Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME III : PART IV AND CONCLUSIONS

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GLOSSARY OF KEY TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dopamine
Neuromediator involved in the mechanisms of pleasure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART IV

PUBLIC POLICY OPTIONS

CHAPTER 19

THE INTERNATIONAL LEGAL ENVIRONMENT

This chapter could begin and end with the same words: The international drug control conventions are, with respect to cannabis at least, an utterly irrational restraint that has nothing to do with scientific or public health considerations.

Very useful restraint, to be sure, if one favours prohibition, for when the advocates of such policy run out of scientific and public health arguments, they can simply fall back on the conventions that Canada has signed. More than signed, in fact: owing to the efforts of certain men, police officers and federal public servants, Canada was a leading proponent of those conventions.

Currently, three conventions govern the entire life cycle of drugs, from cultivation of the plants to their consumption: the *Single Convention on Narcotic Drugs, 1961* (Single Convention),[1] the 1971 *Convention on Psychotropic Substances* (Psychotropics Convention)[2] and the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Trafficking Convention).[3] They create not only international law concerning drugs but also control mechanisms and bodies, both political and bureaucratic.

Yet these agreements have a history that began well before the Single Convention, a history that sheds light on the issues that led to their development and on their contemporary significance. That is the subject of the first section. The conventions create obligations, as shown in the second section, detailed obligations that are morally rather than legally binding. And they are a patchwork of compromises that leave states with some leeway, as we shall see in the third section.

[1] Single Convention on Narcotic Drugs, 1961 (RTC 1964/30), amended by the Protocol amending the Single Convention on Narcotic Drugs, 1961 (RTC 1976/48). The Single Convention came into force in Canada in 1964 and the Protocol in 1976.

[2] Convention on Psychotropic Substances, RTC 1988/35. It came into force in Canada in 1988.

[3] Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, RTC 1990/42, which came into force in Canada in 1990.

A GENEALOGY

The genealogy of the international conventions governing drug production and trade is fascinating and unique. The story begins in the mid-19th century, when Britain and China fought two opium wars, both quickly won by the British. In this era, the roles were reversed: the British owned the lucrative opium monopoly of the East India Company and refused to relinquish it, while the Chinese had been trying for decades to stamp out opium use, not so much for health reasons as for economic ones, since this trade was exacting a heavy toll.

> *China had long exercised the upper hand in its economic relations with the Occident. Silks, teas, fine pottery, and other items flowed west. Yet the Middle Kingdom desired little from the outside. (…) Encouraging the China opium trade therefore solved several related problems for colonial governments. Opium production provided a living for numerous peasants, merchants, bankers, and governments officials. Exports to China earned hard currency, thereby reducing specie outflow.* [4]

While Britain balked at introducing control mechanisms that would deprive it of hard currency, the United States realized at the turn of the century that this was a perfect opportunity to assert itself on the international scene.

The drug story's geopolitical ingredients blended with well-known domestic political interests, racist attitudes and economic interests in a complex cocktail. In Chapters 11 and 12, we touched on certain aspects of the anti-Chinese racism that marked the turn of the century in Canada. The same phenomenon existed in the U.S.

> [Translation] *The United States had a number of reasons for acting on this proposal. The official reason was a moral one: at a time when the temperance leagues and the churches were demanding Prohibition, puritan America decided to take the lead in civilization's world crusade. It claimed to be protecting uncivilized races from the ravages of opium and alcohol. But it also had some less virtuous reasons. Under pressure from the trade unions, which feared competition from Chinese labour, it passed the Exclusion Laws, openly xenophobic legislation whose purpose was to control the yellow peril. It therefore spread the myth of the 'unsavoury Chinese opium addict,' devoted to his habit and ready to contaminate American youth.* [5]

Naturally, the Chinese government vigorously protested against the Exclusion Laws, but the Middle Kingdom, a victim of its conflicts and its internal disorganization, lacked the resources to make an impact on the international scene. While continuing to combat opium use within its own territory, China set about promoting poppy cultivation at the local level.

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[4] McAllister, W.B., (1999) *Drug Diplomacy in the Twentieth Century. An international history*, pages 10-11.
[5] Caballero, F., and Y. Bisiou (2000) *Droit de la drogue.* Paris: Dalloz, 2nd edition, page 36.

The pharmaceutical industry, which had been booming since the mid-19th century, was able to produce more and more low-priced medicines, many of which contained extracts of coca or opium.

> *The mid-1880s euphoric reaction of cocaine set off a chain reaction. Pharmaceutical companies rushed to fill orders, but fresh coca leaf was unavailable in sufficient quantity. Consequently, the price skyrocketed. To meet demand and share in the profit, several imperial powers stepped up efforts to develop commercially saleable coca. (…) Within a few years, coca production increased dramatically, coca paste processing became commonplace, coca leaves became a commodity traded on the international market and pharmaceutical manufacturers competed for business on the basis of price, availability, and quality of product. Hardly available in 1885, cocaine became quickly emblematic of the modern, technological, international, political economy. (…) By the early twentieth century, cocaine ranked third in terms of dollar value among drugs. The popularity of the two drugs superseding cocaine, morphine and quinine, resulted from the same constellation of factors – a burgeoning pharmaco-industrial complex.* [6]

The third factor was the growing professionalism and social power of the medical community. The latter was essentially working against a form of popular medicine, ostensibly because it was a source of abuse and charlatanism, but mostly because it was practised outside the medical establishment and thus was less tightly controlled by scholarly medical "authority". Certain of its science, the powerful medical lobby would quickly swing into action and demand the regulation of drugs and sole authority to diagnose and prescribe.

Last but not least, there were moral considerations. The temperance movements fighting the moral and social "vices" of alcohol and drugs were growing rapidly and carried substantial political clout, which the prohibitionists wielded brilliantly.

The last piece of the puzzle was the 1906 decision by Britain's new Liberal government to oppose the forced opium trade between India and China, which made it possible for the Chinese government to launch an extensive campaign against opium consumption and production. In 1907, the British agreed to reduce exports of Indian opium to China by 10 per cent a year, provided that China would permit independent verification of its own production cuts. The accord proved more effective than the two countries expected, until the Manchu (Ch'ing) dynasty fell in 1911. After that, the Chinese warlords began encouraging opium production on a large scale to finance their military spending. Nevertheless, future prohibition advocates would view the 1907 "ten-year agreement" as the first successful opium "treaty"; for the next 60 years. This agreement was to set the tone for international drug control negotiations.[7] The stage was now set for the first in a long series of international conferences, treaties and conventions, as shown in the table below.[8]

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[6] McAllister, *op. cit*., pages 15-16.

[7] McAllister, *op. cit*., pages 24-27.

[8] This table and the text of this section are taken from the excellent report prepared by the Library of Parliament at the Committee's request: Sinha, J. (2001) *The History and Development of the Leading*

Multilateral Agreements on Narcotics and Psychotropic Substances[9]

Date and place signed	*Title of agreement*	*Date of entry into force*
26 February 1909 Shanghai, China	Final Resolutions of the International Opium Commission [1]	Not applicable
23 January 1912 The Hague, Netherlands	International Opium Convention	11 February 1915 / 28 June 1919 [2]
11 February 1925 Geneva, Switzerland	Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium	28 July 1926
19 February 1925 Geneva, Switzerland	International Opium Convention	25 September 1928
13 July 1931 Geneva, Switzerland	Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs [3]	9 July 1933
27 November 1931 Bangkok, Thailand	Agreement for the Control of Opium Smoking in the Far East	22 April 1937
26 June 1936 Geneva, Switzerland	Convention for the Suppression of the Illicit Traffic in Dangerous Drugs	26 October 1939
11 December 1946 Lake Success, New York, USA	Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936	11 December 1946
19 November 1948 Paris, France	Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931, for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946	1 December 1949
23 June 1953 New York, USA	Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium	8 March 1963
30 March 1961 New York, USA.	Single Convention on Narcotic Drugs, 1961	13 December 1964
21 February 1971 Vienna, Austria	Convention on Psychotropic Substances	16 August 1976
25 March 1972 Geneva, Switzerland	Protocol amending the Single Convention on Narcotic Drugs, 1961	8 August 1975
20 December 1988 Vienna, Austria	United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	11 November 1990

1 This is the only document in the table that is not an enforceable multilateral treaty. It is included because it marks the beginning of substantial international cooperation on drug control.
2 China, the Netherlands, and the U.S. implemented the Convention in 1915 (Honduras and Norway followed suit later that year). It did not come into force globally until it was incorporated into the Treaty of Versailles in 1919.
3 As amended by the Protocol signed at Lake Success, New York, on 11 December 1946.

International Drug Control Conventions. Ottawa: Library of Parliament, Parliamentary Research Branch, available on the Committee's Web site at www.parl.gc.ca/illegal-drugs.asp .

[9] Sources: Canadian Treaty Series; Kettil Bruun, Lynn Pan and Ingemar Rexed, (1975) *The Gentlemen's Club: International Control of Drugs and Alcohol*, Chicago: University of Chicago Press; United States, (1972) *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971*, Washington, D.C.: Bureau of Narcotics & Dangerous Drugs.

The 1909 Shanghai Conference

U.S. interest in international drug control grew substantially following the Spanish-American War, which led to its acquisition of the Philippines in 1898.[10] The acquisition brought with it what the American administration perceived as a serious problem: a government-run opium supply monopoly. Under the guidance of the new Episcopal Bishop of the Philippines, Charles Henry Brent, the monopoly was shut down. Yet smuggling continued, and Brent, who regarded the opium issue as a moral question and use of the drug as *"a social vice … a crime,"* persuaded President Theodore Roosevelt to support holding an international meeting in Shanghai to remedy what was clearly a regional problem.[11]

In February 1909, the International Opium Commission[12] met in Shanghai, with Brent as its president. However, because the participants did not have the necessary plenipotentiary powers to conclude a treaty, the result was simply a collection of facts and a set of non-binding recommendations. In the discussions on the Commission's terms of reference, one question that arose was whether drug-related medical issues, such as addiction and its treatment, should be considered; the proposal was defeated (by a majority of one) because it was felt that there was insufficient medical expertise present at the meeting.[13] This set a telling precedent: most subsequent drug meetings would be attended predominantly by diplomats and civil servants, with little significant input from medical experts.

The negotiations during the Commission's meetings laid the groundwork for future conferences. The U.S., aggressively represented by Hamilton Wright, tried to persuade the colonial powers to support a narrow definition of "legitimate use" of opium, under which any non-medical or non-scientific use–by Western medical and scientific standards–would be considered illicit. The colonial powers advocated a softer approach, which would permit "quasi-medical use". In the final wording of Resolution 3, the Commission concluded "that the use of opium in any form otherwise than for medical purposes is *held* by *almost* every participating country to be a matter for prohibition *or for careful regulation*; and that each country in the administration of its system or regulation purports to be aiming, as opportunity offers, at progressively increasing stringency" (emphasis as in original).

The Commission was, in fact, far from "international". The focus was on China's opium problems–five of the nine resolutions mentioned China by name–and the U.S. and Britain dominated the discussions. The U.S. was pushing for prohibition and felt that China needed assistance with its domestic opium problems. Britain worked to

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10 Lowes, P.D. (1966) *The Genesis of International Narcotics Control*. Geneva: Droz, page 102.

11 Bewley-Taylor, D.R. (1999) *The United States and International Drug Control.* page 19.

12 The Commission included all the colonial powers in the region – Britain, France, Germany, Japan, the Netherlands, Portugal and Russia – and China, Siam [now Thailand], Persia [now Iran], Italy and Austria-Hungary. (McAllister (2000), page 28)

13 Bruun *et al.* (1975), page 11; Lowes (1966), page 187-188.

protect its lucrative Indian opium trade, arguing that curbing such trade would be useless until China brought its domestic production under control.[14]

Underlying the U.S. delegation's hard-line stance at the Shanghai meeting were key domestic political and economic goals that would also colour later negotiations. It was assumed that if other countries controlled their own opium production and exports, the U.S. would not be burdened with the task, because the poppy and the coca leaf had never been grown in appreciable quantities in North America. Furthermore, international agreements calling on countries to take drastic internal measures provided ammunition for Brent and Wright, who were pressuring the U.S. government to develop stringent domestic drug control laws.[15]

The 1912 Hague International Opium Convention

At the Shanghai meeting, the Americans had proposed a future conference to draft an international drug control treaty that would include the Shanghai resolutions in an expanded and more stringent form. This proposal was contested by the other countries and went nowhere. In the years that followed, however, the U.S. lobbied continually and forcefully around the world for a new conference. Addressing the opium problem directly, publicly and internationally was a way for the U.S. to achieve its domestic control objectives, to put an end to the profitable drug trade dominated by the colonial powers, and to curry favour with the Chinese and thereby improve Sino-American economic relations.[16]

Twelve countries agreed to meet at The Hague on 1 December 1911 to draft a treaty.[17] Once again, the meeting was chaired by Brent, and Wright led the U.S. delegation. Most states had demanded amendments to the U.S. draft agenda, which focused on stringent control of opium production, manufacture and distribution in Asia. For example, Britain insisted that manufactured drugs such as morphine, heroin, and cocaine be considered. This was an attempt to dilute the opium agenda and deflect attention from Indian opium production. Britain also hoped that a fair treaty would create a level playing field for British pharmaceutical companies to compete with the dominant German synthetic drug industry.[18]

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[14] Walker III, William O., (1991) *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954*, Chapel Hill, N.C.: University of North Carolina Press, page 16-17; Lowes (1966), page 152-153.

