to weigh the interests of the state versus the rights of the individual, as prescribed by the Supreme Court of Canada in *Cunningham*, to determine if the criminal prohibition on marijuana possession struck “the right balance” between the individual and society. On the side of the individual, the Court weighed the deleterious effects on the individual and his or her family of imprisonment, and of having a criminal record. The Court also noted the disrespect and distrust for the drug laws fostered by the prohibition on marijuana possession. With respect to the state interest in retaining the ban on marijuana possession, the Court weighed the fact that it serves to minimize the harm to potential users and to society associated with cannabis use which, “however small, ... is neither insignificant nor trivial.”⁴⁶ The Court also noted that, in practice, a person convicted of simple possession of marijuana can likely expect a minor fine or a discharge, unless the person is a repeat offender.⁴⁷ Nonetheless, the Court observed, the threat of imprisonment remains and, in any event, “every year thousands of Canadians are branded with criminal records for a ‘remarkably benign activity.’ ”⁴⁸

In the end, Justice Braidwood observed that the result of the balancing of interests was “quite close,” and that “there is no clear winner.”⁴⁹ However, he noted that Parliament is owed some deference in matters of public policy and returned to his conclusion that, although the threat posed by marijuana was not large, it did not need to be for Parliament to act.⁵⁰ The principles of fundamental justice demand only a “reasoned apprehension of harm.”⁵¹ As this had been demonstrated, the majority dismissed the accused’s section 7 challenge to the prohibition on marijuana possession.

In a dissenting opinion, Justice Prowse, while agreeing with much of Justice Braidwood’s analysis, found that section 7 and the harm principle required a greater degree of harm to justify a criminal prohibition than merely non-trivial or not insignificant. Because the accused was able to demonstrate the absence of evidence indicating a reasonable apprehension of “serious, substantial or significant” harm, Justice Prowse would have ruled that the criminal prohibition on simple possession violated section 7 of the Charter.⁵²

The Ontario Court of Appeal decision in *R. v. Clay*,⁵³ released on 31 July 2000, dealt with almost the same issues and arguments as those in *Malmo-Levine*. Moreover, a unanimous panel of the Ontario Court of Appeal reached the same conclusion as the majority in the British Columbia Court of Appeal judgement released the previous month.

⁴⁶ *Ibid.*, at para. 150.

⁴⁷ *Ibid.*, at para. 153.

⁴⁸ *Ibid.*, at para. 155.

⁴⁹ *Ibid.*, at paras. 155 and 156.

⁵⁰ *Ibid.*, at paras. 156 and 158.

⁵¹ *Ibid.*, at para. 158.

⁵² *Ibid.*, at paras. 165 and 167-86.

⁵³ (2000), 49 O.R. (3d) 577.

In *Clay*, Justice Rosenberg, for the court, accepted the “harm principle” elucidated by Justice Braidwood in *Malmo-Levine*.⁵⁴ Justice Rosenberg noted, among other things, that the notion of a “harm principle” encompassed by section 7 would be consistent with Justice Sopinka’s statement in *Rodriguez* that where the “*deprivation of the right in question does little or nothing to enhance the state’s interest (whatever it may be), it seems ... that a breach of fundamental justice will be made out, as the individual’s rights will have been deprived for no valid purpose.*”⁵⁵

Moreover, in applying the “harm principle” to the criminal prohibition on marijuana possession, the Court came to the same conclusion as the majority in *Malmo-Levine*: Because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to act as it has done and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7.⁵⁶

Justice Rosenberg, for the Court in *Clay*, noted that while the original basis for extending the ban on narcotics to include marijuana may have involved “*racism*” as well as “*irrational, unproven and unfounded fears,*” the valid objective of protecting Canadians from harm has remained constant.⁵⁷ The Court also rejected the relevance (for the purposes of constitutional analysis) of arguments and evidence showing that other legal substances, such as alcohol and tobacco, cause greater harm than marijuana: “[*t*]he fact that Parliament has been unable or unwilling to prohibit the use of other more dangerous substances does not preclude its intervention with respect to marijuana, provided Parliament had a rational basis for doing so.”⁵⁸ The Court concluded that it did and upheld the prohibition on marijuana possession, except as it related to persons who need it for medical reasons (which was dealt with by the Court in the companion case of *R. v. Parker*—discussed below).⁵⁹

As in *Malmo-Levine*, the Court in *Clay* found that section 7 of the Charter was triggered by the possibility of imprisonment, which implicated the accused’s liberty interest. However, the Court in *Clay* went further and addressed the argument that personal use of marijuana *per se* was protected as an aspect of liberty and/or security of the person based on the expanded conception of these interests recognized by Justices of the Supreme Court of Canada in decisions such as: *B. (R.) v. Children’s Aid Society of Metropolitan Toronto*; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*; and *Rodriguez* (all discussed above). The Court concluded that personal marijuana use (apart from its genuine medicinal use) did not engage the “*wider aspect of liberty*” which protected the freedom to make decisions of “*fundamental personal importance.*”⁶⁰ Nor did it fall within the sphere of personal autonomy, which encompassed the right to “make

⁵⁴ *Ibid.*, at paras. 28-31.

⁵⁵ *Ibid.*, at para. 31.

⁵⁶ *Ibid.*, at paras. 34 and 37.

⁵⁷ *Ibid.*, at para. 34.

⁵⁸ *Ibid.*, at para. 36.

⁵⁹ *Ibid.*, at paras. 37 and 38.

⁶⁰ *Ibid.*, at para. 13.

choices concerning one's own body" and a right to "basic human dignity" as aspects of security of the person.⁶¹

The *Malmo-Levine*, *Caine* and *Clay* cases are currently before the Supreme Court of Canada. The cases will revolve around whether section 7 of the Charter contains the "harm principle" and the associated question of what is the appropriate threshold of harm: is it enough that the harm is "neither insignificant nor trivial" or must there be reasonable apprehension of serious, substantial or significant harm?

CONCLUSIONS

Conclusions of Chapter 15	
	<ul style="list-style-type: none">➤ The cost of prosecuting drug offences in 2000-2001 was \$57 million with approximately \$5 million or roughly 10% of the total budget relating to prosecuting cannabis possession offences.➤ In 1999, it is estimated Canadian criminal courts heard 34,000 drug cases that involved more than 400,000 court appearances.➤ The Drug Treatment Court initiatives seem very encouraging, although comprehensive evaluations are needed to ensure these programs are effective.➤ Disposition and sentencing data with respect to drug-related offences are incomplete and there is an urgent need to correct this situation.➤ Correctional Service Canada spends an estimated \$169 million annually to address illicit drugs through incarceration, substance abuse programs, treatment programs and security measures; expenditures on substance abuse programs are unreasonably low, given the number of inmates who have substance-abuse dependence problems.➤ A criminal conviction can negatively affect a person's financial situation and his or her career opportunities, and restrict travel. In addition, it can be an important factor in future dealings with the criminal justice system.➤ Provincial courts of appeal have so far maintained the constitutionality of cannabis prohibition. They have found that because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to

⁶¹ *Ibid.*, at paras. 14-18.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

act as it has done, and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7 of the Charter. These decisions have been appealed, and the Supreme Court of Canada will soon decide whether cannabis prohibition is constitutionally sound.

CHAPTER 16

PREVENTION

Prevention is a key component of public health strategies and is increasingly part of the array of measures used to fight crime, especially crime related to the abuse of psychoactive substances. Viewed—in theory, at least—as a public health issue, an illegal drugs policy should therefore call for a strong prevention strategy.

Nothing, however, is more fluid, vague, even controversial, than prevention. The measures used to enforce the law are clear: they give power to the police and set down guidelines for the courts in dealing with people found to be in breach of the law. Correctional measures are equally clear: they implement the sentences imposed by the courts. Already, the measures used to treat people with drug problems are vague; there is no consensus on what constitutes treatment, when treatment begins and, most importantly, when treatment ends. The literature makes a distinction between primary, secondary and tertiary prevention; prevention through social development and situational development; universal, specific and indicated prevention; and prevention of use, at-risk behaviour and abuse, yet does not agree on the specific content of each field or the approach that should be taken in public policy.

When it comes to illegal drugs, the legal and political context makes the issue of prevention even harder to clarify and actions even harder to define. There are policies and initiatives in place that aim to prevent at-risk behaviour related to alcohol, such as heavy drinking, driving under the influence and domestic violence. In some circumstances and used in some forms, alcohol can be a “dangerous” substance; what we want to do is preclude those circumstances and identify the indicators of abuse so that we can prevent at-risk behaviour from leading to excessive, even pathological behaviour. It is possible to make these distinction and not deal with use *per se* because alcohol is a legal substance. But the national legal context surrounding illegal drugs and the interpretation of international drug policies (see Chapter 19 on the latter subject) are such that because they are defined *a priori* as harmful substances, illegal drugs must not be used. Another way of putting it is that any use is abuse. The glossary published by the United Nations Office for Drug Control and Crime Prevention states:

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

*In the context of international drug control, drug abuse constitutes the **use** of any substance under international control for purposes other than medical and scientific.¹ (Our emphasis)*

If use is abuse, if individuals or organizations involved in prevention are unable to make distinctions that are essential in setting objectives and devising preventive measures, what hope is there of establishing successful prevention programs?

The international context on drugs is decidedly full of surprises. Each year, the International Narcotics Control Board, whose mandate is to monitor the implementation by Member States of the various international conventions, publishes an annual report which includes, in its first section, a commentary on a specific theme. The 1997 report commented on prevention. Regretting that the social environment was promoting drug use, the report noted:

Preventing the abuse of drugs is becoming an increasingly difficult endeavour, at least partly because of the rapid and growing spread of messages in the environment that promote drug abuse. Many of them can be regarded as public incitement and inducement to use and abuse drugs. Therefore, present efforts at prevention need to be strengthened and innovative prevention initiatives need to be developed and implemented.

(...)

While the elimination of all forms of drug experimentation, use and abuse will never be achieved, it should not be a reason to give up the ultimate aim of all prevention efforts, namely a drug-free society.²

Among the various factors favourable to drug use and abuse, the Board cited popular culture (songs, films, etc.), the media, the Internet, the promotion of hemp products and political campaigns. The report equates advocating for liberal policy options to the promotion of drug use and suggests a rather disquieting notion of prevention:

Sensationalism, the desire to be provocative and the need for higher ratings, may also be behind the fact that several television companies in some countries in western Europe appear to be broadcasting many more programmes in support of a change in the drug law, if not the outright legalization of drugs, particularly cannabis, than programmes examining the consequences of following such a policy and the harm arising from it. Preventive education campaigns aimed at accurately informing the public in general of the effects of drugs and drug abuse will help to promote a more rational approach to drug problems and to avoid sensationalism.

(...)

It is possible to curb the showing by public broadcasting media, such as the press, radio, film and television, of favourable images of drug abuse. In some countries, it is possible to do this through legislation; in others it can be done through voluntary codes of practice; in still others, however, no

¹ UNDCP (2000), *Demand Reduction. A Glossary of Terms*, Vienna: author, page 22.

² International Narcotics Control Board (1997) "Preventing drug abuse in an environment of illicit drug promotion." *Annual Report of the International Narcotics Control Board for 1997*. Vienna : INCB, paragraphs 2 and 4.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

restrictions on promoting drug abuse are in place because freedom of information and freedom of speech are considered to be more important than limiting the promotion of illicit drugs. The Governments of those countries may need to reconsider whether unrestricted access to and the propagation of such information are detrimental to the social and health conditions of their populations.

(...)

Election campaigns have been conducted with candidates standing for parliament on a drug legalization platform. Some campaigns, such as the successful campaigns for the "medical" use of cannabis in Arizona and California in the United States of America, have sought to change the law (...). Such political campaigns need to be met with rational arguments and unambiguous language pointing out the manifold problems that might arise from the decriminalization of drugs and that certainly would arise from the legalization of drugs, in particular the health and economic consequences of such action. (...) The Board notes with regret that despite the fact that (...) Governments of States that are parties to the 1988 Convention are required to make the incitement or inducement to take drugs a criminal offence, either this has not been done or the law has not been enforced.³

If criticisms of the current public policies and demands for alternative approaches are equated with condoning drug use, if prevention means curbing freedom of speech – whether or not one agrees with these critiques – then one has to wonder what prevention is about.

Of course there are, as this chapter will show, many prevention programs that are not aimed solely or even particularly at the prevention of use, but rather the prevention of at-risk behaviour. Harm reduction, for example, is not only a general strategy for dealing with psychoactive substances, but is also a preventive approach that seeks to lower the risks associated with drugs and drug control without requiring abstinence. However, harm reduction is the subject of much controversy and criticism because it is based on the premise that use of drugs is a social reality.

Is law enforcement a preventive measure? Many practitioners, not just police officers, would surely say it is, and they would be right insofar as visible police presence or community policing does have some preventive effect. But in the current context, this is designed to prevent use, not at-risk behaviour, and does so through deterrence, not education or empowerment. And Chapter 14 showed that its effectiveness is very limited. Are sentences, including deprivation of liberty, preventive measures? Of course they are, at least for the time the offender is under supervision or in custody (although drugs are available in prison). But we saw in Chapter 15 that criminalization and penalisation do not deter use. And it is generally admitted that intervention by the justice system is in fact a sign that preventive measures have failed (or were not taken). Are citizenship education, health awareness and self-esteem programs preventive measures? They are indeed, but so, too, are social justice and fairness initiatives, efforts to reduce inequities and measures aimed at improving relations with Aboriginal peoples. If everything is prevention, what, then, constitutes the field of prevention?