[15] Musto (1999), page 36-37.

[16] William B. McAllister, (1992) "Conflicts of Interest in the International Drug Control System," in William O. Walker III, ed., *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park, Pennsylvania: Pennsylvania State University Press, page 145.

[17] Germany, China, the United States, France, Britain, the Netherlands, Italy, Japan, Persia [now Iran], Portugal, Russia and Siam [now Thailand].

[18] McAllister (2000), page 32-33; Bruun *et al.* (1975), page 11-12.

Chapters I and II of the 1912 *International Opium Convention*[19] (1912 Hague Convention) dealt with raw and prepared opium. For example, Article 1 required parties to "enact effective laws or regulations for the control of the production and distribution of raw opium" unless such laws were already in place. The Convention also recognized the U.S.-initiated principle of restricting opium use to medical and scientific purposes. Chapter IV was aimed at reducing drug trafficking in China.

Chapter III focused on licensing, manufacturing and distribution controls on synthetic drugs, but Germany ensured that the provisions were weak and vague. Article 10 allowed countries to simply make their "*best endeavours*" to implement these controls. Furthermore, Germany refused to sign the treaty until it was agreed that all countries would have to ratify[20] the Convention before it came into force. This was an effective tactic for delaying control measures as it took almost a decade for all countries to ratify the agreement. Germany did so only because ratification was a condition of the Treaty of Versailles that ended the First World War in 1919.[21]

Wright used the 1912 Hague Convention in his campaign for U.S. domestic legislation, arguing that a federal law was necessary for the U.S. to fulfil its obligations under the Convention. In 1916, the U.S. Supreme Court ruled that this was not so, but by then the *Harrison Narcotics Act of 1914* had become the first federal drug control law in the U.S.; it would remain a pillar of U.S. drug policy for the next few decades.[22]

The establishment of the League of Nations in 1919 following the First World War provided the international community with a centralized body for the administration of drug control. In 1920, the League created the Advisory Committee on the Traffic in Opium and other Dangerous Drugs, commonly known as the Opium Advisory Committee (OAC), the precursor to the United Nations (UN) Commission on Narcotic Drugs. The League Health Committee, forerunner of the UN World Health Organization, was also formed. Administration of the 1912 Hague Convention had originally been the responsibility of the Netherlands, but was transferred to the Opium Control Board (OCB) created by the OAC. Enforcement of the Convention was sporadic as the countries on the OCB were the ones profiting most from the drug trade.[23]

The League began to consider demand-side socio-medical issues such as why individuals use drugs, what constitutes drug abuse, and what social factors affect abuse.

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[19] Done 23 January 1912; in force 28 June 1919.

[20] Ratification is the process by which each country enacts national implementing legislation – unless the new international obligations are already met by domestic legislation – and thereby consents to the treaty's application within its territory.

[21] McAllister (2000), page 36-37; Bruun *et al.* (1975), page 12; Lowes (1966), page 182-186.

[22] Musto (1999), page 59-63. Since the U.S. Constitution did not allow a direct federal role in criminalizing drug use, Wright designed the *Harrison Act* as a tax statute; physicians, pharmacists, wholesalers and retailers had to obtain a tax stamp to distribute drugs. The Treasury Department was responsible for enforcing the statute. Thus, the use of drugs was limited through access restrictions. (McAllister (2000), page 35)

[23] McAllister (1992), page 145-146.

However, prohibition and supply-side issues soon regained the ascendancy as preparations began and talks were held, again at the instance of the U.S., for a new treaty in the mid-1920s. In general, the international regime has tended to separate the study of drug-related medical and social problems, including etiological questions, from that of drug control problems.[24]

The 1925 Geneva Opium Conventions

Even though the U.S. had chosen not to join the League of Nations, its influence in international drug control matters remained strong. Worried by the 1912 Hague Convention's limited effect on the smuggling of opium and, increasingly, drugs manufactured in East Asia, the U.S. pressured the League to convene a new conference. The League feared that if it did not comply, the U.S. might act independently.[25]

Between November 1924 and February 1925, two back-to-back conferences were held, and two separate treaties were concluded. The first Geneva Convention[26] focused on opium-producing nations; signatories were permitted to sell opium only through government-run monopolies and were required to end the trade completely within 15 years.

The second Geneva Convention, the *International Opium Convention*[27] (1925 Geneva Convention), was intended to impose global controls over a wider range of drugs, **including, for the first time, cannabis**, which was referred to as "Indian hemp" (marijuana) in Article 11 of the Convention. Articles 21 to 23 required Parties to provide annual statistics on drug stocks and consumption; the production of raw opium and coca; and the manufacture and distribution of heroin, morphine and cocaine. Chapter VI replaced the OCB with an eight-member Permanent Central Opium Board (PCOB).[28] Chapter V of the second Convention set up a PCOB-monitored import certification system to control the international drug trade by limiting the amount that each country could legally import.

While the 1912 Hague Convention had focused on domestic controls, the Geneva Conventions were an attempt to improve transnational control. The U.S. had proposed strict adherence to the principle that drugs should be used only for medical and scientific purposes and that there should be stringent controls on drug production at the source. When these proposals were flatly rejected at the second conference, the U.S.

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[24] McAllister (2000), page 46-50; Lowes (1966), page 188.

[25] McAllister (2000), page 50-51.

[26] *Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium,* done 11 February 1925, in force 28 July 1926.

[27] Done 19 February 1925; in force 25 September 1928.

[28] The PCOB was intended to be impartial and politically disinterested, but its operations remain extremely political to this day (it still exists). Since its inception, its membership has always included a representative from Britain, the U.S. and France. (McAllister (2000), page 83)

delegation walked out of the conference and never signed the treaties. The Chinese delegation withdrew as well, because no agreement could be reached on the suppression of opium smoking.[29] Instead, the two countries concentrated on enforcing the 1912 Hague Convention.

The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement

The import control system put in place following the 1925 Geneva Convention was only partially effective, as drugs were simply transhipped through non-signatory countries. In 1931, the League of Nations convened a further conference in Geneva to place limits on the manufacture of cocaine, heroin and morphine, and to control their distribution. The result of the conference was the *Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*[30] (1931 Limitation Convention).

In 1931, Canada abandoned its policy of simply reacting to international drug control efforts and began playing an active role in supporting U.S. efforts to expand control at the source. Colonel Charles Henry Ludovic Sharman, Chief of the Narcotics Division in the Department of Pensions and National Health, was the principal architect of Canada's domestic and international drug policy until the 1960s. Canada, through Sharman, was heavily involved in the negotiations leading up to the 1931 Limitation Convention.[31]

A new player also emerged from within the U.S. delegation: Harry J. Anslinger, first Commissioner of the newly created Federal Bureau of Narcotics, a position he would hold for 33 years. A firm believer in prohibition and the control of drug supplies at the source, Anslinger is widely recognized as a prime mover in the development of U.S. drug policy and, by extension, international drug control into the early 1970s.[32]

The centrepiece of the 1931 Limitation Convention was the manufacturing limitation system set out in Chapters II and III. Parties were required to provide the PCOB with estimates of their national drug requirements for medical and scientific purposes, and on the basis of those estimates, the PCOB would calculate manufacturing limits for each signatory. A Drug Supervisory Body (DSB) was created to administer the system. The Convention's effectiveness was seriously undermined by Article 26, which absolved states of any responsibilities under the Convention for their

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[29] Bruun *et al.* (1975), page 14.

[30] Done 13 July 1931; in force 9 July 1933.

[31] Giffen *et al.* (2000), page 483.

[32] See, for example, McAllister (2000), page 89-90; Bewley-Taylor (1999), page 102-164; Bruun *et al.* (1975), page 137-141; Inglis (1975), page 181-190. See also Harry J. Anslinger and Will Oursler, "The War against the Murderers," in William O. Walker III, ed., *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict*, Wilmington, Delaware: Scholarly Resources Inc., 1996.

colonies. Article 15 required states to set up a "special administration" for national drug control, modelled to some extent on the U.S. domestic control apparatus.[33]

The Convention came into force quickly because various countries and the League of Nations thought it might provide a useful model for arms control negotiations. The League even prepared a report explaining how the principles set out in the 1925 Geneva Convention and the Limitation Convention could be applied to disarmament issues.[34]

In late 1931, another conference was held in Bangkok to address opium smoking in the Far East. The treaty[35] it produced was weak, primarily because the U.S. attended only as an observer and the European colonial powers were unwilling to implement effective controls on opium use while there was significant opium overproduction and smuggling. The fact that the U.S. strategy of absolute prohibition had made little impact on opium trafficking and use in the Philippines did not strengthen the U.S.'s hand in pushing for the elimination of poppy cultivation. The key result of the Bangkok conference was that it convinced the U.S. that a firmer approach was needed to combat raw material production and illicit drug trafficking.[36]

The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs

Based on initiatives of the International Police Commission, forerunner of the International Criminal Police Organization (INTERPOL), negotiations had begun in 1930 to develop a treaty to stem illicit drug trafficking and punish traffickers severely through criminal sanctions.[37]

In 1936, the *Convention for the Suppression of the Illicit Traffic in Dangerous Drugs*[38] (1936 Trafficking Convention) was concluded in Geneva. The U.S., led by Anslinger, had attempted to include provisions that would criminalize all activities–cultivation, production, manufacture and distribution–related to the use of opium, coca (and its derivatives) and cannabis for non-medical and non-scientific purposes. Many countries objected to this proposal, and the focus remained on illicit trafficking.[39] Article 2 of the Convention called on signatory countries to use their national criminal law systems to "severely" punish, "particularly by imprisonment or other penalties of deprivation of liberty," acts directly related to drug trafficking.

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33 Anslinger would use this provision continually in the future as a way of protecting his position and the Federal Bureau of Narcotics from being altered through reorganization. (McAllister (2000), page 98, 108-109)

34 *Ibid.*, page 110-111.

35 *Agreement for the Control of Opium Smoking in the Far East*, done 27 November 1931, in force 22 April 1937.

36 Taylor (1969), page 275-279; McAllister (2000), page 106.

37 Taylor (1969), page 288-298.

38 Done 26 June 1936; in force 26 October 1939.

39 Taylor (1969), page 293-295.

The U.S. refused to sign the final version because it considered the Convention too weak, especially in relation to extradition, extraterritoriality and the confiscation of trafficking revenues. The U.S. was also worried that if it signed, it might have to weaken its domestic criminal control system to comply with the Convention. In fact, the Convention never gained widespread acceptance, as most countries interested in targeting traffickers concluded their own bilateral treaties.

Despite its minimal overall effect, the 1936 Trafficking Convention marked a turning point. All the previous treaties had dealt with the regulation of "legitimate" drug activities, whereas the 1936 Trafficking Convention now made such activities an international crime subject to penal sanctions.

The Second World War

In the late 1930s, the Opium Advisory Committee (OAC) of the League of Nations began to question the international drug control regime's emphasis on prohibition and law enforcement. Some countries proposed combating abuse through public health approaches, including psychological treatment, dispensary clinics and educational programs. Asserting the U.S. belief that addicts could only be cured through institutionalization, Anslinger, supported by Sharman, was able to block all OAC efforts to consider social and etiological approaches to drug problems. Instead, at Anslinger's insistence, the focus remained on developing a new treaty to impose prohibition and supply control worldwide.[40]

Ironically, in anticipation of war, many countries (in particular the U.S.) built up stockpiles of opium and opium products intended for medical purposes.[41] The Second World War put further development of the international drug control apparatus on hold.

The 1946 Lake Success Protocol

Following the war, the drug control bodies and functions of the League of Nations were folded into the newly formed United Nations.[42] The UN Economic and Social Council (ECOSOC) took over primary responsibility through its Commission on Narcotic Drugs (CND), which replaced the OAC. Under the CND, the Division of Narcotic Drugs (DND) was charged with the preparatory work for conferences. The PCOB and the DSB continued under the CND in their respective roles of compiling

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[40] McAllister (2000), page 126-127.

[41] The possibility of war accentuated the hypocrisy and opportunistic nature of the U.S. prohibitionist position. In 1939, Anslinger "was simultaneously pursuing a League-sponsored treaty to curtail agricultural production in far-off lands, a regional agreement that would allow him to commence poppy cultivation at home, and a global acquisition program that amassed the world's largest cache of licit opium yet assembled." (McAllister (2000), page 133)

[42] See Bewley-Taylor (1999), page 54-59; Bruun *et al.* (1975), page 54-65.

statistics for national estimates and administering previous treaties. Canada's Sharman became the first Chair of the CND and also held a seat on the DSB.

All these changes in responsibility and organization meant that the existing international drug control treaties had to be amended. The amendments were made in a Protocol[43] signed at Lake Success, New York, on 110 December 1946.

The 1948 Paris Protocol

Anslinger and Sharman campaigned hard to ensure that the CND would report directly to ECOSOC as an independent organization. They were afraid that if the main drug control apparatus was a larger health or social issues organization, such as the World Health Organization (WHO) or the United Nations Educational, Scientific and Cultural Organization (UNESCO), etiology and treatment issues might take precedence over the prohibition focus. In particular, they wanted to ensure that governments would be represented by law enforcement officials rather than physicians or others with sociology or public health backgrounds. Furthermore, the USSR showed interest in considering the social factors underlying drug abuse. For the Western powers to have agreed with the Soviet Union would have undermined their hard-line stance against Moscow and communism in the looming Cold War.

Although control remained principally with ECOSOC, the World Health Organization (WHO), in particular its Drug Dependence Expert Committee, became responsible for deciding what substances should be regulated.[44] This authority was given to the WHO in an international Protocol[45] signed in Paris in 1948. Article 1 stated that if the WHO found a drug to be "*capable of producing addiction or of conversion into a product capable of producing addiction,*" it would decide how to classify the drug within the international drug control structure. The Protocol also brought under international control specific synthetic opiates not covered by previous treaties.

The 1953 New York Opium Protocol

By the late 1940s, it became clear that the large number of international drug treaties, with their differing types and levels of control, had become confusing and unwieldy. Anslinger, Sharman and their allies had the CND recommend to ECOSOC the idea of consolidating all existing treaties into one document. It would also be an

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[43] *Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936*, done 11 December 1946, in force 11 December 1946.

[44] Bruun *et al.* (1975), page 70.

[45] *Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931, for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946*, done 19 November 1948, in force 1 December 1949.

opportunity to bring in more stringent prohibition-based controls.[46] This plan was sidelined for a decade when the Director of the DND, Leon Steinig, proposed the creation of an "International Opium Monopoly" in an attempt to end the illicit trade and guarantee wholesale licit opium supply.

Throughout the 1950s, Cold War tensions pushed Anslinger to rebuild the U.S. stockpile of opium and opium derivatives, often by making large purchases from Iran through U.S. pharmaceutical companies. Many European countries were also stockpiling. The multinational pharmaceutical companies in Europe and the U.S. feared that a monopoly like the one proposed by Steinig would lead to restrictions and higher prices. Anslinger and Sharman along with the British, Dutch and French killed the monopoly discussions in the CND. The French representative on the CND, Charles Vaille, suggested a new opium protocol as an interim solution until the treaties could be consolidated. ECOSOC approved a plenipotentiary conference, and Anslinger seized the new protocol initiative as an opportunity to impose strict global controls on opium production.[47]

The Protocol[48] (1953 Opium Protocol), finalized in New York in 1953, Article 2 stated bluntly that Parties were required *to "limit the use of opium exclusively to medical and scientific needs."* Various provisions were included to control the cultivation of the poppy and the production and distribution of opium. Article 6 restricted opium production to seven states, and Parties could only import or export opium produced in one of those countries.[49] The Protocol comprised the most stringent international drug control provisions yet, but it never gained the support Anslinger had hoped for. It did not receive sufficient ratifications to bring it into force until 1963, and by then it had been superseded by the 1961 Single Convention.

THE THREE CURRENT CONVENTIONS

The Single Convention on Narcotic Drugs, 1961

The Single Convention has played a central role in the creation of the modern prohibitionist system of international drug control. It is a continuation and expansion of the legal infrastructure developed between 1909 and 1953.

The work of consolidating the existing international drug control treaties into one instrument began in 1948, but it was 1961 before an acceptable third draft was ready to

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[46] ECOSOC approved the recommendation in two resolutions: 159 II D (VII) of 3 August 1948, and 246 D (IX) of 6 July 1949. See also McAllister (2000), page 172; Bewley-Taylor (1999), page 137.

[47] McAllister (2000), page 172-179.

[48] *Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium*, done 23 June 1953, in force 8 March 1963.

[49] The seven producing countries were Bulgaria, Greece, India, Iran, Turkey, the USSR and Yugoslavia.

be presented for discussion at a plenipotentiary conference.[50] The conference began in New York on 24 January 1961, and was attended by 73 countries, each "with an agenda based on its own domestic priorities."[51]

William B. McAllister has divided the participating states into five distinct categories based on their drug control stance and objectives.

- Organic states group: *As producers of the organic raw materials for most of the global drug supply, these countries had been the traditional focus of international drug control efforts. They were open to socio-cultural drug use, having lived with it for centuries. While India, Turkey, Pakistan and Burma took the lead, the group also included the coca-producing states of Indonesia and the Andean region of South America, the opium- and cannabis-producing countries of South and Southeast Asia, and the cannabis-producing states in the Horn of Africa. They favoured weak controls because existing restrictions on production and export had directly affected large segments of their domestic population and industry. They supported national control efforts based on local conditions and were wary of strong international control bodies under the UN. Although essentially powerless to fight the prohibition philosophy directly, they effectively forced a compromise by working together to dilute the treaty language with exceptions, loopholes and deferrals. They also sought development aid to compensate for losses caused by strict controls.*

- Manufacturing states group: *This group included primarily Western industrialized nations, the key players being the U.S., Britain, Canada, Switzerland, the Netherlands, West Germany and Japan. Having no cultural affinity for organic drug use and being faced with the effects that drug abuse was having on their citizens, they advocated very stringent controls on the production of organic raw materials and on illicit trafficking. As the principal manufacturers of synthetic psychotropics, and backed by a determined industry lobby, they forcefully opposed undue restrictions on medical research or the production and distribution of manufactured drugs. They favoured strong supranational control bodies as long as they continued to exercise* de facto *control over such bodies. Their strategy was essentially to "shift as much of the regulatory burden as possible to the raw-material-producing states while retaining as much of their own freedom as possible."*

- Strict control group: *These were essentially non-producing and non-manufacturing states with no direct economic stake in the drug trade. The key members were France, Sweden, Brazil and Nationalist China. Most of the states in this group were culturally opposed to drug use and suffered from abuse problems. They favoured restricting drug use to medical and scientific purposes and were willing to sacrifice a degree of national sovereignty to ensure the effectiveness of supranational control bodies. They were forced to moderate their demands in order to secure the widest possible agreement.*

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[50] One of the Canadian delegates to the CND, National Health and Welfare official Robert Curran, played the leading role in drafting a document that would be acceptable to all countries as a starting point for negotiations (McAllister (2000), page 205). For an analysis of this third draft, see Leland M. Goodrich, "New Trends in Narcotics Control", *International Conciliation*, No. 530, November 1960.

[51] McAllister (1992), page 148.

- Weak control group: *This group was led by the Soviet Union and often included its allies in Europe, Asia and Africa. They considered drug control a purely internal issue and adamantly opposed any intrusion on national sovereignty, such as independent inspections. With little interest in the drug trade and minimal domestic abuse problems, they refused to give any supranational body excessive power, especially over internal decision-making.*

- Neutral group: *This was a diverse group including most of the African countries, Central America, sub-Andean South America, Luxembourg and the Vatican. They had no strong interest in the issue apart from ensuring their own access to sufficient drug supplies. Some voted with political blocs, others were willing to trade votes, and others were truly neutral and could go either way on the control issue depending on the persuasive power of the arguments presented. In general, they supported compromise with a view to obtaining the broadest possible agreement.*

The result of all these competing interests was a document that epitomized compromise. The Single Convention clearly upheld and expanded existing controls and in its breadth was the most prohibitionist document yet concluded, though it was not as stringent as it might have been. It was free of the costly features of the 1953 Opium Protocol, such as the provision restricting opium production to the seven specified countries. Sharman no longer negotiated for Canada, and Anslinger had played a minor role in the conference owing to conflicts with the U.S. State Department. The latter was content with the Convention because U.S. influence was assured within the UN supervisory bodies and the prohibitive framework had been expanded to include tight controls over coca and cannabis. Since the U.S. originated the idea of the Single Convention, walking out of the conference would have meant losing face in the UN and given the impression of weakness vis-à-vis the Soviet Union during a tense Cold War period.[52]

The principal foundations of the previous treaties remained in place in the Single Convention.[53] Parties were still required to submit estimates of their drug requirements and statistical returns on the production, manufacture, use, consumption, import, export, and stockpiling of drugs.[54] The import certification system created by the 1925

[52] Anslinger was extremely disappointed with the Single Convention because he believed that the opium control provisions were not stringent enough (e.g., Article 25 still allowed any country to produce up to five tons of opium annually, albeit subject to strict controls). He attempted to derail the Convention by lobbying countries to ratify the 1953 Opium Protocol in hopes of obtaining the number of ratifications needed to bring it into force. He failed, and his influence waned after that. (Bewley-Taylor (1999), page 136-161)

[53] Only the 1936 Trafficking Convention was not included in the Single Convention and remained in force separately, because agreement could not be reached on which of its provisions should be included in the Single Convention (McAllister (2000), page 207-208). Article 35 of the Single Convention simply encouraged cooperation between countries to combat illicit trafficking.

[54] Single Convention, Articles 19 and 20.

Geneva Convention was maintained. Parties were required to license all manufacturers, traders and distributors, and all transactions involving drugs had to be documented.[55] The Single Convention built on the trend of requiring Parties to develop increasingly punitive criminal legislation. Subject to their constitutional limitations, Parties were to adopt distinct criminal offences, punishable preferably by imprisonment, for each of the following drug-related activities in contravention of the Convention: cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation.[56] Furthermore, the granting of extradition was described as "desirable."[57]

The Convention assigned substances to one of four schedules based on level of control. Schedules I and IV were the most stringent and covered primarily raw organic materials (opium, coca, cannabis) and their derivatives, such as heroin and cocaine. Schedules II and III were less strict and contained primarily codeine-based synthetic drugs. At the U.S.'s insistence, cannabis was placed under the heaviest control regime in the Convention, Schedule IV. This regime included drugs such as heroin (the WHO considered any medical use of heroin to be "obsolete"). The argument for placing cannabis in this category was that it was widely abused. The WHO later found that cannabis could have medical applications after all, but the structure was already in place and no international action has since been taken to correct this anomaly.

The U.S. was pleased with the Single Convention as it broadened control over cultivation of the opium poppy, coca bush and cannabis plant, though the measures were not as stringent as the ones Anslinger had negotiated in the 1953 Opium Protocol.[58] Articles 23 and 24 of the Convention set up national opium monopolies and put very strict limitations on international trade in opium.

Article 49 of the Convention required Parties to completely eliminate all quasi-medical use of opium,[59] opium smoking, coca leaf chewing, and non-medical cannabis use within 25 years of the coming into force of the Convention. All production or manufacture of these drugs was also to be eradicated within the same period. Only Parties for which such uses were "traditional" could take advantage of delayed implementation; for others, prohibition was immediate. Since the implementation period ended in 1989, these practices are today fully prohibited, and the drugs may be used only for regulated medical and scientific purposes.

Apart from consolidating the previous treaties and expanding control provisions, the Single Convention also streamlined the UN's drug-related supervisory bodies. The PCOB and the DSB were merged in a new body, the International Narcotics Control Board (INCB), responsible for monitoring application of the Convention and

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55 *Ibid.*, Articles 21 and 29-32.
56 *Ibid.*, Article 36.
57 *Ibid.*, Article 36(2).
58 Single Convention, Articles 22-28.
59 The limit was 15 years for the quasi-medical use of opium.

administering the system of estimates and statistical returns submitted annually by Parties.[60] The INCB was to have eleven members, three nominated by the WHO and eight by Parties to the Convention and UN members. The manufacturing lobby's effectiveness in the negotiations was evident in the knowledge requirement for WHO nominees: *"medical, pharmacological or pharmaceutical experience."*[61] The INCB was given a limited power of embargo: it could recommend that Parties stop international drug trade with any Party that failed to comply with the provisions of the Convention.[62]

The Convention's emphasis on prohibition was reflected in the minimal attention paid to drug abuse problems. Only Article 38 touched on the social (demand) side of the drug problem by requiring Parties to *"give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts."* Furthermore, it was considered "desirable" that Parties "establish adequate facilities for the effective treatment of drug addicts," but only if the country had *"a serious problem of drug addiction and its economic resources [would] permit."* The inadequate recognition of demand/harm reduction approaches, such as prevention through education, has been one of the key criticisms of both the Single Convention and international drug control treaties in general.[63]

The Single Convention effectively consolidated several decades' worth of assorted drug control machinery into one key document administered by one principal body, the United Nations.