³ *Ibid.*, paragraphs 18, 21, 25 and 27.

Addressing the issue of prevention means considering at the same time government policies on illegal drugs. This is particularly true in the case of cannabis. Preventive messages, as will be seen later, must be credible. The message that smoking tobacco causes lung cancer and cardiovascular disease is credible, at least in part because it is based on a large body of epidemiological studies that have established a strong, statistical cause-and-effect link. The same is true for impaired driving and the wearing of seatbelts. However, as Chapters 6, 7 and 8 have demonstrated, the findings for cannabis are by no means as cut and dried and the weight of the evidence would tend to indicate that it a much less harmful substance than most other psychoactive substances. Contrary to what many told us, marijuana is not illegal because it is dangerous and this is well established in the history of national drug law and international conventions.

The UNDCP glossary also states:

Prevention is defined broadly as an intervention designed to change the social and environmental determinants of drug and alcohol abuse, including discouraging the initiation of drug use and preventing the progression to more frequent or regular use among at-risk populations.⁴

A careful reading of this definition is in order. It says that preventive intervention aims to prevent the abuse of drugs *and* alcohol. In the case of drugs *only*, however, one must aim to prevent people from becoming users in the first place, since drug use will progressively increase. Yet, the research on marijuana does not support this distinction. Alcohol – and before that tobacco – are far more likely than marijuana to lead to more frequent use, even at-risk use, and to be a gateway to other illegal drugs. But alcohol, like tobacco, is legal. Marijuana is not.

Any discussion of prevention entails discussion of the limits of government intervention and of how one conceives of human action. How far should government interventions go in identifying groups at risk without further stigmatizing groups already at risk? To what extent are humans rational beings who act in their best interest provided they are given the right information?

Finally, any discussion of prevention in the Canadian context necessarily has a constitutional dimension: to the extent that preventive measures are matters of health provinces have the primary jurisdiction, and to the extent that prevention is education provinces have exclusive jurisdiction. As we saw in Chapter 12 on the history of federal legislation on illegal drugs, it was no accident that the *Narcotic Control Act* was criminal in nature: since Parliament is authorized to adopt criminal legislation pursuant to the criminal law power conferred by the constitution. The federal government's role in the field of prevention of drug use is limited at best and non-existent at worst *proprio motu*.

This chapter on prevention begins with a statement that will come as no surprise to health or justice experts: when it comes to prevention, there is lots of talk, but the

⁴ *Ibid.*, page 58.

resources allocated are small and the initiatives weak. The second section asks the question: what prevention? We look at current knowledge of the factors underlying prevention initiatives and the effectiveness of some preventive measures, with special emphasis on one of the most important weapons in the war on drugs, the DARE program. The third section looks at the harm reduction approach to prevention. As in the other chapters, our conclusions are in the form of observations that may serve to guide future actions.

INITIATIVES THAT FALL SHORT OF THE MARK

When Canada's Drug Strategy was launched in 1987, the government acknowledged that most federal initiatives had focused on reducing supply and that there had to be more emphasis on prevention. Of the \$210 million initially allocated to the first five-year strategy, no less than 32% was earmarked for prevention. In the second phase of the strategy, which ran from 1992 to 1997, the total budget increased to \$270 million, with a similar percentage earmarked for prevention.

In 1994, the Government of Canada introduced the National Strategy on Community Safety and Crime Prevention and created the National Crime Prevention Council, now the National Crime Prevention Centre (Department of Justice). When Phase II of that strategy was launched in 1998, funding was \$32 million annually; by 2001, funding had increased to more than \$65 million. The strategy

*is aimed at reducing crime and victimization by addressing their root causes through a social development approach. Crime prevention through social development (CPSD) is a long-term, proactive approach. It is directed at removing those personal, social and economic factors that lead some individuals to engage in criminal acts or to become victims of crime. The National Strategy is investing in projects that address risk factors in people's lives, such as abuse, violence, poor parenting and drug and alcohol abuse.*⁵

Where do things really stand? The stakeholders are probably in complete agreement that there is a need for prevention. But they are equally unanimous that the actions that have been taken are short of the mark. Otherwise stated, everyone talks prevention, but no one does much about it. The observations made before the Committee cover five sets of considerations: (1) there is not enough prevention; (2) prevention lacks focus; (3) there is not enough evaluation of preventive measures; (4) prevention and social messages about cannabis are contradictory; and (5) there are exemplary practices and successful preventive measures that need to be promoted more widely.

⁵ National Crime Prevention Centre, statement of objectives, on line at www.crime-prevention.org

Not enough prevention

For many organizations, police departments and government agencies involved in the war on drugs, it is clear that there is not enough prevention. That view is measured in terms of spending levels and cuts in prevention staff.

Think of the last time that you saw a drug prevention message on television. Probably one that many of us would recognize is the fried egg commercial representing what happens to your brain. Unfortunately, that was an American ad. I cannot recall a recent anti-drug ad on television. We have produced proactive materials on many other issues in our country. There are campaigns on tobacco and breast cancer. We really have very little material in the drug prevention area. We are not saying that we want more money for policing and arresting people. We agree with the current balance. We think that not only crime prevention, but also drug awareness is a vital tool in making a difference. [...] We believe, first, that there is a role for police in prevention and awareness as well as in enforcement. We have excellent partnerships with teachers, parents and community groups. Community policing has really started to come together in the last 10 years. [...] One of our problems is that some of our programs are dated. Very little effort is put into the prevention aspect. I do not want to be quoted exactly on dollars. However, a report about a year ago indicated that the United States spent about \$12 per capita on prevention and awareness. In Canada, the comparative figure was less than \$1. I think it was in the area of 20 cents or 30 cents.⁶

Since 1988 and 1989, when we had the Really Me campaign, we have had no federal or, in B.C., provincial campaign speaking about drugs. [...] When there was a decrease in consistent prevention messages and the National Drug Strategy ended, I witnessed numerous community coalitions and task forces on drugs that dried up and went away and no provincial funding followed it. I watched in Nakusp, Penticton, the Sunshine Coast, Whistler and many other places as excited people were no longer able to keep going because the attention in the country turned to the population health bandwagon. There was a loss of interest, funding levels and prevention, and at the same time, an increase in messages about hemp, “medical marijuana” and other ideas. [...] When you have this going on for years, common sense would tell you we would have some erosion in the gains we had made in consumption. With that, and with some of the changes in drug sentencing and enormous growth in cannabis availability, certainly in British Columbia, it is no wonder we see these changes.⁷

[Translation] Third observation: efforts to prevent substance abuse are clearly inadequate. The task involves budget (increase allocations for prevention in various areas), coordination (provide a better framework for practices in this area) and research (establish clear program evaluation parameters, determine the effectiveness of existing programs, promote winning strategies). There is a particular need for more substance abuse prevention initiatives in the following areas:

⁶ Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 82-83.

⁷ Dr. Colin R. Mangham, Director of Prevention Source B.C., testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, September 17, 2001, Issue 6, pages 74-75.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- schools (beginning in middle school) and other areas of young people's lives (e.g., streets, parks, youth centres);
- workplaces;
- front-line services in the health and social services system.⁸

*We had an excellent Canadian program developed in Nova Scotia in conjunction with the Nova Scotia Addictions Foundation known as PACE, the Police Assisted Community Education. We, along with a pharmacist, a doctor, a nurse and some athletes were among the people that went to schools to talk to the students about peer pressure, why some students feel compelled to use drugs, about stealing and different moral ethics, and other subjects relating to drug use. Unfortunately, because of the budget cuts, the programs were cut. The money for evaluations, for increasing the program, or for improving the program no longer existed.*⁹

*In the 1970s and 1980s, there was support for community-based ongoing prevention efforts. However, in the 1990s, the federal and provincial governments cut a lot of the funding and there has been commensurate rise in drug use. During that same period, multi-faceted prevention efforts such as those directed at tobacco, seat-belts, fire safety, fitness, and dental health, to name a few, made major inroads.*¹⁰

Prevention of social and health problems is often the poor cousin of practice. Whether in health or in justice, the reality is that much more is spent on treatment and intervention after the fact than on prevention. This is true for health issues in general and illegal drugs in particular.

According to the study by Single *et al.*,¹¹ the direct and indirect cost of illegal drug abuse in 1996 was approximately \$1.5 billion. Of that amount, \$400 million was spent on law enforcement (police, Customs, courts, correctional services, etc.), and approximately \$35 million was spent on prevention, that is, roughly 2% of the total, compared with more than 25% on efforts to fight drugs. Put a different way, the per-capita cost of illegal drugs is roughly \$48; by comparison, about \$12 is spent on drug control, and about \$1 on prevention.¹² **We agree with other stakeholders that spending on prevention is woefully inadequate.**

⁸ Quebec Standing Committee on the Campaign against Drugs (2000), *Consultation 2000. La toxicomanie au Québec : Cap sur une stratégie nationale*, Quebec City: author, page 13.

⁹ Chief Superintendent R.G. Lesser, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 8, page 14.

¹⁰ Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, November 7, 2002, Issue 10, page 86.

¹¹ Single, E., *et al.* (1996), *The Costs of Substance Abuse in Canada*, Ottawa: Canadian Centre on Substance Abuse.

¹² These figures do not take into account funds allocated to drug abuse prevention by the National Crime Prevention Strategy that was really implemented beginning in 1998.

Prevention lacks focus

Preventing cannabis use probably requires a different approach than preventing the use of heroin or ecstasy. By the same token, prevention of use by students will not be handled the same way as prevention of use by street kids, and preventive measures aimed at Aboriginal youth will be different from those aimed at white youth. We will see in the next section that the risk factors and protective factors are not the same for all social groups.

However, stakeholders point out that prevention messages and the way they are delivered are often inaccurate. We see either universal messages the real effectiveness of which is hard to measure, or messages that are aimed at specific social groups but are not necessarily geared to the reality of the people being targeted.

[Translation] Of particular note are weaknesses in secondary prevention. Programs aimed more specifically at high-risk groups are not enough. There is little effective screening where early intervention might make all the difference in preventing problems from getting worse, and this is true not only of youth, but of client groups of all ages. There is at present a lack of consistency in the messages being conveyed and the initiatives being taken. There is a lack of program stability. And in some areas, a great deal of ground has been lost (e.g., gradual loss of substance abuse prevention educators).¹³

Prevention is not 'one size fits all.' Broad population approaches are needed, but so too are narrow focussed activities that target a specific risk group. Of course, prevention is proactive. It promotes personal responsibility. It is highly cost effective: For the cost of one treatment centre, you can fund prevention initiatives that reach hundreds and, indeed, thousands of kids.¹⁴

If the focus is prevention, the objectives have to be clarified: is the goal to prevent use, at-risk behaviour or abuse? The chosen preventive measures will be fundamentally different depending on what objectives are set. This point was made in a recent document produced for Health Canada on best practices in the area of prevention:

Clear and realistic goals that logically link program activities to the problems and factors found in a community are necessary to guide implementation. Clear and measurable goals will permit evaluation to determine whether the program achieved its objectives. Goals will vary with the community and the circumstances; however, important considerations for all programs are the points at which use and problematic use of different substances generally begin. [...] Accordingly, for youth who are not yet using (i.e., either not considering use or thinking about use) the program aim would be primary prevention. Programs working with a population largely consisting of youth who have initiated use and continue to use, a secondary prevention or harm reduction aim makes most sense. Each of these aims logically lead to

¹³ Quebec Standing Committee on the Campaign against Drugs, *op. cit.*, page 14.

¹⁴ Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, November 7, 2002, Issue 10, page 85.

*particular activities and messages (e.g., use of more intensive approaches with those using or preparing to use).*¹⁵

With respect to prevention, there is also a sense that anything and everything is possible by adopting anti-drug rhetoric. However, as we will show in the next section, preventive measures have to zero in more on known risk and protective factors. And because there are many risk factors, preventative action should be multifaceted and involve the community.

There is not enough evaluation of preventive measures

Another reason there is not enough prevention is that no one takes the time or devotes the resources to evaluate programs and demonstrate their effectiveness. As the saying goes, an ounce of prevention is worth a pound of cure. Similarly, one dollar invested in prevention saves five dollars down the road. That may be true, but proving it is something else.

Conducting evaluation studies is not an easy task. If they are to be credible, studies often require a complex methodology. They are also expensive. And most importantly, they cannot – or at least should not – be rushed in order to meet political timelines: to determine, for example, whether a program aimed at preventing drug use among youth is effective, “graduates” have to be monitored for no less than a year (normally at least three years) after they received the program. Canada is not in the habit of doing evaluative research, and, as we saw for Canada’s Drug Strategy, we did not set clear objectives or provide the means to evaluate initiatives.

As a result of this situation, prevention – a weak segment if ever there was one – pays the price when even the smallest budget cut is made.