Convention on Psychotropic Substances

In the 1960s, following the signing of the Single Convention, drug use and abuse exploded around the world, especially in developed Western nations.[64] The increase was particularly evident in the pervasive use and availability of synthetic psychotropic substances developed since the Second World War, such as amphetamines, barbiturates and LSD. Most of these drugs were not subject to international control, and because national systems of regulation differed widely, trafficking and smuggling flourished.[65]

Throughout the 1960s, the CND and the WHO debated the issue of control of psychotropic drugs at regular meetings and made various recommendations to member

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[60] Single Convention, Articles 5 and 9-16.

[61] *Ibid.*, Article 9(1)(a).

[62] *Ibid.*, Article 14(2).

[63] See, for example, *Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961*, Toronto, Addiction Research Foundation, 1983, page 10-11; recommendations 4, 5, 15, 19 and 20.

[64] See, for example, Vladimir Kuševic, (1977) "Drug Abuse Control and International Treaties", *Journal of Drug Issues*, Vol. 7, No. 1, page 35-53. See also McAllister (2000), page 218-220; Musto (1999), ch. 11; McAllister (1992), page 153-162; Bruun *et al.* (1975), ch. 16; Inglis (1975), ch. 13.

[65] The U.S. attempted to regulate psychotropic substances through the Bureau of Drug Abuse Control, established under the *Drug Abuse Control Act of 1965*. This statute also shifted the constitutional basis for drug control from the taxing power to interstate and commerce powers, a change that led to the demise of Anslinger's Federal Bureau of Narcotics and the birth of the Bureau of Narcotics and Dangerous Drugs (BNDD) under the federal Department of Justice. (Musto (1999), page 239-240)

states concerning the national control of particular substances, including stimulants, sedatives and LSD. In January 1970, the CND discussed a draft treaty prepared by the UN Division of Narcotic Drugs on the international control of psychotropic drugs. Following some modifications by the CND, this document became the basis for negotiations at a plenipotentiary conference convened in Vienna on 11 July 1971; this conference produced the Psychotropics Convention.[66]

The 1961 Single Convention had been used as a template for the draft Psychotropics Convention, and many of the former's features are found in the latter: CND/INCB administrative authority, schedules establishing different levels of control for different drugs, mandatory transaction documentation and licensing, an import/export control system, illicit trafficking provisions and criminal sanctions. Though superficially quite similar, the two Conventions are in fact extremely different. The Psychotropics Convention imposes much weaker controls. The reason for this becomes apparent when the positions of the negotiating stakeholders are examined and selected parts of the two treaties are carefully compared.[67] The overwhelming influence of the multinational pharmaceutical industry on the Psychotropics Convention was particularly obvious.[68]

In contrast to the five negotiating groups identified by McAllister for the Single Convention, there were only two distinct blocs with conflicting positions at the Vienna conference. One group included mostly developed nations with powerful pharmaceutical industries and active psychotropics markets; this was essentially the "manufacturing group." The other group consisted of developing states, supported by the socialist countries, with few psychotropic manufacturing facilities; this was to a large extent the "organic group." At the 1971 negotiations, however, the positions of the two groups were *completely reversed*. The manufacturing group adopted the traditional arguments of the organic group: weak controls, national as opposed to international controls, and national sovereignty taking precedence over any supranational UN body. The rationale for these positions was that strict controls would be difficult to enforce and would cause financial loss. The organic group, on the other hand, pushed hard for strict controls similar to those it had been forced to accept in the Single Convention.[69]

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[66] Kuševic (1975), page 38.

[67] McAllister (1992), page 154-162; Kuševic (1975), page 38-41. McAllister's comparison is highly detailed, and well worth reading; Kuševic provides useful background and commentary. See also S.K. Chatterjee (1988) *A Guide to the International Drugs Conventions*, London: Commonwealth Secretariat, page 15-33, for a more technical, lower-level comparison of the two Conventions.

[68] The lead author of the preliminary draft, Arthur Lande, had ended his career at the UN shortly before the Vienna conference. He attended the conference as representative of the U.S. Pharmaceutical Manufacturer's Association, one of many industry observers. Another example of the industry's blatant influence involved a group of six small Latin American countries. They uncharacteristically supported weakening the treaty and were all represented by a Swiss national who was not fluent in Spanish and was not a government official, a diplomat or a narcotics expert. He worked for the European pharmaceutical giant Hoffmann-LaRoche. (McAllister (2000), page 232; Kuševic (1975), page 39)

[69] McAllister (1992), page 154; Kuševic (1975), page 39.

A comparison of the Preambles of the two Conventions is revealing. Although the Preamble is not legally binding, it encapsulates the spirit of the instrument. In the Single Convention, addiction is described as *"a serious evil for the individual … fraught with social and economic danger to mankind."* It is recognized, however, that *"the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes."* By contrast, the Psychotropics Convention makes no mention of the "serious evil" of "addiction," but rather notes *"with concern the public health and social problems resulting from the abuse of certain psychotropic substances."* As well, it is recognized that *"the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should not be unduly restricted."* The overall tone of the Psychotropics Convention Preamble is less harsh, and it implies that *"abuse of certain," not all, psychotropics, is not as serious a problem as "addiction to narcotic drugs"* in general.

The approach to categorizing drugs by means of schedules with varying levels of control also differed between the two Conventions. In the 1961 Single Convention negotiations, when the placement of a drug in a particular schedule was disputed, the drug almost always ended up in a schedule not favoured by the organic group – for example, the placement of cannabis in Schedule IV. The manufacturing group's insistence on this classification method was based on the idea that narcotic drugs should be considered hazardous until proven otherwise. This reasoning did not apply, however, when U.S. economic interests were at stake. In 1971, the U.S. delegation argued forcefully and often successfully that organic raw materials should be assigned to the strictest schedules, while their manufactured derivatives should be placed in the weaker schedules.

The Psychotropics Convention also contains four schedules of control, but they are substantially different in nature and organization from those of the Single Convention. For example, the most stringent schedule in the Single Convention is Schedule IV,[70] which is equivalent to Schedule I[71] in the Psychotropics Convention. In both cases, the drugs included may be used only by authorized persons in government-operated medical or scientific institutions, and their manufacture, import and export are strictly controlled. The weakest schedule in the Psychotropics Convention is Schedule IV, which contains tranquilizers. Some manufacturing states tried to eliminate Schedule IV by arguing that such drugs were sufficiently regulated by national controls and that international control was therefore unnecessary. In the end, Schedule IV was retained, albeit with a much shorter list of drugs. However, the principle on which drugs were classified was completely reversed, in particular by the U.S.: *"unless there was substantial proof that a substance was harmful, it should remain uncontrolled."*[72]

[70] Which includes cannabis and heroin, for example.
[71] Which includes hallucinogens, such as LSD.
[72] McAllister (1992), page 158.

Another key difference between the two Conventions is revealed by a close comparison of the schedules. Previous treaties, including the Single Convention, not only covered the base substances but also extended control to include their salts, esters, ethers and isomers, i.e., their derivatives. In contrast, derivatives were *completely absent* from the schedules of the Psychotropics Convention. As a result, every substance to be covered under the treaty regime must be specified by name. In practical terms, that is impossible because new derivatives are constantly being produced, and they comprise 95 per cent of the substances developed by pharmaceutical firms. If a general reference to derivatives had been included, new substances would have been covered automatically. This omission was apparently the result of a deal made between political representatives when the technical experts were not present; the derivatives had to be sacrificed in order to get the manufacturing states to sign the treaty.[73]

The system of estimates set out in Article 19 of the Single Convention requires Parties to report annually to the INCB how much of each controlled substance they will need for the next year. This system is one of the pillars of the international drug control regime and dates back to the second Geneva conference, which led to the 1925 International Opium Convention. It was *completely excluded* from the Psychotropics Convention. As McAllister has pointed out, *"[t]his omission was clearly in the interests of the manufacturing states, because without estimates of need it is impossible to calculate whether more of a substance than can legitimately be put to use is being fabricated."*[74] This allowed multinationals to manufacture unlimited quantities of psychotropic substances without being constrained by annual production limits based on licit need.

These omissions–derivatives and estimates–were largely corrected during the 1970s and 1980s through quiet recourse to customary international law by the DND and the INCB. The latter asked Parties to submit psychotropics information and statistics not required by the Convention. The initial positive responses from various organic group states were then used to persuade others to follow suit. Similarly, the CND and the WHO simply announced that derivatives would be included in the schedules. Some governments complied and others were eventually forced by international pressure to do likewise.

Article 3 of the Single Convention gives the WHO the key role in determining whether, on the basis of a medical or scientific analysis, a new drug should be added to a schedule and thus placed under international control. The WHO's recommendation is submitted to the CND, which makes the final decision. However, any Party may appeal the CND's decision to ECOSOC within 90 days. ECOSOC's decision is final. While a decision is being appealed, the CND may still require Parties to place control measures on the substance in question.

Under the Psychotropics Convention, the WHO continues to make recommendations based on medical and scientific criteria. However, Article 2(5)

[73] McAllister (2000), page 233.
[74] McAllister (1992), page 157.

explicitly directs the CND to bear in mind *"the economic, social, legal, administrative and other factors it may consider relevant"* in coming to its decision. Furthermore, Article 17(2) states that the CND's decision is subject to approval by a two-thirds majority of CND members.[75] The CND's decision may still be appealed to ECOSOC, and Parties have up to 180 days to do so. In addition, ECOSOC's decision is not necessarily final; there is the possibility of continual appeals. Lastly, while a decision is being appealed, Article 2(7) allows a Party to take "exceptional action" and exempt itself from certain control measures ordered by the CND pending the outcome of the appeal. The cumulative effect of all of these additions to the Psychotropics Convention is that it can be much harder for the WHO to bring a new psychotropic drug within the control system than to add a new narcotic drug to the Single Convention.

The criteria for placing a new drug under control also differ between the two Conventions. According to Article 3 of the Single Convention, a narcotic drug will come within the control regime if it is *"liable to similar abuse and productive of similar ill effects as the drugs"* in the relevant schedule. The prerequisites under Article 2(4) of the Psychotropics Convention are significantly more stringent. The WHO must find:

> *(a) that the substance has the capacity to produce*
> *(i) (1) a state of dependence, and*
> *(2) central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood, or*
> *(ii) similar abuse and similar ill effects as a substance in Schedule I, II, III or IV, and*
> *that there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control.*

Taking the lead for the manufacturing group on this point, the U.S. and Britain were the most adamant about including such highly restrictive criteria.[76]

The Psychotropics Convention is far ahead of the Single Convention's superficial attempt to address the demand side of drug problems (Article 38 described above). Article 20 of the 1971 treaty is a milestone in that it introduced the concepts of public education and abuse prevention into the legal infrastructure of international drug control. In particular, it enjoins Parties to *"take all practical measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, and [to] coordinate their efforts to these ends."* Parties are also required to promote "as far as possible" the training of personnel to carry out these tasks and encouraged to further the study and public awareness of etiological issues related to abuse. Although these provisions leave plenty of room for countries to avoid taking measures, they are a definite improvement over the Single Convention.

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[75] The U.S. tried to increase it to a three-quarters majority. (McAllister, 2000, page 161)
[76] *Ibid.*, page 159.

The penal provisions in Article 22 of the Psychotropics Convention allow states to use treatment, education, after-care, rehabilitation and social reintegration instead of just conviction or punishment in dealing with abusers who commit offences under the Convention. While the acknowledgement of treatment and rehabilitation is an improvement over previous strictly penal provisions, such measures are intended as a supplement to imprisonment rather than as an alternative.[77]

On the whole, the 1971 negotiations resulted in a treaty that was significantly weaker than the Single Convention. Furthermore, any possibility of revisiting the provisions of the Psychotropics Convention was not realistic in the early 1970s, as a new chapter in the U.S. "war on drugs" was beginning.[78]

Protocol amending the Single Convention on Narcotic Drugs, 1961

In the early 1970s, U.S. President Richard Nixon officially declared "war on drugs" in response to the massive drug abuse in the U.S. and the social damage it was causing. This announcement had global repercussions.[79]

In 1971, as part of the Nixon administration's international anti-narcotics campaign, U.S. officials suggested creating a government-funded, UN-administered fund to combat drug abuse.[80] The United Nations Fund for Drug Abuse Control (UNFDAC) was launched in 1971 with an initial $2 million donation from the U.S. Other governments were reluctant to contribute because of the motives behind the Fund. This reluctance was well founded as UNFDAC essentially became a U.S. tool.

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[77] United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, page 353-354.

[78] The U.S. war on drugs is considered to have begun with the enactment of a federal drug control law known as the *Harrison Narcotics Act of 1914*, and has continued ever since at varying levels of intensity. The most recent supporters of the war on drugs include President Nixon in the late 1960s and early 1970s, President Ronald Reagan in the 1980s, President George Bush in the late 1980s and early 1990s, President Bill Clinton in the 1990s and now President George W. Bush. A great deal has been written about the war on drugs. See, for example, Steven R. Belenko, ed., *Drugs and Drug Policy in America: A Documentary History*, Westport, Connecticut: Greenwood Press, 2000; H. Richard Friman, *NarcoDiplomacy: Exporting the U.S. War on Drugs*, Ithaca, New York: Cornell University Press, 1996; James A. Inciardi, *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy*, Palo Alto, California: Mayfield Publishing Company, 1986; Kenneth J. Meier, *The Politics of Sin: Drugs, Alcohol and Public Policy*, Armonk, New York: M.E. Sharpe, 1994; Musto (1999); William O. Walker III, *Drug Control in the Americas*, revised edition, Albuquerque, New Mexico: University of New Mexico Press, 1989; Steven Wisotsky, *Beyond the War on Drugs: Overcoming a Failed Public Policy*, Buffalo, New York: Prometheus Books, 1990.

[79] Musto (1999), page 248-259; Bruun *et al.* (1975), ch. 10.

[80] The U.S. campaign included massive international funding for crop substitution, technical assistance to improve the administration and law enforcement, initiatives to combat smuggling, and coordination of educational programs. However, many developing countries were wary of U.S. money with strings attached. The Americans saw the Fund as a way to get around that reluctance. (McAllister (2000), page 236-237)

The emphasis was on law enforcement and crop substitution rather than abuse and demand-oriented strategies. Money went primarily to projects that involved U.S. allies and focused on countries where the U.S. had been unable to stop opium production.[81]

The Fund was also sharply criticized for succumbing to the inefficiency of the UN's bureaucratic machinery: *"A large proportion of the money allocated to the Fund's various programs is in fact spent on supporting an ever-expanding bureaucracy to administer the programs. Indeed many of the Programs appear to serve no purpose other than to provide occupation for the enlarged secretariats."*[82] It was also argued that the UNFDAC should be transferred from the drug control bodies under ECOSOC to the United Nations Development Program, which was better able to assess the development and aid needs of recipient countries.[83]

Another key initiative of the Nixon administration was to strengthen the Single Convention. As a result of heavy U.S. lobbying, a UN plenipotentiary conference was convened in March 1972 to amend the Convention.[84] What came out of the conference was the Single Convention Protocol. The main goal of the amendments was to expand the INCB's role in controlling licit and illicit opium production and illicit drug trafficking in general. The U.S. wanted to revive certain aspects of the 1953 Opium Protocol by attempting to reduce licit opium production. However, in 1972, licit production was just meeting licit demand, and few countries were willing to risk a global shortage of opium for medical use.[85] Consequently, the U.S. proposals were significantly diluted.

The backbone of the Single Convention Protocol consists of provisions that enhance the INCB's powers, especially in relation to illicit trafficking. In Article 2 of the Single Convention, the definition of the INCB's functions now includes an explicit reference to the prevention of *"illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs."* Article 35 encourages Parties to supply the INCB and the CND with information on the illicit drug activity in their territory; as well, the INCB is empowered to advise Parties on their efforts to reduce illicit drug trafficking. When Parties conclude extradition treaties with one another, such agreements are now deemed to automatically include the drug-related offences set out in the Single Convention, including trafficking.[86] Article 22(2) of the Psychotropics Convention says only that it is "desirable" that such offences be made extraditable.

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[81] *Ibid.*, page 238.

[82] Bruun *et al.* (1975), page 281.

[83] *Ibid.*, page 282; Kuševic (1975), page 51.

[84] U.S. ambassadors were selected specifically for the purpose of visiting signatory countries to persuade their leaders to support the amendments proposed by the U.S. It is widely believed that the conference was largely an instrument that Nixon planned to use in the approaching presidential election. (Kuševic (1975), page 47)

[85] Kuševic (1975), page 48. According to Kuševic, it would have been better to try to reduce the *diversion* of licit demand into the illicit market.

[86] Single Convention, Article 36, as amended by the Single Convention Protocol, Article 14.

The Protocol amended the Single Convention's abuse prevention provisions to bring them into line with Article 20 of the Psychotropics Convention.[87] The amended Single Convention also echoes the Psychotropics Convention by now allowing countries to use *"treatment, education, after-care, rehabilitation and social reintegration"* either as an alternative to or in addition to conviction or punishment.[88]

Although not as stringent as originally intended by the U.S., the Single Convention Protocol continued the prohibitive tradition of the international drug control regime, especially against opium, and stepped up the war on illicit trafficking.

Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

Numerous national and regional drug control initiatives were launched in the 1970s and 1980s.[89] In Europe, the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, also known as the "Pompidou Group," was created to facilitate discussions between countries. In addition, the Heads of National Law Enforcement Agencies (HONLEA) met regionally - in Asia and the Pacific in the 1970s, and in Africa, Latin America and Europe in the 1980s - to improve police and customs drug enforcement cooperation. INTERPOL expanded its operations and became "an important clearinghouse for information and a sponsor of local, regional, and global drug enforcement meetings."[90]

Meanwhile, concerns arose within the UN and among its main control-oriented members that the anti-trafficking efforts of the international drug control system were being compromised by the fact that certain nations were not Parties to the Conventions or did not have domestic law enforcement systems capable of properly combating illicit trafficking.[91] In 1984, the UN General Assembly adopted resolution 39/141, which called on ECOSOC to instruct the CND to prepare "as a matter of priority" a draft convention considering *"the various aspects of the problem [of illicit drug trafficking] as a whole and, in particular, those not envisaged in existing international instruments."* Thus, the goal was to add an additional, trafficking-specific layer to the drug control system to complement the two existing Conventions.

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87 *Ibid.*, Article 38, as amended by the Single Convention Protocol, Article 15.

88 *Ibid.*, Article 36, as amended by the Single Convention Protocol, Article 14.

89 In the U.S., the war on drugs lost some momentum in the 1970s during the administrations of Presidents Gerald Ford and Jimmy Carter. Eleven U.S. states decriminalized certain aspects of marijuana regulation and were supported by well-known organizations such as the American Medical Association, the American Bar Association, the American Public Health Association and the National Council of Churches. President Ronald Reagan reversed this trend in the early 1980s. (Wisotsky (1990), page xviii)

90 McAllister (2000), page 242-243.

91 Bewley-Taylor (1999), page 167; David P. Stewart, "Internationalizing the War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances," *Denver Journal of International Law and Policy*, Vol. 18, No. 3, Spring 1990, page 387-404.

The draft treaty was finalized at the 1987 UN Conference on Drug Abuse and Illicit Trafficking. Also at this Conference, a Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control[92] (CMO) was adopted to encourage states to fulfil their existing treaty obligations. The CMO focused on four areas: (1) prevention and reduction of illicit demand; (2) control of supply; (3) suppression of illicit trafficking; and (4) treatment and rehabilitation. Many of the objectives described in the CMO were reflected in the draft treaty. Between 25 November and 20 December 1988, representatives of 106 states met in Vienna to negotiate a final text. The result was the Trafficking Convention.

The Trafficking Convention is essentially an instrument of international criminal law. Its aim is to harmonize criminal legislation and enforcement activities worldwide with a view to curbing illicit drug trafficking through criminalization and punishment. Under the Convention, Parties are required to enact and implement very specific criminal laws aimed at suppressing illicit trafficking. These laws relate to such aspects of the problem as money laundering, confiscation of assets, extradition, mutual legal assistance, illicit cultivation, and trade in chemicals, materials and equipment used in the manufacture of controlled substances. As with the other two Conventions, the CND and the INCB are charged with administration of the Convention. Furthermore, for minor offences, the Trafficking Convention allows demand-side measures to be used as an alternative to conviction or punishment.[93]

The Preamble describes illicit trafficking as *"an international criminal activity"* and points out the *"links between illicit traffic and other related organized criminal activities which undermine the legitimate economies and threaten the stability, security and sovereignty of States."* It also stresses *"the importance of strengthening and enhancing effective legal means for international co-operation in criminal matters for suppressing the international criminal activities of illicit traffic."* Even the single reference in the Preamble to demand-side issues is couched in terms specific to criminal law: *"Desiring to eliminate the root causes of the problem of abuse of narcotic drugs and psychotropic substances, including the* ***illicit demand*** *for such drugs and substances and the enormous profits derived from illicit traffic"* (emphasis added). The implication is that drug users also are to be considered criminals. The Preamble clearly reflects its prohibitionist roots, even explicitly reaffirming *"the guiding principles of existing treaties in the field of narcotic drugs and psychotropic substances and the system of control which they embody."*

Accordingly, the cornerstone of the Trafficking Convention is Article 3: "Offences and Sanctions." Here the treaty breaks new ground by *requiring* that Parties "legislate as necessary to establish a modern code of criminal offences relating to the

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[92] *Declaration of the Conference on Drug Abuse and Illicit Trafficking, and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control*, UN document ST/NAR/14, 1988.

[93] For a detailed description of the provisions of the Trafficking Convention, see William Gilmore, *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, London: Commonwealth Secretariat, 1991; Stewart (1990). Since Stewart was a member of the U.S. delegation that took part in the negotiations, his article presents the U.S. perspective on the treaty.

various aspects of illicit trafficking and to ensure that such illicit activities are dealt with as serious offences by each State's judiciary and prosecutorial authorities."[94] The mandatory offences, set out in Article 3(1), include the following:

- The production, manufacture, distribution or sale of any narcotic drug or psychotropic substance in violation of the provisions of the Single Convention or the Psychotropics Convention;
- The cultivation of the opium poppy, coca bush or cannabis plant in violation of the above Conventions;
- The possession or purchase of any narcotic drug or psychotropic substance for the purpose of illicit trafficking;
- The manufacture, transport or distribution of materials, equipment and substances for the purpose of illicit cultivation, production or manufacture of narcotic drugs or psychotropic substances;
- The organization, management or financing of any of the above offences.[95]

Furthermore, Article 3(2) of the Trafficking Convention requires each Party, subject to its constitutional principles and the fundamental principles of its legal system, to establish criminal offences for the possession, purchase or cultivation of drugs for personal consumption.

SOME LEEWAY?

Three points bear making concerning the substance of the current conventions.

The first has to do with the absence of definitions. The terms drugs, narcotics and psychotropics are not defined in any way except as lists of products included in schedules. It follows that any natural or synthetic substance on the list of narcotics is, for the purposes of international law, a narcotic, and that a psychotropic is defined in international law by its inclusion in the list of psychotropics.[96] The only thing that the 1961 Convention tells us about the substances to which it applies is that they can be abused. The 1971 Psychotropics Convention, which, as noted earlier, reversed the roles in that the synthetic drug producing countries wanted narrower criteria, indicates that the substances concerned may cause dependence or central nervous system stimulation or depression and may give rise to such abuse as to *"constitute a public health problem or a social problem that warrants international control."*

The second point, following from the first, relates to the arbitrary nature of the classifications. While cannabis is included, along with heroin and cocaine, in Schedules

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[94] United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, page 48.

[95] See Stewart (1990), page 392; Gilmore (1991), page 5.

[96] Caballero and Bisiou, *op. cit.*, page 26.

I and IV of the 1961 Convention, which carry the most stringent controls, it is not even mentioned by name in the 1971 Convention, though THC is listed as a Schedule I psychotropic along with mescaline, LSD and so on. The only apparent criterion is medical and scientific use, which explains why barbiturates are in Schedule III of the 1971 Convention and therefore subject to less stringent controls than natural hallucinogens. These classifications are not just arbitrary, but also inconsistent with the substances' pharmacological classifications and their danger to society.

Third, if there was so much concern about public health based on how dangerous "drugs" are, one has to wonder why tobacco and alcohol are not on the list of controlled substances.