*One of the biggest problems is that our programs have never had an evaluation component. Whenever we had the opportunity to implement new programs, it was done “quick and dirty.” There was very little money. Our only approach was to pump something out and see if it worked. We have all learned that if you are going to do something, do it properly. We should set up new programs with evaluative components in order to know that we are doing the right things at the right time for the right people. In other words, programs should consider the message, the messenger and effectiveness.*¹⁶

The Committee is of the opinion that any future Canadian drug strategy **will have to include mechanisms and resources to evaluate the various components and in particular to evaluate preventive measures.**

¹⁵ Roberts, G., et al. (2001), *Preventing Substance Abuse Problems Among Young People. A Compendium of Best Practices*, Office of Canada’s Drug Strategy, Health Canada, Ottawa: Supply and Services, pages 30-31.

¹⁶ Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 82-83.

Preventive and social messages in contradiction

For some observers, the fact that society has become more tolerant of cannabis in recent years has contributed to increasing levels of use among young people and undermined the prevention efforts.

The other important part to remember is acceptability in terms of how drug use is perceived. Even more than availability, acceptability is affected by legal sanctions. When we have sanctions against drugs, it reduces social acceptability and helps hold consumption down. Two aspects of acceptability are perceived risk in using the drug and perceived social acceptance of the drug. Those are two tools we have to keep consumption down.¹⁷

According to the 1996 Monitoring the Future study by the University of Michigan, today's teens are less likely to consider drug use harmful and risky, are more likely to believe that drug use is widespread and tolerated, and feel more pressure to try illegal drugs than at any other time in the last decade. [...]

The implication of these perceptions is that these factors influence an increase or decrease in the levels of drug use. Legalization of illicit drugs would only weaken these perceptions further. It tells our children that adults believe drugs can be used responsibly. It suggests that there is less risk and that drugs are more acceptable to society. [...] Another influence is the media and the power of communication. Media coverage of individuals smoking marijuana in cannabis clubs tells kids that drug taking can be fun. Within this atmosphere, it is very difficult, if not impossible, to reach children and convince them that doing drugs is harmful. Increased drug availability and drug use will worsen our crime problems. Increased drug use has terrible consequences for our citizens.¹⁸

As one American commentator said, telling children that marijuana is a dangerous drug is one thing, but what happens when they find out in high school that their friends are using it without frying their brains? The message probably has to be adapted to the audience, the context and the objectives. However, it is surely just as necessary to tell children and adolescents the truth in prevention programs about drugs, their real effects and about what we still do not know. If our society engages in contradictory debate over cannabis, it is not because some pot activists are manipulating the media; otherwise we would have to question the ability of our media to remain neutral and keep a critical distance. In light of the epidemiological findings presented in Chapter 6 and the scientific research on the effects of cannabis presented in Chapter 7, we believe that **alarmist rhetoric on the effects of cannabis is probably counterproductive for the very people who legitimately hope to prevent its abuse.**

¹⁷ Dr. Colin R. Mangham, Director, Prevention Source B.C., testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, September 17, 2001, Issue 6, page 74.

¹⁸ Michael J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 77-78.

That was among the points raised in the recent Health Canada report on best prevention practices.

*The most important principle for every program, regardless of program goal, is that drug information be scientifically accurate, objective, non-biased and presented without value judgment. [...] Even if younger participants initially accept messages that focus solely on the negative aspects of drug use, once they receive more accurate information, there is a danger that all the messages received earlier will lose credibility. [...] Fear-arousing messages accompanied by incorrect or exaggerated information are not effective, and can generate scepticism, disrespect and resistance toward any advice on substance use or other risk behaviour. [...] Similarly, simplistic messages that young people believe to be unrealistic (e.g., just say 'no') or not feasible (e.g., play sports when there are not facilities readily available) will not be seen as credible.*¹⁹

There is a body of knowledge on which we have to draw

Without question, there is a widespread preventive practice in Canada that has developed on a trial-and-error basis and is frequently nursed along with limited resources by people who truly believe in it. As we will show in the next section, there is also a body of knowledge on the initiatives that are most likely to have a real effect on risk factors and the processes most likely to support strong preventive measures.

One of the problems is that this “knowledge” all too often remains in the heads of a few people, primarily because few or no evaluative studies are conducted. What studies are done appear in scientific journals and are seen by experts but do not reach practitioners. And there are still few systematic means of disseminating information. This raises the question of how practices proven elsewhere can be adapted to other contexts.

*We suggest to the Committee that rather than focusing on reforming our drug laws, efforts would be much better spent on examining strategies focused on prevention. Canada's Drug Strategy points out that first and foremost, prevention is the most cost-effective intervention. If we know that to be true, should we not focus our attention on tactics that will ensure greatest possible return on our investment? [...] In a compendium of best practices by the Canadian Centre on Substance Abuse, the authors draw attention to the importance of parental influence in high-risk behaviour among youth. [...] Numerous studies completed at the Center on Addictions and Substance Abuse at Columbia University which include extensive research into prevention programs, have reached the same conclusion.*²⁰

Finally, in our years of work and prevention we have come to understand that the real problem is not so much a drug problem as a people problem. That is, all people - especially kids who have suffered abuse, neglect, trauma, and addiction in the home - seek ways to deal with their feelings of anger, despair, hopelessness or powerlessness. Some may have feelings of boredom, curiosity or a desire to belong

¹⁹ Roberts, G., *et al.* (2001), *op. cit.*, page 40.

²⁰ Brief from the Focus on the Family Association to the Special Senate Committee on Illegal Drugs, May 14, 2002.

*Marijuana and other drugs can seem to solve or at least soothe these emotions. [...] Alternatively, there is great potential through prevention to foster informed, confident, capable young people, who from the earliest ages learn sound mental health practices that are drug-free ways to manage these pressing and understandable human feelings.*²¹

PREVENTING WHAT AND HOW?

Agreeing on the need for prevention is a bit like agreeing on the importance of virtue. Yet, as we saw in the introduction to this chapter, whether we all agree on the very concept of prevention is not all that clear. The United Nations Office for Drug Control and Crime Prevention glossary defines prevention as follows:

Prevention activities may be broad-based efforts directed at the mainstream population(s), such as mass general public information and education campaigns, community-focused initiatives and school-based programs directed at youth or students at large. Prevention interventions may also target vulnerable and at-risk populations, including street children, out-of-school youth, children of drug abusers, offenders within the community or in prison, and so on. Essentially, prevention addresses the following main components:

- *Creating awareness and informing/educating about drugs and the adverse health and social effects of drug use and abuse, and promoting anti-drug norms and pro-social behaviour against drug use;*
- *Enabling individuals and groups to acquire personal and social life skills to develop anti-drug attitudes and avoid engaging in drug-using behaviour;*
- *Promoting supportive environments and alternative healthier, more productive and fulfilling behaviours and lifestyles, free of drug use.*²²

What this means, then, is taking initiatives that alter the factors leading to drug abuse, where all use is abuse in the case of an illegal substance or a substance controlled by international conventions. The definition identifies as a factor in abuse first-time use of drugs, on the premise that introduction – at least in people considered to be “at risk” – leads to more frequent use or use of other substances. The proposed areas of action indirectly identify other factors: the absence of information on the adverse effects of drug use and social norms that are insufficiently anti-drug, inadequate personal and social skills to resist drug use, and unsatisfactory lifestyles that are not health oriented are other factors in drug abuse.

But what do we know about the reasons why people use drugs, marijuana in particular? We know that men use more alcohol and drugs and that women use more prescription drugs. Do we really know why? We think that there may be more than

²¹ Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, November 7, 2002, Issue 10, page 90.

²² UNDCP (2000), *op. cit.*, page 58.

150 million marijuana users in the world, and we have said that there are approximately 3 million a year in Canada; are we to conclude that those people lacked the personal and social skills needed to resist drugs? When, at what point, does use become a problem? Depending on the answers to those questions, the entire prevention strategy will be different.

Genetic baggage aside, public health factors are a function of:

*[Translation] [...] environmental factors related to the setting in which the person lives, from conception to death: the social as well as the physical environment. Education, employment, income, family and social relationships, and distribution of wealth are all factors that come into play. There is a close link between socio-economic status and health and well-being: that link is confirmed by data on hospitalization, disability, health problems and mortality in a given population. Other factors of course include lifestyle and behaviour, such as tobacco use and diet. Even though these are factors that can be changed and are often targeted by prevention, they are also largely conditioned by socio-economic factors. The last factor is health services, the level and organization of which vary from community to community and country to country.*²³

It is true that epidemiological data tend to show that young marijuana users are more likely to be from disadvantaged socio-economic backgrounds, are more likely to smoke tobacco, and probably have parents who smoke or even use marijuana. These are referred to as environmental risk factors. According to some authors, regular or heavy users, those who are at risk, also suffer low self-esteem, are more likely to drop out of school or not finish high school, and do not perform as well academically. These are personal risk factors.

Another term in the vocabulary of prevention besides “risk factor” is “protective factor”. The United Nations Office for Drug Control and Crime Prevention defines “protective factor” as follows:

*A factor that will reduce the probability of an event occurring which is perceived as being undesirable. This term is often used to indicate the characteristics of individuals or their environments, which reduce the likelihood of experimentation with illegal drugs. For example there is some evidence from research in developed countries that each of the following are, statistically at least, protective in relation to illicit drug use: being female; of high socio-economic status; being employed, having high academic attainment; practising a religion; and being a non smoker.*²⁴

Epidemiological data show that use is lower among women, non-smokers and people who practise a religion. However, the data are not as clear in terms of the impact of socio-economic status or level of schooling.

²³ Public Health Directorate, *Les inégalités sociales de la santé. Rapport annuel 1998 sur la santé de la population*. [social inequity in health; 1998 annual report on public health], Montreal: Régie régionale de la santé et des services sociaux de Montréal-Centre.

²⁴ UNDCP, *op. cit.*, page 60.

One of the key works in the literature on prevention is without question the 1995 research by Hawkins *et al.*²⁵ The authors give a comprehensive list of risk factors related directly or indirectly to drug abuse, divided into five categories: individual, family, school, peer and community environment. These factors were identified based on a series of longitudinal studies that tracked children and adolescents over long periods.

*Recent longitudinal research has identified risk and protective factors in the individual and the environment that consistently predict drug involvement. Moreover, the evidence indicates that the likelihood of drug abuse is higher among those exposed to multiple risk factors and that the risk of drug abuse increases exponentially with exposure to more risk factors. The higher rates of drug abuse among criminal and homeless populations are consistent with studies of personal, social and environmental risk factors that are predictive of substance abuse. This line of research suggests that intervention to prevent drug abuse should focus on reducing multiple risk factors in family, school, peer, and community environments.*²⁶

1. Individual factors

The authors include among the individual factors identified by the research family history, genetic history, biochemical characteristics, early and persistent behavioural problems, alienation and rebelliousness, attitudes favourable to drug use, and early introduction to drugs.

2. Family factors

These factors include parents who use or permit the use of substances, poor parenting, poor parent-child relationships and family conflict.

3. School factors

These factors include academic failure and a weak commitment to school; intelligence is not a factor, but the school environment and learning difficulties have a determining effect.

4. Peer factors

Peer rejection in primary school and peers who use drugs are also factors related to substance abuse.

5. Environmental factors

The availability of drugs, legal and cultural norms, poverty and an unstable living environment.

²⁵ Hawkins, D.J., M.W. Arthur and R.F. Catalano (1995), "Preventing Substance Abuse" in Tonry, M., and D.P. Farrington (eds.), *Building a Safer Society: Strategic Approaches to Crime Prevention*, Chicago: University of Chicago Press.

²⁶ Hawkins, D., *op. cit.*, page 368.

The authors identify as protective factors individual characteristics (resilience, social and personal skills, intelligence), the quality of childhood relations in the family and especially at school, and individual and social objection to drug use.

These factors must not be confused with causes. They are statistical links that are themselves limited by methodological problems related to measurement of behaviour, evaluation of the impact of intervention, and other considerations.²⁷

*A clear advantage of the protective/risk factor approach is the understanding that many social and health problems are linked by the same root factors – an understanding that can lead to better integration of strategies and economizing of resources. However, because a factor is linked to substance use problems does not necessarily mean that it causes such problems. Consequently, the actual preventive effect of addressing one or another of the protective or risk factors is not very clear and no doubt varies between the factors. Nevertheless, it appears that addressing protective or risk factors in several domains of a young person's life (i.e., individual, school, family and community) can lead to positive outcomes.*²⁸

Hawkins *et al.* reviewed a series of initiatives—prenatal and neonatal, and preschool, primary school and secondary school—that were evaluated. They found that the most promising strategies are multidisciplinary approaches involving the community.