We conclude from these observations that the international regime for the control of psychoactive substances, beyond any moral or even racist roots it may initially have had, **is first and foremost a system that reflects the geopolitics of North-South relations in the 20th century**. Indeed, the strictest controls were placed on organic substances - the coca bush, the poppy and the cannabis plant - which are often part of the ancestral traditions of the countries where these plants originate, whereas the North's cultural products, tobacco and alcohol, were ignored and the synthetic substances produced by the North's pharmaceutical industry were subject to regulation rather than prohibition. It is in this context that the demand made by Mexico, on behalf of a group of Latin American countries, during the negotiations leading up to the 1988 Convention, that their use be banned must be understood. It was a demand that restored the balance to a degree, as the countries of the South had been forced to bear the full brunt of the controls and their effects on **their own** people since the inception of drug prohibition. The result may be unfortunate, since it reinforces a prohibitionist regime that history has shown to be a failure, but it may have been the only way, given the mood of the major Western powers, to demonstrate the irrationality of the entire system in the longer term. In any case, it is a short step from there to questioning the legitimacy of instruments that help to maintain the North-South disparity yet fail miserably to reduce drug supply and demand.

Putting aside such questions of substance, we will now examine how much leeway countries have within the current conventions to adopt less prohibitionist policies.

Several states have adjusted their criminal enforcement systems to allow *de facto* possession of small amounts of certain soft drugs, such as cannabis and its derivatives, for personal consumption while remaining within the legal bounds of the Conventions.[97] Although the Conventions do not permit legalization or even decriminalization of possession, those countries have circumvented the limitations by criminalizing possession, as required by the treaties, but not strictly enforcing the

[97] For example, Belgium, Denmark, Germany, the Netherlands, Poland and some Australian states. Switzerland is currently considering a bill to legalize cannabis. The next chapter provides more detail on the Australian, Dutch and Swiss approaches in particular.

legislation, or they have effectively "depenalized" the offences by exempting them from punishment.[98]

According to some observers, such approaches clearly violate the spirit of the Conventions, especially the Trafficking Convention, which seems to use the term "trafficking" very broadly to include demand-side activities within a supply-oriented control regime. Yet there is a legal basis for these "softer" approaches because the treaties do not explicitly forbid them.

The hard-nosed criminal law approach adopted by the international drug control system has drawn criticism from human rights activists. Some maintain that the imprisonment penalties are excessive for soft-drug offences such as possession of a small amount of cannabis for personal consumption.[99] It is argued that imprisonment in such circumstances is disproportionate to the offence and therefore violates the inherent dignity of persons, the right to be free from cruel and degrading punishment, and the right to liberty, as set out in such instruments as the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights*, and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*[100] It has also been argued that drug use is a human right and should be recognized as such in the *Universal Declaration of Human Rights*.[101]

The Trafficking Convention is the only one of the three Conventions that mentions human rights. Article 14(2) of the Trafficking Convention explicitly requires Parties "to respect fundamental human rights" when they take measures to prevent and eradicate the illicit cultivation of plants containing narcotic or psychotropic substances, such as opium, cannabis and coca. The same provision also requires states to take into account traditional licit uses, where there is historical evidence of such use, and protection of the environment.

There are three factors that provide states, including Canada, with some leeway. The first is the fact that the conventions recognize the primacy of national legal systems. Indeed, the international drug agreements have no direct application in

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98 See Krzysztof Krajewski, "How flexible are the United Nations drug conventions?" *International Journal of Drug Policy*, No. 10, 1999, page 329-338. Krajewski provides an excellent overview of the conventions' legal limits in the area of legalization and prohibition. He concludes that legalization or decriminalization would probably require amendment of Article 3(2) of the Trafficking Convention. See also the discussion on legalization in Dupras (1998), page 24-33; and Alfons Noll, "Drug abuse and penal provisions of the international drug control treaties," *Bulletin on Narcotics*, Vol. XXIX, No. 4, October/December 1977, page 41-57.

99 See, for example, the following pages on the Web site of Human Rights Watch, a human rights non-governmental organization: http://www.hrw.org/campaigns/drugs/ and http://www.hrw.org/worldreport99/special/drugs.html.

100 The full text of these international instruments is available on the Web site of the Office of the UN High Commissioner for Human Rights: http://www.unhchr.ch/html/intlinst.htm.

101 See Erik Van Ree, "Drugs as a Human Right," *International Journal of Drug Policy*, Vol. 10, 1999, page 89-98. Van Ree proposes the addition of a new Article 31 to the *Universal Declaration of Human Rights*: Everyone has the right to use psychotropic substances of one's own choice.

national law. To make them enforceable within its territory, the state must enact a law; in Canada, that law is the *Controlled Drugs and Substances Act.* Specifically, the conventions variously state that the proposed penalties are to be imposed "subject to [the Parties'] constitutional provisions" or "*having due regard to their constitutional, legal and administrative systems.*" In Canada, the provisions of the *Canadian Charter of Rights and Freedoms* and the interpretations given to them by the Supreme Court are the framework for interpreting the international conventions on drugs.

The second, slightly more technical point suggests that sanctions for possession apply only to possession for the purposes of trafficking, especially in view of this provision's position between two articles on trafficking and of its earlier wording.[102] Failing to punish people for possession for personal use would not be, strictly speaking, prohibited. That is the legal opinion of an expert asked by Switzerland's Federal Office of Public Health to comment on its draft legislation to legalize cannabis: [Translation] "*The statute's general depenalization of the consumption and small-scale cultivation of cannabis would be compatible with the conventions.*"[103] With regard to cannabis trade and supply, the author writes: [Translation] "*Even though regulating cannabis trade with a licensing system does not appear to be out of the question, some practical problems remain, partly because of the control mechanisms required by the 1961 Convention, and partly because the international community interprets the 1988 Convention as an obligation to punish the buying and selling of cannabis.*"[104]

The third factor is that the conventions impose moral obligations on states and not legal obligations, much less penalties or sanctions for violating them, and that they also include review or amendment mechanisms.

CONCLUSIONS

As we have seen in Chapters 5, 6 and 7, cannabis is widely used in every part of the world, does not have the harmful effects ascribed to it, and poses little risk to public health. Consequently, it in no way deserves to be included in the convention schedules that list what are supposed to be the most dangerous drugs. Cannabis even has therapeutic uses recognized by Canadian courts. For the above reasons, **we recommend that Canada notify the international community of its intent to seek**

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[102] See Daniel Dupras (1998) *Canada's International Obligations under the Leading International Conventions on the Control of Narcotic Drugs.* Ottawa: Library of Parliament, available on the Committee's Web site at www.parl.gc.ca/illegal-drugs.asp .

[103] Peith, M., (2001) "Compatibilité de différents modèles de dépénalisation partielle du cannabis avec les conventions internationales sur les stupéfiants" [Compatibility of various models of partial depenalization of cannabis with international narcotics conventions]. Legal opinion requested by the Federal Office of Public Health of the Swiss Confederation, page 14.

[104] *Ibid.*, page 15.

the declassification of cannabis as part of a public health approach that would include stringent monitoring and evaluation.

Conclusions of Chapter 19	
	➢ **The series of international agreements concluded since 1912 have failed to achieve their ostensible aim of reducing the supply of drugs.** ➢ **The international conventions constitute a two-tier system that regulates the synthetic substances produced by the North and prohibits the organic substances produced by the South, while ignoring the real danger which those substances represent to public health.** ➢ **When cannabis was included in the international conventions in 1925, there was no knowledge of its effects.** ➢ **The international classifications of drugs are arbitrary and do not reflect the level of danger those substances represent to health or to society.** ➢ **Canada should inform the international community of the conclusions of our report and officially request the declassification of cannabis and its derivatives.**

CHAPTER 20

PUBLIC POLICIES IN OTHER COUNTRIES

As just seen, the international conventions provide the framework for the criminal policy approaches the signatory states may adopt. We have also seen that interpretations vary as to the nature of the obligations they create, specifically with regard to use, and thus possession, for personal purposes. Some interpretations go so far as to suggest that, with regard to cannabis, certain forms of regulation of production could be possible, without violating the provisions of the conventions, as long as the State took the necessary steps to penalize illegal trafficking.

The vast majority of Canadians have heard about the "war on drugs" which the USA is conducting and about its prohibitionist approach, but many would be surprised to see the major variations between states, indeed between cities, within that country. Even fewer know that Sweden enforces a prohibitionist policy at least as strict as that of the US, but through other means. Many of us have, in one way or another, heard about the "liberal" approach introduced in the Netherlands in 1976. Fewer people know of the Spanish, Italian, Luxembourg or Swiss approaches, which are even more liberal in certain respects. More recently, Canadians learned of the decision by the UK's Minister of the Interior to reclassify cannabis as a Class C drugs, but it is not clear that we know precisely what that means. In view of the preconceptions that many may have in relation to France with regard to wine, many may be surprised to learn that its policy on cannabis appears more "conservative" than that of neighbouring Belgium, for example.

As may be seen, once the overall framework of the puzzle has been established by the international community, ways of putting the pieces together vary widely between states, and at times among the regions of a single state. That is why, in order to learn about the experience and approaches of other countries, the Committee commissioned a number of research reports on the situations in other countries[1] and heard representatives of some of those countries in person.[2]

We of course had to make some choices, limiting ourselves to the western countries of the northern hemisphere. This is a weak point, we agree, but our resources

[1] Those reports, prepared by the Parliamentary Research Branch staff, concern Australia, the United States, France, the Netherlands, the United Kingdom, Sweden and Switzerland. Exact references appear in Appendix B.

[2] We heard representatives of the United States, France, the Netherlands and Switzerland.

were limited. In addition, as we wanted to compare public policies with data on use trends and judicial practices, we were forced to choose countries with an information base. In our hearings of representatives of those countries, we were mainly limited by time.

In this chapter, we describe the situations in five European countries – France, the Netherlands, the United Kingdom, Sweden and Switzerland – and in Australia and the United States.

FRANCE[3]

Different forms of logic

The new direction taken by the Law of 1970,[4] currently in effect, which penalizes drug use, is, in some respects, more apparent than real. Internal public policy had begun to change in the late nineteenth century, leading to the adoption of the great law on narcotics in 1916, providing criminal penalties for importing, trafficking, possession and use. That legislation, which was particularly strictly enforced for the time (up to three years in prison for narcotics offences) introduced the offence of "use in society". Its passage had been preceded by an intensive "public health campaign" in which narcotics were [translation] "*accused by their detractors of being the root of most of society's ills, that is to say of comprehensively promoting depopulation, moral decadence and, even worse, violent and criminal acts*".[5]

That law was supplemented by the Law of 1922 and the Executive Order of 1939, which stepped up and reinforced its prescriptions. The Law of 1922 required judges to order out of the country persons convicted of trafficking or facilitating use, while the Executive Order increased prison terms to five years. The Law of 1922 also authorized the police to enter homes without prior legal authorization. In Charras' view, "*these various provisions made the French legislation one of the most draconian in Europe.*"[6]

The "therapeutic injunction", another factor causing tension in the 1970 legislation, is in some instances considered the very core of France's drug legislation. Under that provision, [translation] "*an obligation of care may be imposed on every drug user at three points in the penal process:*

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[3] In this section, we have drawn on a study report prepared by the Library of Parliament: C. Collin, *National Drug Policy: France,* Ottawa: Library of Parliament, 2001, report prepared for the Senate Special Committee on Illegal Drugs.

[4] Law No. 70-1320 of December 31, 1970, respecting health measures in the fight against substance abuse and repression of the trafficking in and use of poisonous substances.

[5] I. Charras, "L'État et les 'stupéfiants'" : archéologie d'une politique publique répressive", in *Drogue. Du bon usage des politiques publiques.* Les cahiers de la sécurité intérieure, page 13.

[6] I. Charras, *op. cit.*, pages 15-16.

- *upon entry into the judicial process, the prosecution may propose an alternative to trial;*
- *during trial, the trial judge or juvenile court judge may impose medical supervision;*
- *at sentencing, the court may impose a health measure either because the user has previously refused it or, on the contrary, to extend it if it commenced under the previous article.*" [7]

Characterized as a [translation] "*humanist counterweight to a repressive policy*",[8] the therapeutic injunction has often been considered by various French observers as an awkward compromise between police powers on the one hand and medical powers on the other.[9]

However, in characterizing the French system as falling between repressing the user as an "offender" and treating him as a "patient", there is a risk of disregarding another aspect of the French approach to drugs at least until the 1970s: the country's foreign policy and the logic of its tax system.

> [Translation] "*The prohibition against drugs is a recent phenomenon. Unlike China, which, since the eighteenth century, has sought to prohibit the use of opium, European countries did not discuss prohibition until the twentieth century. Furthermore, prohibition did not actually become effective until after the 1950s, and there has been no real desire to provide medical care to users until the past 20 years. Before being prohibited or prescribed, narcotic use was taxed through opium and cannabis tax monopolies.*" [10]

Bisiou identifies five known monopolies in the history of colonial France: India from 1864 to 1954, Indochina from 1864 until 1975, in Laos; Oceania from 1877 to 1922 and two cannabis monopolies operated concurrently with tobacco monopolies, one in Tunisia between 1881 and 1954 and the other in Morocco between 1914 and 1952. Another monopoly, the existence of which has not been confirmed, purportedly existed in Lebanon.[11]

These monopolies offered various advantages from a tax and policy standpoint. For tax purposes, they generated significant cash flows, making it possible to finance colonization; from a policy perspective, they were well accepted by the colonies to the extent they pre-existed French colonization and were already well accepted by local populations. What is interesting is the moral character of the "vicious substances" which justified the system for the taxation of luxury products whose consumption

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[7] L. Simmat-Durand, "Les obligations de soins en France." in C. Faugeron, ed., *Les drogues en France. Politiques, marchés, usages.* Paris: Georg éditeur, 1999, page 111.

[8] M. Setbon, *L'injonction thérapeutique. Évaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés.* Paris: Observatoire français des drogues et des toxicomanies, 2000, page 11.

[9] See *inter alia* L. Simmat-Durand, *La lutte contre la toxicomanie. De la législation à la réglementation.* Paris: L'Harmattan, 2000; J. Bernat de Celis, *Drogues : Consommation interdite.* Paris: L'Harmattan, 1996; and H. Bergeron, *Soigner la toxicomanie. Les dispositifs de soins entre idéologie et action.* Paris: L'Harmattan, 1996.

[10] Y. Bisiou, "Histoire des politiques criminelles. Le cas des régies françaises des stupéfiants.", in C. Faugeron, ed., *Les drogues en France. Politiques, marchés, usages.* Paris: Georg éditeur, 1999, page 89.

[11] Bisiou, *op. cit.*, page 90.

authorities did not wish to encourage. Although abolished at decolonization and characterized by certain internal contradictions between the economic imperatives of profitability and health objectives, this policy, starting in the 1930s, also came under extensive criticism from the international community, whose orientations, as noted above, were increasingly prohibitionist. The history of state drug monopolies has nevertheless marked French history (as it did Dutch, British and Portuguese history) and was another factor in addition to domestic policy.

Thus it was not one single drug policy that France had in the twentieth century, but three often competing forms of logic on the issue. But it was not until the *Mission interministérielle de lutte à la drogue et à la toxicomanie* [Interministerial Mission on Anti-Drug and Addiction Activities] (MILDT) was reinforced in the mid-1990s that a trend emerged toward a more integrated and coherent overall policy.

An integrated public policy

MILDT was established in the early 1980s during the first seven-year term of French President François Mitterrand. Over the years, however, it either lacked leadership or did not have the resources to achieve its ambitions. It was not until Nicole Maestracci was appointed in 1995, under the socialist government of Prime Minister Jospin, that MILDT began to become more visible and take stronger public action. Its activities were directed in particular by the strong controversies and demonstrations conducted by stakeholders of various types (hospital physicians concerned by AIDS, members of NGOs, drug addicts, specialists and others) who criticized the scientific bases of the main objectives of France's drug policy. At the centre of the debate was a need for a harm reduction approach, focusing on reducing AIDS transmission by intravenous drug users and methadone treatment for drug addicts.[12]

In February 1994, only one small group of 77 addicts had access to methadone treatment, whereas there were 160,000 heroin addicts in France at the time. In 1998, medication substitution treatments were offered in France to a group of up to 70,000 addicts, the vast majority of whom received Subutex and methadone replacements.[13] This new development clearly shows that public authorities now consider harm reduction a fundamental component of France's drug policy.[14]

On June 16, 1999, the French government introduced a three-year plan clearly reflecting this paradigm shift since palliative and preventive measures became legitimate

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[12] See Ms. Nicole Maestracci, President, Mission interministérielle de lutte à la drogue et à la toxicomanie [Interministerial Mission for the Fight Against Drugs and Drug Addiction], testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, October 1, 2001, Issue no. 7, page 9-10.

[13] Michel Kokoreff, "Politique des drogues en France, entre loi pénale et réduction des risques", presentation to the Senate Special Committee on Illegal Drugs, 2001.

[14] Henri Bergeron, "Comment soigner les toxicomanes?" *Sociétal*, June-July 1998, pages 45-49.

goals in the French policy context. As to criminal policy, the main legislative framework – the law of 1970–has not been amended and drug use is still considered an offence. However, in a circular, the Minister of Justice has asked prosecutors not to seek prison terms and to promote treatment in drug cases.

The plan is based on European and international data and on recent reports, interdepartmental consultations and scientific studies providing fundamental observations on France's policy on drugs and drug abuse. The emergence of new use profiles such as the use of numerous drugs (both legal and illegal), increased cannabis and alcohol use among young people and greater availability of synthetic drugs were the main concerns expressed. Information bases and systems have also come under criticism from various quarters concerning:

- the lack of coordination among prevention programs and their limited accessibility (e.g., school drug prevention programs are offered to less than 40 per cent of students and those concerning alcohol and tobacco to less than 20 per cent);
- the lack of social and professional support;
- the fact that there is no ground for agreement among the various stakeholders (law enforcement, social welfare, education and public health);
- the excessive importance attached to heroin addicts in the administration of specialized treatment at a time when use among the members of this addicted group has stabilized;
- the difficulty in reconciling law enforcement with the public health strategy.[15]

Criminal law enforcement with respect to drug users has been constantly marked by the difficulties inherent in reconciling suppressive activities with public health imperatives. The number of users who have been questioned by authorities has doubled over the last five years, without the judicial system having permitted adequate and effective cooperation with physicians and social workers.[16]

Furthermore, observing the declining number of trafficking arrests at the local level since 1996, elected representatives and the general public find this hard to understand in view of the importance they feel should be attached to monitoring drug

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[15] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), *Three-Year Plan to Combat Drug Use and Prevent Dependence 1999-2001*. Available online at: http://www.drogues.gouv.fr/uk/what_you_need/whatyouneed_intro.html.

[16] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), "An Information Booklet Summarising the Government's Plan for the Fight Against Drugs and the Prevention of Addiction 1999-2000-2001", *Drugs: No More, Risk Less*, MILDT, December 1999, page 7. Available online at: http://www.drogues.gouv.fr/fr/index.html.

supply. Lastly, the shortage of reliable indicators has prevented any in-depth, or even comprehensible, assessment of existing programs.

Based on these observations, the government has developed a three-year plan defining action priorities, objectives and measures that should be taken. Two key factors – integration and knowledge – are the watchwords of this effort. Integration is viewed from two standpoints: for the first time, France will have an integrated policy on all psychoactive substances, drugs, medications, alcohol and tobacco.

> *The fact that we were talking about alcohol, tobacco and medication at the same time as we were talking about drugs no doubt made everyone feel closer to the situation because everyone had the experience of consuming a product, be it legal or illegal. This was an important aspect that did not result in our saying that all of the products should come under the same legislative regime, but [that made it possible, regardless of the product used] to distinguish between occasional use and problem use.* [17]

The other aspect of integration is a reinforced effort among the 19 departments that form the MILDT under the chairmanship of the Prime Minister.

The second watchword of this French effort is knowledge. As noted above, a certain number of observers had noted weaknesses in the knowledge apparatus, including reports commissioned by various authorities (discussed below). In the wake of the impetus given by President François Mitterrand to the creation of the European Monitoring Agency for Drugs and Drug Addictions, France, in 1993, established the French Monitoring Centre for Drugs and Drug Addictions. The mission of the French Centre, which is an "independent" agency, is to "develop the observation network in order to monitor recent trends in drug use, conduct regular epidemiological surveys on the public and implement a comprehensive public policy evaluation framework".[18] To do so, it organizes its work along three main lines: observation and improvement of indicators, monitoring of recent trends and policy evaluation. The Centre has a staff of 25 persons and a budget of 18 million French francs (approximately Cdn $3.5 million). It is also the national focal point in the network of the European Monitoring Centre for Drugs and Drug Addictions.

Legislative framework

French law related to illicit drugs is drawn from many sources including four codes: the Code of Public Health (code de la santé publique), the Penal Code, the Code of Penal Procedure, and the Customs Code. The main legislative framework is the law of 31 December 1970, which amended the Code of Public Health and created a legislative framework based on both the application of repressive measures and health-related dispositions. The objectives of the Law of 1970 were to severely repress

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[17] Nicole Maestracci, testimony before the Senate Special Committee on Illegal Drugs, page 13.

[18] Observatoire français des drogues et des toxicomanies, *Drogues et dépendances. Indicateurs et tendances 2002.* Paris: author, 2002, page 291.

trafficking, prohibit the use of narcotics, and yet propose alternatives to the repression of use, as well as to ensure free and anonymous care for users seeking treatment. [19] It must be noted that most articles of the Law of 1970 (originally written into the Public Health Code) have since been integrated into the new penal code that came into force in 1994 except for infractions related to drug use, which are still sanctioned through the Public Health Code. French law is also governed by international law since France has ratified the UN conventions related to drugs.

Classes of drugs

French law does not distinguish between illicit substances and thus, an offence such as drug use is prosecuted and judged in the same way regardless of the illicit substance involved. However, judicial authorities may take into consideration the nature of the substance, the quantity and any prior criminal records in their decision to prosecute, reduce the charges or not prosecute an offender. Illicit substances are listed in an annex to Decree Law of 22 February 1990 and include the following:

List I: narcotic substances such as heroin, cocaine, cannabis, methadone, opium, etc.;
List II: substances such as codeine, propiram, etc.;
List III: psychotropic substances such as amphetamines, Ecstasy, LSD, etc.; and
List IV: synthetic drugs such as MBDB, 4-MTA, Ketamine, Nabilone, THC, etc.[20]

Offences and penalties

Public or private drug use in France is prohibited and criminalized by the Law of 1970 (article L3421-1 of the Code of Public Health). The penalty for illicit drug use is up to one year in prison or a fine of 25,000 French Francs, or diversion to a court-ordered treatment program (therapeutic injunction–in French, "*injonction thérapeutique*"). This article of the Code of Public Health applies to all users without any distinction as to the type of illicit substance used.

The Code of Public Health also provides for the monitoring of drugs users by health authorities (article L3411-1). Prosecutors may not undertake legal action against an offender if that person can provide medical certification that he has undertaken some form of therapy or has submitted himself to medical supervision since the commission of the infraction. However, if the offender does not supply a medical certificate to that effect, prosecutors may request that an individual who has made use of illicit drugs follow a drug addiction treatment program or be placed under medical monitoring (article L3423-1). The involvement in a court-ordered treatment program

[19] Observatoire français des drogues et des toxicomanies (OFDT), *Drogues et toxicomanies : indicateurs et tendances*, 1999 Edition, page 20. Available online at: http://www.drogues.gouv.fr/fr/index.html.
[20] Observatoire européen des drogues et des toxicomanies (OEDT)/ *European Legal Database on Drugs (ELDD), France Country Profile, French Drug Legislation*. Available online at: http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=FR.

suspends legal proceedings and these will not be pursued if the individual completes the detoxification program.[21] It is not uncommon for a repeat offender to be subjected to more than one court-ordered treatment program as more repressive measures are rarely used for simple drug use, particularly cannabis use.

As mentioned above, the Ministry of Justice – in a directive dated June 1999 – asked prosecutors to prioritize treatment over incarceration for small-time offenders and problematic drug users. Practice has shown that therapeutic alternatives are used mainly for simple users and that most cases of simple drug use receive a warning with the request to contact a social or health service. When legal proceedings are undertaken, the magistrate may also force, and not simply order, the accused to undertake a detoxification program but in this case, judicial authorities take charge of the case rather than health authorities. In these cases, if the user completes the treatment, no penalties may be imposed on the individual but the use of such measures are extremely rare. [22] As well, a detoxification treatment may be a condition attached to a conditional prison sentence, parole or judicial supervision. In France, the delinquent user is thus seen mostly as a sick person to whom therapy must be offered. [23]

On the drug trafficking side, the Law of 1970 has been modified on several occasions, creating new offences such as the selling or supplying drugs for personal use (17 January 1986) and drug-related money laundering (31 December 1987), or enacting new procedures such as the confiscation of drug trafficking profits (14 November 1990) to comply with Article 5 of the United Nations Convention (19 December 1988).[24] Currently, trafficking offences include selling or supplying drugs for personal use with a penalty of up to five years and a fine of up to 500,000 F (articles 222-39 of the Penal Code) and a more serious offence for transportation, possession of, supply, sale and illicit purchase of narcotics with a penalty of up to 10 years and a fine up to 50 million F (article 222-37). Illicit imports and exports of narcotics are also punishable by 10 years' imprisonment and a fine up to 50 million F but when the offence is committed by a criminal organization, the penalty increases to 30 years of imprisonment (article 222-36). Furthermore, trafficking in narcotics might also be punishable as a customs offence (contraband and similar offences) with a maximum sentence of three years' imprisonment and fines equalling two-and-one-half times the value of the illegal merchandise. Prosecutions under the Customs Code do

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[21] Comité consultatif national d'éthique, *Rapports sur les toxicomanies*, rapport nº 43, November 23, 1994, page 19. See: http://www.ccne-ethique.org/français/start.htm.