*The evidence suggests that multistrategy approaches that address multiple risks while enhancing protective factors hold the most promise for preventing substance abuse. The current challenge for substance abuse prevention research is to test prevention strategies that empower communities to design and take control of their own efforts to explicitly assess, prioritize, and address risk and protective factors for substance abuse.*²⁹

Prevention is not, however, a formula that can be used over and over in the exact same way. The characteristics of local communities, existing social relationships, and the strength of community organizations are among the factors that play a key role in the success of preventive measures. There is growing consensus among authors on a series of steps that are most likely to bring about success. The compendium of best practices published by Health Canada proposes the following:

- Build a strong framework
 - Address protective factors, risk factors and resiliency
 - Seek comprehensiveness
 - Ensure sufficient program duration and intensity
- Strive for accountability
 - Base program on accurate information
 - Set clear and realistic goals

²⁷ Hawkins D., *et al.*, *op. cit.*, pp. 363-367.

²⁸ Roberts, G., *et al.* (2001), *op. cit.*, page 24.

²⁹ Hawkins, D., *et al.*, *op. cit.*, page 404.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

- Monitor and evaluate the program
- Address program sustainability from the beginning
- Understand and involve young people
 - Account for the implications of adolescent psychosocial development
 - Recognize youth perceptions of substance use
 - Involve youth in program design and implementation
- Create an effective process
 - Develop credible messages
 - Combine knowledge and skill development
 - Use an interactive group process
 - Give attention to teacher or leader qualities and training

What actions are proven and promising? The compendium lists a number of Canadian intervention programs, but none has really undergone comprehensive evaluation.

A number of people who spoke at our hearings, police officers in particular, mentioned the DARE (Drug Abuse Resistance Education) program.

*We use a revised, Canadian version of DARE, which is not the program most people have been hearing about for years. We are achieving success and acceptance with it.*³⁰

*We were unable to continue to fund Canadian programs, and to the credit of the RCMP and its members across the divisions, they turned to DARE, the Drug Abuse Resistance Education, from the United States. It was a pre-made, off-the-shelf program. Our budget still does not permit us to develop Canadian programs or to do evaluations. Unfortunately and embarrassing is that of the money that has gone to teaching Canadian police officers to instruct, a total of \$750,000 has been paid for by the United States. The Canadian government has not funded any DARE training.*³¹

DARE was introduced in the United States in the early 1980s by the Los Angeles Police Department. In 1996, the program was being used by 70% of school districts and was serving 25 million students. Some 25,000 American police officers were trained to deliver the DARE program in schools. DARE is also used in 44 other countries around the world. It includes a number of modules delivered in different ways depending on the community. Basically, it entails a series of visits from kindergarten to grade four in which the children are given short lessons on personal safety, respect for the law, and drugs. The main 17-week program is designed for students in grades five and six. A 10-week program for middle-school students focuses on resistance to peer pressure, the ability to make personal choices, conflict resolution and anger management. Another 10-week program for high-school students focuses on personal

³⁰ Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, page 83.

³¹ Chief Superintendent R.G. Lesser, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 8, page 14.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

choices and anger management. Finally, DARE+ is an after-school program for high-school students built around recreational activities. The main 17-week program for grades five and six is the one most frequently used (81% of American school districts). It is delivered by a uniformed police officer and focuses on the ability to resist drugs. It provides information on drugs and their effects, self-esteem, and alternatives to drugs. The program includes lectures, group discussions, audio-visual presentations, exercises and role playing.

A document we received from the RCMP shows that the DARE Program is being taught in 1,811 schools in 584 different communities in Canada outside Quebec. Alberta leads the way with 150 school districts, 583 schools and more than 21,400 students in 2001, followed by Ontario (40 districts, 346 schools, 10,940 students) and British Columbia (60 districts, 289 schools, 10,800 students). All these schools offer the main 17-week program. In 2001, the program served more than 53,000 students. In all, the various components of the DARE program reached more than 65,000 Canadian students in 2001.

We do not know how much the program has been “Canadianized”. To our knowledge, there have been no studies to evaluate the program’s impact. The document we received is the first phase of an evaluation study that should, in the second phase, provide data on impact. The first phase of the study deals with students’, teachers’ and parents’ opinions, preferences and perceptions.³² The study looked at all of the grade 5 and grade 7 students in the West Vancouver school district who took the program (500 and 570 students, respectively), as well as their parents and teachers. The findings showed a very high level of satisfaction with the program:

- 97% of the students, 95% of the teachers and between 78% and 94% of the parents, depending on the grade, were in agreement with the program and the program objectives;
- 78% of the teachers agreed with the content of the DARE program for their grade level;
- 72% of the students felt that the information they received was valid and up to date;
- 97% of the teachers were very satisfied with the relationship between the police officer delivering the program and the students;
- 96% of the students said they understood the message;
- 88% of the students said that DARE had helped them resist drugs in middle school; the result was 58% in high school;
- between 82% and 89% said that they had a better understanding of the dangers of drugs.

These are only some of the findings. The data are in line with what can be found on the DARE’s U.S. Internet site and in a number of evaluations. However, those evaluations measured opinions, perceptions and attitudes, not behaviour. To some extent, these results, positive though they may be, are not really surprising.

³² Curtis, C.K. (1999), *The efficacy of the Drug Abuse Resistance Education program (DARE) in West Vancouver schools. Part 1 – Attitudes toward DARE: An examination of opinions, preferences, and perceptions of students, teachers, and parents*, West Vancouver RCMP.

In contrast, almost all of the evaluations that have endeavoured to measure the impact of the DARE program on behaviour, specifically the prevention or reduction of drug use, have shown that the program had no impact or, at best, very little and very short-term impact.

The compendium of best practices produced for Health Canada contains a separate section on the DARE program which states in part:

There have been many D.A.R.E. reviews and evaluations, but few rigorous scientific evaluations. While some evaluations show positive results, studies published in peer reviewed journals, including a 5-year prospective study and a meta-analysis of D.A. R.E outcome evaluations, have been consistent in showing that the program does not prevent or delay drug use, nor does it affect future intentions to use. On the positive side, it does seem to boost anti-drug attitudes, at least in the short-term, increase knowledge about drugs and foster positive police-community relations. Also, acceptance of the program is generally quite high among police presenters, students and their parents.³³

Of course, the absence of program impact can be attributed to the requirements of the evaluation. However, these requirements are the same as those used for other program evaluations.

In 1997, a major report on what works, what does not work and what is promising in the area of crime prevention was tabled in the United States Congress; Congress had commissioned the report from a team of prominent researchers at a number of American universities.³⁴ The report had the following to say about the DARE program:

Several evaluations of the original 17-lesson core have been conducted. Many of these are summarized in a meta-analysis of DARE's short-term effects sponsored by NIJ [National Institute of Justice]. This study located 18 evaluations of DARE's core curriculum, of which 8 met the methodological criterion standards for inclusion in the study. The study found:

- 1. Short term effect on drug use are, except for tobacco use, non significant;*
- 2. The sizes of the effects on drug use are slight. Effect sizes average .06 for drug use and never exceed .11 in any study. The effects on known risk factors for substance use targeted by the program are also small: .11 for attitudes about drug use and .19 for social skills.*
- 3. Certain other programs targeting the same age group as DARE [...] are more effective than DARE. [...]*

Four more recent reports, three of them longitudinal, have also failed to find positive effects for DARE. Lindstrom (1996), in a reasonably rigorous study of approximately 1,800 students in Sweden, found no significant differences on measures of delinquency, substance use, or attitudes favoring substance use between students who did and did not receive the DARE program. Sigler and Talley (1995) found no difference in the substance use of seventh grade students in Los Alamos, New Mexico who had and had not received the DARE program 11 months before. Rosenbaum et coll. (1994) report on a study in

³³ Roberts, G., et al., *op. cit.*, page 171.

³⁴ Sherman, L.W., et al. (1997), *Preventing Crime: What Works, What Doesn't, What's Promising*. A Report to the United States Congress, Washington, DC: US Department of Justice.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

which 12 pairs of schools (involving nearly 1,600 students) were randomly assigned to receive or not receive DARE. Although some positive effects of the program were observed immediately following the program, by the next school year no statistically significant differences between DARE and non-DARE students were evident on measures of the use of cigarettes or alcohol. [...] These studies and recent media reports have criticized DARE for (a) focusing too little on social competency skill development and too much on effective outcomes and drug knowledge; (b) relying on lecture and discussion format rather than more interactive teaching methods; and (c) using uniformed police officers who are relatively inexperienced teachers and may have less rapport with students.

[...]

In summary, using the criteria adopted for this report, DARE does not work to reduce substance use. [...] No scientific evidence suggests that the DARE core curriculum, as originally designed or revised in 1993, will reduce substance use in the absence of continued instruction more focused on social competency development.³⁵

This information is in the public domain. It has been available for many years. Considering the limited resources available for the prevention of drug abuse in Canada, federal authorities and the RCMP ought to have looked at that information before deciding to implement even a Canadian version of the DARE program. Beyond the rhetoric that may please some, there are in this case—and this is so rare that we must take advantage—comprehensive studies which show that the program is not meeting its stated goals.

The same study identifies other programs that are much more likely to have a positive impact on drug use and abuse, in particular programs that develop social skills. The Canadian compendium also describes a number of programs that have undergone equally comprehensive evaluation and have shown positive results.

Like one of our witnesses, we seriously question the police-led practice used to deliver drug education in schools:

I have a quick aside about police-led drug education. We, personally, have some concerns with police officers teaching many hours of drug education in the classroom. We do not think it is sustainable financially to have paid police officers in at every grade level teaching hours and hours of drug education. Teachers - classroom teachers - are trained to be educators and that includes how to build self-esteem, how to make kids feel more capable. In addition, we know there are good, well-intentioned police officers, but our concern is that some of them do not, in our view, have sufficient training to do the type of education that is required. I am also concerned that the DARE program in the United States is now starting a whole new initiative. [...] they still are not addressing a very fundamental question, which is, 'who is the best person to deliver these?'

We have heard concerns from students and teachers that police-led drug education can be more authoritarian and that it can come across not so much as helping kids to make their own carefully thought out choices, but more to lead them into one specific choice.³⁶

³⁵ *Ibid.*, pages 5-33 to 5-35.

³⁶ Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 10, page 86.

We believe that there is a need for **education about psychoactive substances, forms of use and the related risks. But we also believe that there is a need to rethink the approaches being used and that police officers, if they must be involved, should neither develop the programs nor deliver them to students.**

Lists of risk and protective factors and of successful programs aside, it is key to have a holistic vision of prevention, because drugs are part of a complex social, cultural and historical environment. Analysis of the debate over prevention and prevention practices shows that one of the risks lies in putting forward a reductionist and mechanistic view of personal and community health. We observed in Chapter 6 that the available data showed an increase in marijuana use among high-school students. We also saw in Chapter 10 that public opinion is perhaps more tolerant than it used to be. And we have seen in this chapter that little has been done in the area of prevention. Does this mean, as the Canadian Centre on Substance Abuse has said, that the increase in use is merely the result of all these factors combined?

The resurgence of drug use we are now witnessing is led largely by mainstream youth, indicating that we may have paid a heavy price for changing our focus and neglecting this group in Phase II (of Canada's drug Strategy). Ultimately we must aim our prevention messages at all youth. The Centre believes that all young people-drop-outs and A students alike-are vulnerable to drug use and should be viewed as an at-risk population.³⁷

Is it really the effect of the prevention initiatives taken in the first phase of the strategy (1987-1992) that accounts for the relative decline in use during that period? Is it really the absence of debate and prevention practices in the 1990s that accounts for the increase in use? Strictly speaking, no one knows. Not only was there no evaluation of the first phase of the national strategy, but even the most comprehensive evaluation might not have been conclusive. The increase in use in the 1990s could just as easily have been the result of a series of entirely different factors, such as cutbacks in government services, the decline in the youth labour market or even globalization of world markets, which makes people feel powerless to change their living conditions. There might even be other factors of which we are not yet aware.

In the United States, the use of illegal substances decreased between 1982 and 1991, then started to rise again in 1993. Did policies and approaches change? Incarceration rates for drug-related crimes certainly did not drop. At least as much money was spent on prevention and education programs. The rate of alcohol use among youth under 17 also decreased; can that be attributed to the same factors? Inversely, the proportion of smokers in the population hardly changed at all despite equally or more aggressive awareness and prevention campaigns. What do we make of this? The decrease in illegal drug use may be attributable in part to "war on drugs"

³⁷ Canadian Centre on Substance Abuse (1996), *Canada's Drug Policy. Brief to the Standing House of Commons Committee on Health*, Ottawa: author.

policies, but that is by no means a completely satisfactory explanation. And we also have to consider the social and economic cost.

*The U.S. government's 'War on Drugs' resulted in a tremendous expansion of resources applied to supply reduction and interdiction efforts focused on illegal drugs and in increasingly harsh criminal sanctions against users, including those caught in possession of relatively small amounts of illegal drugs. These policies have apparently had little effect on the availability of addictive drugs or on reducing abuse. They have fueled higher costs associated with prison construction and a tremendous increase in the prison population, leading some to call for legalization of currently proscribed drugs such as marijuana and cocaine.*³⁸

Through all of this, there is little room for a less mechanistic view of individuals. We were reminded of this by J.F. Malherbe in the paper he wrote at our request:

*The human experience is always complex and multifactorial, and no statement of risk referring to a single factor has any meaning for an individual subject (even though certain correlations appear to be well established). The future cannot be predicted for a singular individual on the basis of statistical information. We can therefore wonder at times about the level of scientific training (or honesty) of doctors who confuse "statistical correlation" with "risk factors" and "causes". It is true, however, that it is more convenient to "preach" to people about the causes of cancer than to support and inform them in the often chaotic advance of their freedom toward fuller responsibility for themselves, for others and for the fragile biosphere to which we belong.*³⁹

Professor Malherbe went on to say:

The true harm, the worst of all, the most intolerable, the only one that must absolutely be repressed is wanting to make people happy by deepening their fear of disease and death, without asking each individual to make personal choices and realize his or her preferences. The true, the only harm stems from health ideology, from the furor sanandi, which sketches out our happiness without us being able to enjoy it.

*Does this mean that everything should be permitted without distinction? Of course not. But the test is still to discover step by step through our trials and errors, and it cannot be imposed on us by experts – doctors or economists – in the name of a prior and death-causing order. The joy of fertile disorder is better for life than the boredom of a type of planning, the arbitrary nature of which equals nothing but sterility.*⁴⁰

³⁸ Hawkins, D.J., M.W. Arthur and R.F. Catalano (1995), "Preventing Substance Abuse", in Tonry, M., and D.P. Farrington (eds.), *Building a Safer Society: Strategic Approaches to Crime Prevention*, Chicago: University of Chicago Press, page 344.

³⁹ Malherbe, J.F. (2002), *The contribution in defining guiding principles for a public policy on drugs*. Document prepared for the Special Senate Committee on Illegal Drugs, Ottawa: Senate of Canada, page 7.

⁴⁰ *Ibid.*, page 10.

Moreover, prevention, especially in schools, must provide a forum for open discussion that makes young people accountable and permits the acculturation of substances. Demonization and indoctrination can never take the place of education.

RISK REDUCTION AND HARM REDUCTION

The harm reduction approach has become a preferred tool in preventing AIDS/HIV contamination through intravenous drug use. It was discovered in the late 1980s that IV drug users were a key vector for the transmission of HIV. Needle exchange programs came about as a result.

However, the harm reduction approach creates a number of conceptual and theoretical problems. The first problem is terminology. “Harm reduction” is the term most commonly used in English, but “risk reduction” is also sometimes used. In French, “harm reduction” has been rendered as “*réduction des méfaits*”, but also as “*réduction des dommages*” and “*réduction des risques*”.

Further, the concept and practice of harm reduction have been criticized by some observers who see them as veiled strategies for legalizing drugs.

When I say a ‘harm reduction drug policy,’ I do not mean as we have already initiated in the response to drugs so far. We have tried many things such as needle exchanges and we have tried a harm reduction approach to drinking and driving. I have developed many programs for youth, which is my specialty. If I were called upon to develop a program to teach youth with any certainty about how to use drugs that are now illegal in a safe and moderate way, I do not think I could do so. Drugs fundamentally have effects. They do affect us. For example, it may be the cleanest heroin in the world, but is the person functioning in the family and at work, and are they able to pay for the habit that they will develop? Those are questions that need to be answered.

When I use the term, I mean harm reduction as it has been promoted. The term has become sullied, unfortunately. It began as a noble thing, but has become a key code word for decriminalization or legalization of substances. I would caution you against using the term as it is.⁴¹

Granted, harm reduction strategies are often on a collision course with law enforcement strategies: the situation has arisen often in cities across Canada where heroin addicts leaving needle exchange clinics come face to face with police.

The term “harm reduction” refers more specifically to strategies aimed at reducing the adverse effects of drug use on health, economic status and the social environment for users and those around them.⁴² In addition to needle exchange, harm

⁴¹ Dr. Colin Mangham, page 73.

⁴² See, for example, the work of D. Riley (1996), *Harm Reduction: Concepts and Practice. A Policy Discussion Paper*, Canadian Centre on Substance Abuse, and the discussion paper Dr. Riley prepared for Senator Nolin.

reduction strategies for drug users include such measures as prescription methadone for heroin addicts, medically supervised prescription heroin programs and “safe injection rooms”, or clinics where no prescription is required. Canadian stakeholders agree that these measures are underdeveloped in Canada. Health Canada recently announced that a prescription heroin program would be tested in three major cities. The number of methadone places is said to be insufficient. Moreover, there are no safe injection rooms.

What are the implications of a harm reduction strategy for cannabis? What applications might there be for such a strategy? Harm reduction strategies related to heroin, for example, have been based on knowledge of some of the harmful effects of injecting the drug: HIV and hepatitis C for users (needle exchange programs), unsanitary conditions and risk of violence in places where the drug is injected (safe injection rooms), and petty property crime to get money to buy drugs (prescription heroin). In order to develop harm reduction strategies, we therefore have to know at least something about the ways the drug is used and its direct and indirect harmful effects. What are the harmful effects of cannabis?

We identified some of those harmful effects in Chapters 7 and 8. They include:

- risks for youth under 16 because of their physiological immaturity, in particular the immaturity of their endogenous cannabinoid system;
- risks associated with use that could be described as “occupational” (as opposed to recreational): the person uses marijuana alone, in the morning, to do school work or to carry out a job;
- risks associated with heavy, frequent use over a long period;
- risks associated with inhalation over a long period;
- risks associated with impaired driving, especially when the marijuana is mixed with alcohol.

Based on this knowledge, harm reduction strategies could be developed for cannabis:

- discourage use by youth under 16;
- detect at-risk users, especially among youth;
- provide information on the risks of inhaling and point out that deep inhalation is part of the folklore and is not necessary to obtain the effects;
- use strong measures to discourage impaired driving.

Obviously, like harm reduction strategies for other drugs, these tools are based on recognition of use and an approach that does not call for abstinence. We know full well that these two points may elicit strong reactions from those who believe that cannabis is fundamentally dangerous and may put us at odds with the current legal context.

CONCLUSIONS

Prevention is necessary. Keeping our guiding principles in mind, prevention must be part of a vision of the role of governance as a way of fostering human initiative and a vision of ethics and public health that focus on autonomy. In that sense, it is not an instrument of control, but rather a tool to help set people free. And in the case of cannabis, being set free does not mean not using, but rather having the ability to take a position on and think about the reasons for using and the ability to deal independently with at-risk behaviour.

Conclusions – Chapter 16	
On prevention	<ul style="list-style-type: none">➤ A national drug strategy should include a strong prevention component.➤ Prevention strategies must be able to take into account contemporary knowledge about drugs.➤ Prevention messages must be credible, verifiable and neutral.➤ Prevention strategies must be comprehensive, cover many different factors and involve the community.➤ Prevention strategies in schools should not be led by police services or delivered by police officers.➤ The RCMP should reconsider its choice of the DARE program.
On evaluation	<ul style="list-style-type: none">➤ Prevention strategies must include comprehensive evaluation of a number of key measurements.➤ A national drug strategy should include mechanisms for widely disseminating the results of research and evaluations.➤ Evaluations must avoid reductionism, involve stakeholders in prevention, be part of the program, and include longitudinal impact assessment.
On harm reduction	<ul style="list-style-type: none">➤ Harm reduction strategies related to cannabis should be developed in coordination with educators and the social services sector.➤ Harm reduction strategies related to cannabis should include information on the risks associated with heavy chronic use, tools for detecting at-risk and heavy users, and measures to discourage people from driving under the influence of marijuana.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

CHAPTER 17

TREATMENT PRACTICES

With the exception of the treatment given to offenders imprisoned in federal institutions and Aboriginals, the care available to individuals who are substance-dependent is essentially the responsibility of the provinces and territories. This chapter will therefore be brief since we received only a few submissions and heard few witnesses on this question.

In order to place the discussion in context, we should begin by noting certain data concerning dependency induced by cannabis and its derivatives. We shall then examine the various forms of treatment that are available. Finally, we shall take a brief look at the state of knowledge concerning the effectiveness of these treatments.

CANNABIS DEPENDENCY

Let us first clarify the terminology. We saw in Chapter 7 that, while the word addiction is used most often to refer to those who have a problem of dependency on psychoactive substances, the WHO recommended as long ago as 1963 that this expression not be used because of its vagueness. We prefer to use the term dependency for at least two reasons. First, it is more encompassing and may include different types of addictive behaviour: substance-related (food, alcohol, illicit drugs) and activity-related (gambling, sex, extreme sports, etc.). In the cases of substances, it is also more specific, referring to both the physical and psychological components of dependency. We share the distinction made by the WHO between physical and psychological dependency:

[Translation] ... *psychic dependency is a 'state in which a drug produces a feeling of satisfaction and a psychic urge that requires period or ongoing administration of the drug in order to cause pleasure or to avoid discomfort'.*

Physical dependency is an 'adaptive state marked by the appearance of intense physical problems when the administration of the drug is delayed or its action is counteracted by a specific antagonist. These

*problems, that is the symptoms of withdrawal or abstinence, consist of symptoms and signs of a physical or mental nature that are characteristic of each drug.*¹

And third, it is a more neutral term. While dependency is described as a state induced by the prolonged and abusive consumption of a substance, addiction has a connotation of mental illness, indeed a moral connotation. Some authorities such as NIDA, for example, do not hesitate to classify addiction as a true illness that has certain genetic components. Seen in this way, drug use triggers biophysiological mechanisms that lead to addiction. Hence the focus on abstinence. Treatment programs in Canada tend to regard dependency as a bio-psychosocial phenomenon; “[h]owever, support for the various modifications of the disease model continues in some service sectors”.² It is interesting to note that more rehabilitation programs for alcoholism (51%) than programs for ‘addiction’ (47%) accept a harm-reduction strategy and thus objectives other than abstinence.³

These precisions made, the Committee noted the ambivalence in the terminology, depending on the language. The English name of the *Centre canadien de lutte contre l’alcoolisme et la toxicomanie* [Canadian centre for the battle against alcoholism and addiction] is the Canadian Centre on Substance Abuse (centre canadien sur l’abus des substances). The French title of the brochure published by the Department of the Solicitor General describing the Department’s activities is *La lutte contre la toxicomanie* [the battle against addiction] while the English title is *Countering Substance Abuse* (combattre l’abus de substances). The name of a government organization in Quebec is the *Comité permanent de lutte à la toxicomanie* [standing committee on the battle against addiction]. In addition to projecting a strong moral thrust, the French word “*toxicomanie*” evokes a vocabulary of struggle and combat, whereas the term substance abuse is more neutral and we might even go so far as to say more measured. However, the difference between the two languages cannot be explained by the lack of an appropriate noun in French: *dépendance* is the equivalent of drug addiction, and some in French even use the term addiction. A little rigour and clarity would be beneficial in light of the emotion surrounding the debate about drugs.

Having distinguished between use, at-risk use and excessive use, we feel that we should logically avoid the term drug addiction to refer to dependency induced by excessive use. Moreover, federal government departments and agencies should modify their terminology and ensure that both language versions are in accordance.

How common is cannabis dependency? In Chapter 7 we determined that physical dependency on cannabis was definitely rare and insignificant. Some symptoms of

¹ WHO (1964), *Comité d’experts des drogues engendrant la dépendance*, Technical Reports Series, No. 273, quoted in Caballero and Bisiou, *op. cit.*, pages 5-6.

² Roberts, G. and A. Osborne (1998), *Profile: Substance Abuse Treatment and Rehabilitation in Canada*, Ottawa: Canada’s Drug Strategy, Department of Health, page 20.

³ *Ibid.*

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

addiction and tolerance can be identified in habitual users but most of them have no problem in quitting and do not generally require a period of withdrawal.

As far as forms of psychological dependency are concerned, the studies are still incomplete but the international data tend to suggest that between 5% and 10% of regular users (at least during the last month) are at risk of becoming dependent on cannabis. If we recall that approximately we estimated that approximately 3% or 600,000 adult Canadians have consumed cannabis in the last month and that approximately 100,000 or 0.5% use it on a daily basis; this indicates that somewhere between 30,000 and 40,000 might be at-risk and 5,000 to 10,000 might make excessive use. For 16 and 17 years old, the numbers were between 50,000 and 70,000 at-risk and 8,000 to 17,000 potentially excessive users. The data also indicated that the peak period for intensive use is between 17 and 25 years. These broad parameters indicate where to look to prevent dependency and offer treatment services for those in need.

What form does cannabis dependency take? Most of the authors agree that psychological dependency on cannabis is also relatively minor. In fact, it cannot be compared in any way with tobacco or alcohol dependency and is even less common than dependency on certain psychotropic medications. Ceasing to consume the substance for two to four weeks, which can be accompanied by certain symptoms similar to those involved in nicotine withdrawal (insomnia, irritability, perspiration, etc.), is usually sufficient to cause the symptoms to disappear. When treatment is necessary, in the case of some people, it does not take as long as and is less difficult than the corresponding treatment for dependency on alcohol or “hard” drugs. It is also worthy of note that those seeking treatment for cannabis dependency are younger than those who receive treatment for dependency on other drugs. A number of factors may explain this situation: consumption of cannabis is more a phenomenon of youth than that of other substances, reaching its peak when young people are in their early twenties and declining significantly when they reach their thirties. Young people who need treatment also display problems of multiple addiction since cannabis is not the only drug they consume.

Overcoming dependency or consumption that the user regards as abusive is often a matter of personal choice and does not necessarily require therapeutic intervention.

There is the phenomenon called spontaneous remission. Many people, when they get into their thirties either stop using drugs altogether or tone down their habit. There is an obvious phenomenon of maturity in terms of drug use.

Among long-term users, we also see the retirement phenomenon, that is these individuals become fed up of their drug-using lifestyle. These individuals lose interest in the ongoing quest for drugs and for the pleasure that these drugs can provide them. In fact, it can be equated with a type of cost benefit analysis, whereby as the individual gets older, he/she decides that the habit is no longer worth it. The individual considers that the negative impact of his/her habit is no longer worth it.⁴

⁴ Dr. Céline Mercier, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, Thirty-Seventh Parliament, First Session, December 10, 2001, Issue 12, page 9.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

While most people who experience substance abuse problems do not receive help, there is good evidence that people exposed to some types of treatment subsequently reduce their use of psychoactive substances and show improvement in other life areas. In general, treatment outcomes are improved when appropriate treatments are also provided for significant life problems (communications problems, lack of assertiveness, unemployment).⁵

There is every reason to believe that, as far as cannabis is concerned, most problem users do not make use of the various forms of treatment and probably do not need any, firstly because the effects of cannabis are not as marked as those of other drugs and secondly, because cannabis users are more likely to be integrated into society than hard-drug users, which enables them to make use of their natural support groups. The third reason, in our view, why most cannabis users can avoid the trajectory of dependency is the fact that its use is not associated with “degenerate addiction” in the view of society or in the popular imagination, unlike the use of heroin, for example. Furthermore, a Canadian study has indicated that “few (3%) users of illicit drugs, identified in a population survey, reported seeking any kind of help for drug problems.”⁶

Nevertheless, as in the case of any psychoactive substance, some people opt for or need treatment.

It has in fact been observed in groups undergoing treatment - and this is a theory - that there are two groups of people trying to stop using. First, there are people who have mainly used opiates on a regular basis for six or more years. Second, there is the group of users who have been using for two years or less and no longer want to deal with the secondary effects of drugs.⁷

The decision to seek treatment is determined in particular by the increase in social and personal problems that use of a substance may cause and by the fact that it is often combined with problems of a psychiatric nature.⁸ Women systematically make fewer requests for specialized drug and alcohol treatment services; this situation can be explained by the fact that fewer services are available and women are otherwise looked after by traditional psychiatric services.

However, people do not always choose or at least not totally. Family pressures or pressure in the work place and, in some cases, orders made by judges are only some of the factors that lead people to seek treatment. Furthermore, little is known about the trajectories of people who abuse drugs and especially those who seek treatment for the problem. For example, we do not know to what extent the search for treatment is more the result of other earlier problems—family or psychiatric problems—than of the actual use of the substance itself. In the case of drug users who also have problems with the

⁵ Robert, G. and A, Ogborne (1999) *Best Practices: Substance Abuse Treatment and Rehabilitation*, Ottawa: Canada’s Drug Strategy, page 9.

⁶ Roberts and Ogborne (1999) *op. cit*, page 59.

⁷ Dr. Céline Mercier, *ibid*.

⁸ Roberts and Ogborne, *op. cit*, page 60.

law and a career of delinquency, deviant and delinquent behaviour often precedes the start of a trajectory of drug dependency, as we saw in Chapter 6. Demand for treatment in these cases will result at least as much from a desire – or indeed obligation – to put an end to a criminal career as from the detrimental effects of using the substance.

Can people be forced to seek treatment? That was one of the questions raised by the introduction in France of a requirement to seek care in the 1970 Law respecting narcotics, which has now taken the form of a therapeutic injunction,⁹ and of drug courts in Canada, as we saw in Chapter 15.

Certain sections of the *Criminal Code* deal with the issue of requiring offenders to seek treatment for problems related to alcohol and drugs. For example, where a court is making a probation order, it has the discretion to require, as a condition to the probation order that:

- The offender, if he or she agrees, participate actively in a treatment program approved by the province, subject to the program director's acceptance; and
- The offender visit a treatment facility for assessment and curative treatment in relation to the consumption by the offender of alcohol or drugs that is recommended pursuant to the program (where a program has been established in a province).¹⁰

In addition, when a court imposes a conditional sentence, one of the optional conditions of the probation order may be that the offender participate in a treatment program approved by the province.¹¹

If a person has not been convicted of a criminal offence, it is unlikely that a court will order treatment for alcohol or drug problems, with some exceptions. For example, persons falling under the authority of provincial mental health legislation may be detained because of mental health problems. Such legislation regulates and limits when a person may be confined against their will.

The reluctance of courts to detain a person for substance abuse problems is illustrated in the Supreme Court of Canada decision in *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)*.¹² In this case, a young Aboriginal was five months pregnant with her fourth child and was addicted to glue sniffing, a practice which may damage the nervous system of the developing foetus. The Winnipeg Child and Family Services requested assistance from the courts to involuntarily secure the mother in treatment. The case revolved around the issue of the rights of the unborn child, and the Supreme Court of Canada found that neither tort law nor the court's *parens patriae* jurisdiction supported an order for the detention and treatment of a pregnant woman for the purpose of preventing harm to the unborn child.

⁹ We describe the French system in greater detail in Chapter 20.

¹⁰ *Criminal Code*, paragraphs 732.1(3)(g) and (g.1).

¹¹ *Criminal Code*, paragraph 742.3(2)(e).

¹² [1997] 3 S.C.R. 925.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

In France, the therapeutic injunction has been harshly criticized, especially because it involves enforced treatment. The question is still open despite the guarded assessments that have been made of the results of this practice.¹³

*The therapeutic injunction system has been in place in France since 1970. A study by a colleague at the Institut national de santé et de recherche médicale, in France, showed that many people fell through the cracks because of the therapeutic injunction forcing them to follow a treatment program. These people were never treated, because there were not enough places or follow-up. If we want to set up drug courts in Canada, we shall have to plan effectively and organize consultation mechanisms with the treatment systems to ensure that the required treatment services are available. If we fail to do this, setting up drug courts will be nothing more than a sham, if the people requiring treatment fall through the cracks of the system.*¹⁴

It is estimated that approximately 10% of the offenders imprisoned in federal institutions are there for offences under the *Controlled Drugs and Substances Act*. Moreover and more importantly, it is estimated that at least 50% of all inmates, whether in provincial prisons or federal detention centres, have dependency problems (drugs and alcohol).¹⁵ Generally, few of these inmates receive any kind of treatment. In the United States, studies indicate that fewer than 10% of inmates receive treatment for dependency problems while they are in prison.¹⁶

In the case of provincial institutions, this situation can be explained by the short duration of the sentences and by the budget cuts made in correction institutions in the early 1990s. In the case of federal institutions, treatment programs are available but they are still very far from meeting the needs. Furthermore, it may be somewhat ironic to offer treatment programs in institutions where drugs circulate freely and where it is not uncommon for the inmates to have access to cannabis in particular.

Nevertheless, the treatment offered to inmates is an essential component of their reintegration into society given the magnitude of the problems caused by dependency on drugs, especially harder drugs, and alcohol.

One final comment: some of the people who appeared before us observed that in certain cases cannabis maintenance could be used in combination with other forms of withdrawal and treatment for dependency on opiates.¹⁷ To the best of our knowledge, there are no studies on the subject—for good reason! However, we should note, as we did in Chapter 5, that cannabinoid and opioid systems engage in complex interactions,

¹³ Simmat-Durand, L. (1999), “Les obligations de soins en France”, in Faugeron, C., (ed.) *Les drogues en France. Politiques, marchés, usage*, Paris: Georg.

¹⁴ Dr Serge Brochu, Professor in the School of Criminology at the Université de Montréal, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, Thirty-Seventh Parliament, First Session, December 10, 2001, Issue 12, page 25.

¹⁵ Brochu, S. (1995) *Drogues et criminalité. Une relation complexe*. Montréal : Université de Montréal.

¹⁶ Lipton, D.S. (1995) *The effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision*. Washington, DC: National Institute of Justice.

¹⁷ Among others at a private meeting with staff of the Vancouver Compassion Club.

and we may be justified in assuming that the consumption of Δ 9-THC could cause a dopaminergic response that could reduce opiate withdrawal.

FORMS OF TREATMENT

The 1992 study by Single on the cost of alcohol and drug abuse estimated the cost of specialized treatment for dependency at approximately \$290 million. But it would be misleading not to specify that the largest share of treatment dollars is for alcohol: in the case of residential treatment, \$180 million was for alcohol and \$21 for illicit drugs and in the case of non residential treatment, \$82 for alcohol and \$8 for drugs.¹⁸

Most of this money is provided by the provinces and territories. The federal government directly funds rehabilitation for members of the First Nations living on reserves, members of the RCMP and the Armed Forces, inmates in federal institutions and those who have not lived long enough in a province to qualify for the provincial health insurance plan.

This said, the limited resources devoted to treatment of dependency and the growing pressures in terms of the number and diversity of clients, mean that the availability of treatment is limited.

*Many agencies have received significant cutbacks in recent years. Possibly exacerbating the situation, substance abuse organizations are increasingly being asked to address problem gambling. ... Similarly, Bill C-41, which permits court-ordered substance abuse discretion, has an impact on substance abuse treatment at a judge's assessment and treatment resources.*¹⁹

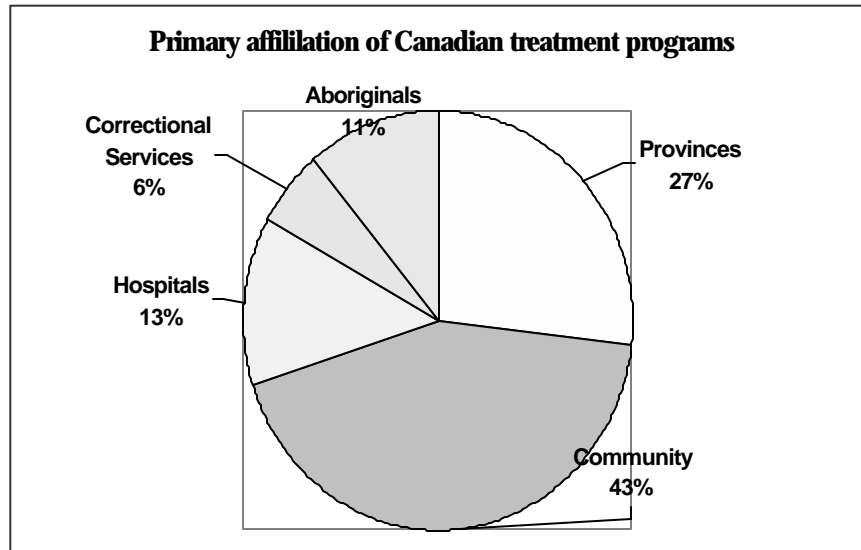
It is probably not an exaggeration to say that the area of addiction treatment is totally fragmented among the individual practices used by therapists, support and assistance groups, such as addicts anonymous, and therapeutic communities; and among pharmacological, cognitivist and behavioural approaches, psychoanalytic, humanist and systemic approaches; among the proponents of freedom of choice for the user and those who promote enforced treatment. Virtually every possible approach to and form of treatment is available.

Recent reports produced for Health Canada bear witness to this. The Profile of Substance Abuse Treatment programs indicates that in 1998 there were at least 1,200 different treatment programs and approximately 7,200 professional counsellors across the country.²⁰ Included in these figures are outpatient, day or evening treatment, short-term and long-term residential, outreach and crisis treatment programs. The breakdown by province and territory may indicate where priorities are set.

¹⁸ Single, E., et. al., *op. cit.*, page 42.

¹⁹ Roberts, G. and A. Ogborne, *op. cit.*, page 23.

²⁰ *Ibid.*, page 6.



Substance abuse treatment services offered across Canada²¹

	Outpatient	Day/Even. Treatment	Short-term residential	Long-term residential	Outreach	Crisis	Total
Nfld	13	2	5	0	2	7	29
NS	9	7	7	6	9	4	42
PEI	2	1	1	1	1	2	8
NB	5	3	3	2	3	5	21
Qc	72	52	59	43	48	44	318
Ont	110	55	43	51	61	64	384
Man	12	5	8	10	8	10	53
Sask	24	9	10	5	14	14	76
Alta	41	22	22	13	14	27	139
BC	128	43	39	28	70	77	385
NWT	7	5	3	2	7	7	31
Yukon	2	1	2	0	0	2	7
TOTAL	425	205	202	161	237	263	1493

The primary affiliation of these programs also gives an indication of their orientation. Fully 43% of existing treatment programs are community-based. One of the implications of this fact is that funding is never secure. Overall, the programs may be broken down as follows:²²

²¹ *Ibid.*, page 8.

²² *Ibid.*, page 14.

In terms of the therapeutic approaches used, 31% make use of confrontation and 40% of psychotherapy, but there are very broad differences between individual provinces and territories and even within a given province.²³

EFFECTIVENESS OF TREATMENT

Once again we should stress the fact that we are not able to discuss specific treatments for cannabis dependency. To our knowledge, no study assessing the effectiveness of these treatments has been completed. Furthermore, of all the treatment and rehabilitation programs that exist in Canada, approximately 14% have been the subject of independent assessments.²⁴

Despite the lack of systematic data, it may be possible to state that approaches to treatments for drug dependency are primarily cognitivist and behaviourist in nature. In the cognitivist approaches, an attempt is made primarily to increase the awareness of the fact that a dependency problem exists: objective information and mechanisms of introspection are used to facilitate this awareness. In the behaviourist approaches, the treatments are designed to facilitate changes in lifestyle. It is known, in fact, that drug taking is part of a way of life revolving around a group of acquaintances and involving the frequentation of specific locations. Changing these patterns will help to create a lifestyle in which these drugs are not used.

How effective is this approach? Most of the authors who have examined dependency treatment programs agree in saying that, beyond the humanistic

²³ *Ibid*, page 22.

²⁴ *Ibid.*, page 15.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

dimensions of the treatment, there is a pool of knowledge indicating that they are relatively effective.

More specifically, most of the studies including those conducted in Quebec show that people who seek assistance in rehabilitation centres show improvement.

[Translation] ... *the people who undertake a rehabilitative approach as part of the services offered in Quebec improve their situation ... this improvement is maintained for a period of six months to one year following the treatment. That is a positive and reassuring result. These results are to the same effect as a very large number of other studies conducted for the most part over the last twenty years.*²⁵

In technical terms, the studies do not permit the conclusion that one approach is any more effective than another. The report prepared for Canada's Drug Strategy describes two mega-summaries of assessments of 24 different methods of treatment conducted in the United States and shows that, while the two groups of researchers agree on the effectiveness of a number of forms of treatment, they do not, on the other hand, agree entirely on the order in which they should be placed. We reproduce below the part of the table that shows the most effective approaches.²⁶

Classification of effective methods of treatment according to two groups of authors

Holder Index	Method	Method	Finney and Monahan Index
18	Social skills training	Community reinforcement approach	59
17	Self-control training	Social skills training	37
13	Brief motivational training	Marital therapy, behavioural	36
12	Marital therapy, behavioural	Disulfiram, implants	34
6	Community reinforcement approach	Marital therapy, non-behavioural	21
6	Stress management training	Stress management training	12
3	Disulfiram, oral	Aversion therapy, chemical	3
3	Aversion therapy, covert sensitization	Psychotropic medication, anti-depressant	2

The studies do not permit us to conclude that the treatment as such makes a difference and, for some of the authors, the decision to register in a treatment program, no matter what form of treatment, would be more conclusive. The studies do not enable us to determine the ideal duration of treatment, but it would appear that the

²⁵ Michel Landry, *The impact on addicts of the treatments offered in Quebec*. Brief submitted to the Senate Special Committee on Illegal Drugs, November 2001.

²⁶ Roberts and Ogborne (1999) *op. cit.*, page 9. Note that these treatments apply to all forms of dependency while most assessment studies relate to alcoholism.

effects of treatment level off after 9 to 12 months. In addition, it is difficult to determine the impact of the intensity of the treatment (how many hours per day, days per week).

Finally and most importantly, the positive impacts relate primarily to consumption habits and to the person's general psychological state. However, the treatments apparently have little effect on the reintegration of the individuals into society, which is a particularly important factor in the case of offenders.

As a final point, treatment is more effective and certainly less expensive than incarceration. In Canada, it is estimated that the cost of applying the drug court process is approximately \$4,500 per person whereas imprisonment costs an average of \$47,000. Even with a success rate of 15%, there can be no doubt that treatment both benefits society and better reflects the real needs of offenders who have problems of dependency.

Speaking more generally, cost-benefit ratio of the treatment has been recognized:

Evidence for the economic benefits of treatment for problems with drugs other than alcohol comes from a large study of drug treatment in the United States (Hubbard et al., 1989). This study involved more than 10,000 drug users and 37 treatment programs that represented three main treatment modalities: methadone maintenance treatment, drug-free outpatient counselling and therapeutic community. ... Two summary measures of these costs were developed: costs to law-abiding citizens, and costs to society. The cost to law-abiding citizens included those associated with crime-related property loss or damage, reduced productivity because of injury or inconvenience occasioned by drug-related crime, and the costs of criminal justice proceedings. Costs to society included cost to victims of drug-related crime, criminal justice costs and "crime/career/productivity costs" incurred when drug users are not involved in earning a legitimate income. The results showed that, in the population studied, both types of costs were lower after treatment than before and that pre-post differences in costs exceeded the costs of treatment.²⁷

²⁷ Roberts and Ogborne, (1999) *op. cit.*, page 68.

CONCLUSIONS

Conclusions of Chapter 17

- **The expression drug addiction should no longer be used and we should talk instead of substance abuse and dependency.**
- **Between 5% and 10% of regular cannabis users are at risk of developing a dependency.**
- **Physical dependency on cannabis is virtually non-existent.**
- **Psychological dependency is moderate and is certainly lower than that for nicotine or alcohol.**
- **Most regular users of cannabis are able to diverge from a trajectory of dependency without requiring treatment.**
- **There are many forms of treatment but nothing is known about the effectiveness of the different forms of treatment for cannabis dependency specifically.**
- **As a rule, treatment is more effective and less costly than a prison sentence.**
- **Studies of the treatment programs should be conducted, including treatments programs for people with cannabis dependency.**
- **Studies should be conducted of the interaction between the cannabinoid system and the opioid system.**

CHAPTER 18

OBSERVATIONS ON PRACTICES

In previous chapters, we described public action by dividing it up into the major sectors of involvement. Before closing the third part of this report, we would like to make some general observations that cut across the individual areas we have examined. The first concerns difficulties in harmonizing the various levels and sectors of involvement; the second, the difficulty in co-ordinating their various approaches; and the third, the costs of drugs and public policy.

DIFFICULTIES IN HARMONIZING THE PLAYERS

Without reopening the debate on the division of power and responsibilities among the various levels of government, we consider it obvious that any public policy on illegal drugs, and cannabis in particular, applies to all three levels. Drugs affect education and health (primarily provincial jurisdictions), justice (a responsibility shared between the federal and provincial governments), public well-being and public safety (which involve all three levels), international relations (a federal responsibility), and even culture, science and research (essentially provincial). Thus we are attempting to make our way through a field that is at least tangled, if not chaotic.

Co-ordinating mechanisms do exist. On the most formal level, the federal-provincial-territorial Deputy Ministers of Health Working Group is responsible for co-ordinating the drug strategy. But we know almost nothing about their discussions, which are held *in camera*, or any concrete results.

The Canadian Centre on Substance Abuse (CCSA) is another coordinating mechanism, but only a few provinces have equivalent partners (Ontario, Manitoba, Alberta and Quebec, with some reservations). And the Centre has neither the budget, the infrastructure nor even the legitimacy, which it would derive from a clear mandate, needed to initiate a genuine national dialogue on the issue.

Yet another coordinating mechanism is the Health, Education and Enforcement in Partnership (HEP) network.. Established in 1994 by the CCSA, the HEP network is rooted in the balanced approach of Canada's Drug Strategy: seeking an equilibrium between supply reduction and demand reduction. HEP unites key players in the health

and enforcement fields in this common focus and includes other partners, notably in education, social services, correctional services and justice. On a national level, its Steering Committee is composed of representatives of the Addictions Foundation of Manitoba, the Canadian Association of Chiefs of Police (co-chair), the Canadian Centre on Substance Abuse (co-chair), the Correctional Service of Canada, the Canadian Federation of Municipalities, Health Canada, Justice Canada, the National Centre for Crime Prevention, the RCMP and the Solicitor-General. How many readers of this report, even among those actively engaged in the drug field, are aware of this partnership, its achievements, actions and benefits?

In Chapter 14, we examined the disparate response of police services across the country to the application of the law—between regions, provinces and territories and, within provinces and territories, between cities. In Chapter 15, we noted that all the evidence suggests that the same holds true of the judicial response. Chapters 16 and 17, on preventive practices and treatment respectively, described the same unequal or fragmented approaches.

In a federation like Canada, it is to be expected that differences in practice and direction will co-exist. How the issue of cannabis is seen and dealt with will not be the same in the greater Vancouver area, with its explosion of growers, as in Quebec, with its criminal motorcycle gangs, or as in Prince Edward Island, which has almost no problems with production or even with abuse of cannabis. The difficulties experienced in the downtown cores of major cities are not those of smaller urban centres. And First Nations people have their own quite specific problems.

Nevertheless, among other effects, the difficulties in harmonizing the action of different levels of government mean in concrete terms that:

- ❖ Results of a successful experiment in prevention conducted in one area of the country will not reach the players in another part.
- ❖ Therapeutic practices that have been proven to be ineffective will continue to be used elsewhere because the information is not circulated.
- ❖ There is no national knowledge infrastructure on use and use trends; for example, the few studies that have been conducted in school environments are not comparable and are not (all contemporary?).
- ❖ Some cities have adopted policies based on the idea of a drug-free society while others are focused on harm reduction.

Notably absent in the development of public policy is the civil society, especially community-based organizations (rehabilitation organizations, for example) and also user self-help support groups (including compassion clubs and groups of users of cannabis for therapeutic purposes).

The hyperbola that would make drugs into a bigger social issue than they actually are aside, it remains that the use of psychoactive substances, legal or illegal, and the resulting problems of dependency that may follow, concern every citizen, every level of

government, throughout the country. This is a *national issue*. That, unquestionably, the future and quality of our health system, the protection of our national interests and security, the quality of education and the protection of the environment are even more important issues does not mean that drugs are not a *national priority*. Or should be, at least. Quite apart from its social and economic consequences, which will be discussed later, the drug issue should be a priority because it concerns the education of children and adolescents, affects the quality and safety of living environments, and causes suffering and wasted lives. Granted that this is not so much the case for cannabis, whose social and economic effects cannot be compared to those of alcohol, but, while agreeing that cannabis calls for a different approach, we cannot isolate it from other psychoactive substances. We need to develop a comprehensive national policy on drugs and addiction, within which cannabis would have a place.

Better harmonization among levels of government and with civil society would allow us to lay the foundations of a shared understanding of the issues presented by psychoactive substances, and above all to develop a common set of indicators for assessing the effectiveness of policies and actions.

INCONGRUITIES OF APPROACH

Some myths are long-lived. Although not supported by the empirical research we have examined, images of cannabis leading to use of hard drugs, damaging brain functions permanently, or causing academic failure, to name but these few, continue to abound.

We are well aware that there is no international consensus among researchers on these issues. But we are equally aware that it is difficult to alter preconceptions. Last year, at an international scientific conference in Europe, whose results we have already cited, some participants concluded that, although a consensus was emerging in the research community, its existence was irrelevant because all the countries represented were signatories of international conventions on drugs. One always finds ways to circumvent reality when it does not fit ideology.

Let there not be finger-pointing. Those who most frequently hold these beliefs about cannabis are also those who are confronted daily with the negative effects of drug abuse: crime and violence for the police officer on the beat; human misery for those in therapeutic practice. Their view of drugs, of cannabis in particular, is naturally coloured by their experience, which puts them in situations of contact with abuse, distress, violence and death. But those users who require treatment are no more representative of the cannabis user population than are the street kids and petty offenders the police see constantly.

Clearly, what is required is a bridge, an intermediary between the worlds of research and the front lines, between decision-makers and field workers and between

them all and civil society. While the research is not perfect, while we deplore the lack of a truly national system of information, the information is, nevertheless, there in quantity, as we have had occasion to observe in the course of our proceedings. But it needs wide circulation, and above all it needs to be the subject of public debate and discussion. The CCSA could disseminate this information and promote discussion, were it given the resources - a role it has never had the means to play.

The researchers themselves must bear some of the responsibility for the situation. They tend not to care whether their work reaches those in positions of power or whether it is distributed in political forums or in the field. Some are still shackled to the idea of "academic freedom," thinking that their involvement in the worlds of decision-making and practice will contaminate the objectivity of their research. It is thus not surprising that knowledge of the players on the ground is limited to what their experience provides; nor are the institutions to which they belong necessarily equipped to systematize and contextualize such knowledge either.

We have observed a serious gulf between the positions taken by the research community and those taken by front-line workers, including the police and the therapeutic community. It would be too easy to reduce the position of the practitioners to "corporate" interests. There is a need for basic discussion and exchange, which is not happening among the various players; and too often the experience-based knowledge derived from practice has no legitimacy in the eyes of the scientific community, though this is the knowledge that attracts the attention of the decision-makers, the media and the general public.

In practice, glaring contradictions arise between the discourse and the approach of the two sides. While young people hear about the potential therapeutic value of cannabis and about decriminalization, they see police operations in the schools and listen to classroom lectures on its dangers. While the primary targets of police action are supposed to be the traffickers, young people read that thousands of people are arrested every year for simple possession of marijuana. While images of junkies destroyed by heroin are flashed in the media, young people also hear that it is available by prescription. And drug users continued to be picked up by the police as they leave needle-exchange clinics. Caught between these contradictory words and actions, how should they know what to think?

These incongruities are exacerbated by the imbalance in power and resources. Non-profit groups that provide cannabis for therapeutic purposes talked about this at length: their credibility with law-enforcement agencies is often hard earned, built over time, with a few individual members of the police. They are well aware that their status is precarious and that they might have to "bail out" at any moment. Public health agencies that attempt to foster discussion and introduce harm-reduction practices are equally aware that they are operating at the outer limits of the law and that their actions are not universally supported. Researchers who wish to study the therapeutic applications of cannabis are restricted by the present system of prohibition.

In the case of alcohol, a decision-making structure exists to give a relatively equal voice to the various players involved. It includes the agencies that regulate production, distribution and sale, the public health organizations that work to reduce at-risk behaviours and clarify the determinants of abuse, the justice system that intervenes to prevent smuggling and arrest those irresponsible people who drive while impaired. The co-operation and dialogue among these players is close and constant, and there are even formal channels for co-operation and dialogue with the distilling and brewing industries. The result, by and large, is uniform practices and views, although this is not to imply that all problems have been solved. But in the field of illegal drugs, there is nothing like this. Dialogue where certain words cannot be spoken or ideas expressed, where certain decisions can never be made and resources are so unequally shared among the players, is merely empty an exercise meant to give the illusion that something is being achieved.

SIGNIFICANT ECONOMIC AND SOCIAL COSTS¹

In 1996, the Canadian Centre on Substance Abuse published the first study on costs related to alcohol, tobacco and drug abuse in Canada.² Estimating costs raises difficult technical questions: what should be included, and how should each element be measured? The very analysis of public drug policies is predicated on the assumption that a number of the associated social costs can be reduced, if not eliminated altogether. These costs are of two major types: those associated with public policy, primarily the cost of prevention and suppression, as well as those of administering the policy; and the costs that would be avoided if the problems stemming from substance abuse were eliminated—the so-called “counter-factual” scenario. In these, the effects of drugs are treated as social costs, that is, as a diminution of the collective well-being. This amounts to saying that all the costs of drug abuse are social costs, or what economists call “externalities” or “spill-overs” – secondary rather than primary consequences.

Moral considerations aside for the moment, there is no doubt that use of drugs can have certain benefits—albeit short-term and to some extent non-rational ones—for the users, and even for those around them. Hyperactive individuals calmed by cannabis, those whose productivity is enhanced by the use of cannabis or whose mental or physical suffering is attenuated, or those who smoke a joint in the evening to relax or

¹ For an excellent discussion of these analyses and for some of the best studies on the subject, see the report prepared for this committee by Jackson, A.Y. (2002) *Costs of drugs and drug policy*. Ottawa, Library of Parliament, report produced for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegal-drugs.asp.

² Single, E. *et al.* (2002) *The Costs of Substance Abuse in Canada: a cost estimation study*. Ottawa, Canadian Centre on Substance Abuse.

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

help them sleep and are in better shape to work the next day as a result, are just a few examples. And they are not unusual cases.

From another point of view, the underground drug economy, not trafficking on a major scale, but small-scale neighbourhood supply, whether in poorer or wealthier areas, generates certain economic benefits and even some capacity to integrate socially. Entire families are supported by small-scale dealing. Houses, cars, travel and luxury clothing are financed by drug sales. The amount of the wealth they generate can be illustrated by the example of British Columbia. In this province alone the cannabis-based economy is estimated to be worth \$6 billion annually. It can be assumed that a major part of this revenue, let us say half, goes to people who are otherwise well integrated socially and are not part of the criminal culture.

The analysis of social costs based only on externalities does not take into account the drug economy.

Ultimately it rests on another hypothesis, equally difficult to defend, which is that the money saved if the social costs of drug use were reduced could be invested elsewhere; in economic theory these costs are known as “opportunity costs”. However, money saved on enforcement of cannabis laws would probably be redistributed within the police organization; other social costs might also arise from the substitution of other substances.

Having set out these caveats, Single’s study produced the following table³.

Total cost of alcohol, tobacco and illegal drugs in Canada, 1992

	Alcohol	Tobacco	Drugs	Total
1. Direct health care costs: total	\$1,300.6	\$2,675.5	\$88.0	\$4,064.1
1.1 morbidity-general care hospitals	666.0	1,752.9	34.0	2,452.9
-psychiatric hospitals	29.0	--	4.3	33.3
1.2 co-morbidity	72.0	--	4.7	76.7
1.3 ambulance services	21.8	57.2	1.1	80.1
1.4 home care	180.9	--	20.9	201.8
1.5 outpatient treatment	82.1	--	7.9	90.0
1.6 ambulatory care: doctors’ fees	127.4	339.6	8.0	475.0
1.7 prescription medications	95.5	457.3	5.8	558.5
1.8 other health care costs	26.0	68.4	1.3	95.8
2. Direct losses in the workplace	14.2	0.4	5.5	20.1
2.1 EAP and health promotion programs	14.2	0.4	3.5	18.1
2.2 drug testing in the workplace	N/A	--	2.0	2.0
3. Direct administrative costs for transfer payments	52.3	--	1.5	53.8
3.1 social assistance benefits and other programs	3.6	--	N/A	3.6

³ Single, E. *et al* (1996) *op. cit.*

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS: CANNABIS

	Alcohol	Tobacco	Drugs	Total
3.2 workers' compensation	48.7	--	1.5	50.2
3.3 other administrative costs	N/A	N/A	N/A	N/A
4. Direct costs for prevention and research	141.4	48.0	41.9	231.1
4.1 research	21.6	34.6	5.0	61.1
4.2 prevention programs	118.9	13.4	36.7	168.9
4.3 training costs for doctors and nurses	0.9	N/A	0.2	1.1
4.4 costs for behavioural modification	N/A	N/A	N/A	N/A
5. Direct costs of law enforcement	1,359.1	--	400.3	1,759.4
5.1 police	665.4	N/A	208.3	873.7
5.2 courts	304.4	N/A	59.2	363.6
5.3 correctional services including probation	389.3	N/A	123.8	513.1
5.4 customs and excise	N/A	N/A	9.0	9.0
6. Other direct costs	518.0	17.1	10.7	545.8
6.1 damages due to fire	35.2	17.1	N/A	52.3
6.2 damages due to traffic accidents	482.8	--	10.7	493.5
7. Indirect costs: loss of productivity	4,136.5	6,818.8	823.1	11,778.4
7.1 loss of productivity due to illness	1,397.7	84.5	275.7	1,757.9
7.2 loss of productivity due to death	2,738.8	6,734.3	547.4	10,020.5
7.3 loss of productivity due to crime	--	--	N/A	N/A
Total	7,522.1	9,559.8	1,371.0	18,452.9
Total % of GDP	1.09%	1.39%	0.20%	2.67%
Total per capita	\$265	\$336	\$48	\$649
Total % of all costs related to substances	40.8%	51.8%	7.4%	100.0%

An examination of these data indicates:

- In 1992, the costs associated with all illegal drugs were \$1.4 billion, compared with \$7.5 billion in the case of alcohol and \$9.6 billion in the case of tobacco.
- Expressed as a percentage of the gross domestic product, the total costs for all substances was 2.67%. Of this, 0.2% was for illegal drugs, 1.09% for alcohol and 1.39% for tobacco.
- The principal costs of illegal drugs are externalities, that is, loss of productivity (\$823 million), health care (\$88 million), losses in the workplace (\$5.5 million), for a total of about 67% of all costs related to illegal drugs.
- The cost of public policies, or opportunity costs, represent about 33% of what.

- The cost of enforcing the law represents about 29.2% of all costs, or about 88% of all policy costs. The balance goes to prevention, research and administration.

Previous studies conducted in British Columbia (1991), Ontario (1988) and Quebec (1988), using different methodologies, established costs of \$388 millions, \$1.2 billion and \$2 billion respectively, for a total cost of \$3.5 billion for these three provinces alone.⁴ These figures demonstrate the extent to which such estimates can vary, according to the methodology selected and the availability of data.

Nevertheless, with the CCSA study taken as the standard, two comments must be made. First, loss of productivity—the major cost—is measured in mortality (\$547 million) and morbidity (\$275 million). Except in the case of traffic fatalities, cannabis is not a cause of death and involves none of this type of social cost. Morbidity corresponds to losses attributed to problems caused by drug use as measured by the difference between the average annual income of users and of the population in general. Here, two further observations about cannabis should be noted. A large proportion of cannabis users are young people who are not yet part of the workforce; and cannabis use involves none of the addiction and attendant problems that follow from heroin or cocaine use. It is, therefore, the costs that can be attributed to cannabis in this regard are likely minimal. If one accepts the methodology of the authors, **cannabis in itself entails few externalities**, which are the main measures of the social cost of illegal drugs.

However, it should also be noted that the study did not calculate the costs of substance-related crime. Alcohol is well known for its frequent association with crimes of violence (at least 30% of all cases), as well as with impaired driving, which results in major social and economic losses. Crime related to illegal drugs is of several types: organized crime, of course; crimes against property committed in order to pay for drugs, true mainly in the case of heroin and cocaine; and crimes of violence committed under the influence of drugs. With the exception of organized crime and driving under the influence, cannabis involves few of the factors that generate criminal behaviour.

Secondly, according to Single's study, the main cost of illegal drugs, after loss of productivity, is the cost of law enforcement, which the study estimates at approximately \$400 million. In Chapters 14 and 15, we noted that police and court costs are certainly much higher than this figure, and probably total between \$1 billion and \$1.5 billion. As Single *et al* state, these are costs that "are incurred as a conscious decision by policy makers, as opposed to those costs imposed on the treatment system and on industry as a result of substance-related morbidity and mortality."⁵ The proportion of these costs attributable to cannabis is, obviously, impossible to determine for certain. But, insofar as 77% of all drug-related offences involve cannabis, and of these 50% involve simple possession, and given that about 60% of incidents result in a charge, of which some

⁴ Single, E. *et al*, *op.cit.*, page 15.

⁵ *Ibid.*, page 57.

10% to 15% of cases the accused receives a prison sentence, it is clear that a considerable proportion of the drug-related activity addressed by the penal justice system is concerned with cannabis. While admitting this to be a very rough estimate, we suggest that about 30% of the activity of the justice system is tied up with cannabis. On the basis of our estimates and the lowest cost of law enforcement, or \$1 billion, it costs about \$300 million annually to enforce the cannabis laws.

In effect, the main social costs of cannabis are a result of public policy choices, primarily its continued criminalization, while the consequences of its use represent a small fraction of the social costs attributable to the use of illegal drugs.

Next to this, the costs of prevention and research pale into insignificance. Single estimates them at approximately \$42 million in 1992, at the height of Canada's Drug Strategy – a strategy that ceased to be funded after 1997. Far from increasing since then, it is probable that expenditures for prevention and research have decreased as a proportion of the total social cost of drugs.

At several points in this report, we have spoken about the Canadian Centre on Substance Abuse, pointing out both its lack of visibility and legitimacy and its lack of resources the two being related. The economic and social costs of illegal drugs alone on the order of \$1.5 billion (which in light of our estimate of the costs of suppression alone is certainly the floor), the annual budget of the CCSA represents a mere 0.1% of them! Considering that the CCSA's mandate is to facilitate everything we have just been discussing, and to serve as a clearing-house for information, practical experience and best practices, there is good reason to wonder whether successive governments have not failed to put their money where their mouth is in their approach to the drug issue. The social costs of alcohol, a substance that also falls within the CCSA's purview, have not even been included in this calculation, though they are at least seven times greater than those of illegal drugs! This is why it is imperative to raise the proportion of funding to the CCSA from 0.1% to 1%—a drop in the bucket for the federal government that would produce inestimable benefits.

CONCLUSIONS

Conclusions of Chapter 18	
Harmonization	<ul style="list-style-type: none">➤ The lack of any real national platform for discussion and debate on illegal drugs prevents the development of clear objectives and measurement indicators.➤ The absence of a national platform makes exchange of information and best practices impossible.➤ Practices and approaches vary considerably between and within provinces and territories.

Co-ordination of approaches

- **The conflicting approaches of the various players in the field are a source of confusion.**
- **The resources and powers for enforcement are greatly out of balance compared with those of the health and education fields and the civil society.**

Costs of cannabis

- **The costs of all illegal drugs had risen to close to \$1.4 billion in 1992.**
- **Of the total costs of illegal drugs at that time, externalities (social costs) represented 67% and public policy costs 33%.**
- **We believe both the social costs of illegal drugs and the public policy costs to be underestimated.**
- **We estimate the cost of enforcing the drug laws to be closer to \$1-1.5 billion per annum.**
- **The principal public policy cost relative to cannabis is law enforcement and the justice system; we estimate this to represent a total of \$300-\$500 million per annum.**
- **The costs of externalities attributable to cannabis are probably minimal (no deaths, few hospitalizations, and very little loss of productivity).**
- **The costs of public policy on cannabis are disproportionately high given the drug's social and health consequences.**

Under-funding of the CCSA

- **The Canadian Centre on Substance Abuse is seriously under-funded; its annual budget amounts to barely 0.1% of the social costs of illegal drugs alone (alcohol not included). Its budget should be increased to at least 1%; that is, approximately \$15 million per annum.**