[22] OEDT/ELDD, *France Country Profile*, 2001.

[23] Comité consultatif national d'éthique, 1994.

[24] United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, December 19, 1988: Article 5, Confiscation 1. Each Party shall adopt such measures as may be necessary to enable confiscation of: (a) Proceeds derived from offences established in accordance with article 3, paragraph 1, or property the value of which corresponds to that of such proceeds; (b) Narcotic drugs and psychotropic substances, materials and equipment or other instrumentalities used in or intended for use in any manner in offences established in accordance with article 3, paragraph 1.

not exclude penal prosecution, and customs sanctions can be added to penal sanctions.[25]

Other offences include the illegal production or manufacturing of narcotics punishable by 20 years in prison and a fine of 50 million F. Here again, when a criminal organization commits the offence, the penalty increases to 30 years' imprisonment (article 222-35). Drug-related money laundering defined as "*facilitating by any means, false justification of the source of assets or revenues of the author of an infraction to narcotics legislation*" is punishable by 10 years imprisonment and a fine of 5 million F (article 222-38). Incitement to drug use or to commit any offence sanctioned by articles 222-234 to 222-239 of the Penal Code or to present these offences in a favourable light is punishable by five years in prison and a fine of 500,000 F (article L3421-4 of the Code of Public Health). This offence is aimed at the media and literary or artistic works. Inciting a minor to use narcotics is punishable by five years' imprisonment and a fine of 700,000 F and in the case of a minor under the age of 15 years or if the offence is committed in or around an educational establishment, the penalty increases to 7 years in prison and a fine of 1 million F (article 227-18). Finally, heading or organizing a group engaged in the production, manufacturing, import and export, transportation, possession, supply, sale, purchase or use of narcotics can lead to a life sentence and a fine of 50 million F (article 222-34).

Key reports

The Pelletier Report

The first assessment of the Law of 1970 and of the French policies with respect to drugs and drug addiction was completed in 1978 by a commission presided by Monique Pelletier, who studied the issue at the request of French President Giscard d'Estaing.[26]

The Pelletier report stated that the difficulties encountered in the implementation of the Law of 1970 were the result of inequalities in handling drug users due in part to the fact that the law did not include an intermediate category between a drug user and a trafficker. The report also attributed the implementation problems to the difficulties encountered in getting legal and health authorities to work together.[27] Doctors were particularly sceptical about the principle of court-ordered treatment and of forcing an individual into treatment. The Pelletier Commission noted as well that legal sanctions were used more often than treatment alternatives. Members of the Pelletier Commission believed that the Law of 1970 deserved a second chance. They suggested

[25] OEDT/ELDD, *France Country Profile*, 2001.

[26] M. Pelletier, *Rapport de la mission d'étude sur l'ensemble des problèmes de la drogue*, Paris: La Documentation française, 1978.

[27] Centre d'aide et d'accueil en toxicomanie (CAAT), *La mise en application de la loi*. See: http://caat.multimania.com/info/app_loi.htm.

that it could benefit from the institution of clear implementation guidelines (circular letters) and the establishment of structural and financial resources to ensure the successful implementation of therapeutic alternatives, both at the judicial and medical level. The report proposed, among other suggestions, that drug users should be differentiated according to the type of illicit substance they use.[28]

Officially today, the law still does not distinguish between illicit substances but in practice many circular letters over the past 20 years have invited prosecutors and judges to differentiate between cannabis use and use of other drugs such as heroin and cocaine. For example, a circular letter (7 May 1978) suggested that cannabis users should not be considered "true" drug addicts, that detoxification treatment may not be the appropriate measure for this type of user, and that they should receive a simple warning. It also invited judges to encourage drug users to contact a drug addiction centre and to only use court-ordered treatment for repeat offenders. This circular letter has been perceived by many as a decriminalization of cannabis use. However, it must be noted that circular letters express the intentions of the Ministry of Justice but can be enforced diversely by prosecutors.[29]

The 1978 circular letter was a point of reference until 12 May 1987 at which time a Justice-Health circular repealed preceding letters and introduced a new distinction for drug use based on the frequency of use.

> [Translation] *For all cases involving drug use, a report had to be sent to the prosecution and dealt with by a specialized judge. "Occasional" users, who were well integrated into society were to be given a simple warning. The letter recommended court-ordered treatment or prosecution for "habitual" users. Illegal foreign users were to be immediately tried and banned from the French territory. Lastly, user-dealers or delinquent users were to be prosecuted as a head dealer or for harming others or goods. This letter also marked a will to revive court-ordered treatment and clarified how it should be enforced.* [30]

This circular letter was a turning point towards more repressive measures for habitual users and user-dealers[31] and the basis of the orientation of legal policy between 1990 and 1995, which focused on reviving court-ordered treatment and distinguishing between occasional users, habitual users, and user-dealers.[32]

The Trautmann Report

The second report was commissioned in 1989 from Catherine Trautmann who, at the time, was the president of the Interministerial Mission for the Fight against Drugs and Drug Addiction. The Trautmann report, submitted in 1990, included a review of

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28 OFDT, 1999, page 25.
29 *Ibid.*
30 *Ibid.*, page 26.
31 CAAT, 2001, page 3.
32 OFDT, 1999, pages 26-27.

available data on drug use and drug addiction, the main difficulties in the fight against drugs, and the drug policy in France from 1978 to 1988.[33]

The report did not recommend any changes to the Law of 1970. Rather, it highlighted the need for more effective actions against drug trafficking, with a particular focus on developing better cooperation between the three main national services involved in the fight against drug trafficking: the police, the gendarmerie, and customs – each of which have a different jurisdiction (urban areas for the police, rural areas for the gendarmerie, borders for customs). It suggested that the policing of French outer borders should be reinforced. The report further proposed that more should be done to deal with the demand side of the drug issue by developing strategies aimed at preventing drug use and drug addiction, particularly among young people. Suggestions related to the care of drug addicts and their integration and reintegration into the community revolved around three main axes: improving health and social services; taking into consideration problems associated with AIDS; and establishing a solid financial management system to support specialized units providing services to drug addicts.

Finally, with respect to the issue of decriminalization or legalization of drugs, in particular cannabis, the Trautmann report was clearly against such propositions. The report stated that the issue is one of preventing drug use and caring for drug addicts, and that decriminalization of cannabis would trivialize drug use and promote earlier and more frequent use of hard drugs.[34]

The Henrion Report

The Henrion Commission produced in 1995 a third report on the drug situation in France.[35] It is interesting to note that the Commission comes to similar conclusions as the two previous reports with respect to the lack of coordination and cooperation between judicial and health authorities and the difficulties in implementing a policy based on both repressive and public health measures. The Commission made note of the limited use of court-ordered treatment and the increasing number of arrests for simple drug use. It recommended first and foremost the development of an evaluation policy to assess the drug situation in France and suggested that French drug policy should give priority to preventing drug use. As well, the report criticized the lack of consistency in law enforcement and inequalities in handling drug users throughout France and recommended that the existing agencies and structures involved in the repression of drug trafficking be given the necessary financial and human resources to successfully achieve their mandate.

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[33] C. Trautmann, *Lutte contre la toxicomanie et le trafic de stupéfiants*. Report to the Prime Minister, Paris: La Documentation française, 1990.

[34] *Ibid.*, Annexe 10, pages 252 and 253.

[35] R. Henrion, *Rapport de la Commission de réflexion sur la drogue et la toxicomanie*. Report to the Minister of Social Affairs, Health and Cities, Paris: La Documentation française, 1995.

However, the Henrion Commission distinguished itself in proposing a reform of the Law of 1970. Members of the Commission debated the issue of decriminalizing cannabis, expressing diverging opinions on the issue. A minority of members (8 out of 17) opposed the idea of decriminalizing the use of cannabis mainly because they thought it would be difficult to maintain a moral interdiction without a legal prohibition. However, a small majority of members (9 out of 17) were in favour of decriminalizing the use of cannabis and possession of small quantities of such substance. They suggested proceeding gradually without effecting any changes to the existing measures sanctioning the supply of cannabis in the hope of better controlling and assessing the consequences of decriminalizing drug use. They also recommended that decriminalization should be accompanied by the enactment of regulations limiting use of cannabis to certain locations and forbidding its use by young people under the age of 16. Regulations would also repress being intoxicated in public places, create an offence of driving under the influence of cannabis, and would prohibit the use of cannabis by certain professionals for safety reasons (i.e., air traffic controllers; pilots, drivers of public transit, etc.). All these measures had to be accompanied by a prevention campaign focusing on the potential negative consequences of using cannabis, an ongoing evaluation not only of cannabis use but of opiates, cocaine and crack as well, and ongoing neurobiological research on the effects of cannabis use. Finally, the offence of incitement to drug use was to be maintained and applied.[36]

The Commission suggested that, if such a reform was applied and there was no deterioration of the situation within two years, the government should then consider a regulation of the commerce of cannabis under the strict control of the state. It should be noted, however, that some members of the Commission thought that such a regulation should be implemented concurrently with the decriminalization of cannabis and that there should not be any trial period.[37] These recommendations have yet to be implemented.

The Henrion Commission also recommended the adoption of a harm reduction policy that would not limit itself to minimizing the health risks related to drug use, but would be grounded in a public health perspective that would rigorously crack down on specific problem behaviours such as discarding needles in a public place.[38]

Expert reports

In Chapters 5, 6 and 7, we have more fully discussed the scientific data from three recent expert reports, the Roques report on the dangerousness of drugs (1995),[39] the Parquet and Reynaud report on addictive practices (1997)[40] and the INSERM expert

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[36] *Ibid*., pages 82-83.
[37] *Ibid*., page 83.
[38] *Ibid.*, page 89.
[39] B. Roques, *La dangerosité des drogues.* Paris: Odile Jacob, 1995.
[40] Reynaud, M. et al., (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Paris : Secrétariat d'État à la Santé et aux Affaires sociales.

report on cannabis (2001).[41] Those three reports, which supplement each other and are largely consistent in their main conclusions, constitute one of the most rigorous international scientific information bases, and certainly the least ideological, that we consulted. As they were not associated with a commission established to study the public policy aspects of the issue, the three commissions were thus likely in a slightly better position to escape the potential contamination of teleological interpretations of research data.

Statistics on use and offences

Use

The following is from a 1999 document entitled *Drugs and Drug Addictions: Indicators and Trends* prepared by the French Monitoring Centre for Drugs and Drug Addictions, which synthesized available data and analyzed drugs and drug addiction in France.[42]

The current trends observed in that report were as follows:

- a strong decrease in overdose-related deaths (554 in 1994, 143 in 1998) and AIDS deaths associated with injection drug use (1,037 in 1994, 267 in 1997);
- an important drop in heroin use since 1996 possibly attributable to an increase in use of substitution treatments;
- normalization of the use of cannabis as its use is becoming more and more commonplace particularly amongst young people;
- cultivating cannabis is a developing phenomenon;
- synthetic drugs have become much more widely available although these drugs still represent a very small percentage of drug consumption;
- cocaine use is increasing; and
- multiple drug use including licit substances such as alcohol, is an emerging phenomenon especially among youth–54% of young people in care in rehabilitation units are users of at least two products.

Surveys conducted in 1995 amongst a representative cross-section of French adults revealed that almost 25% of 18- to 44-year-olds declared having experimented with cannabis and 7.7% stated that they used it on an occasional or regular basis. Surveys conducted amongst conscripts in army selection centres in 1996 also showed that a large percentage (40%) of young men 18-23 years old had experimented with cannabis and 14.5% had used it during the past month.[43] Whereas adolescents are

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41 INSERM, *Cannabis : Quels effets sur le comportement et la santé?* Paris: author, 2001.

42 Observatoire français des drogues et des toxicomanies, *Drogues et toxicomanies : indicateurs et tendances*, 1999 Edition. Available online at: http://www.drogues.gouv.fr/fr/index.html.

43 OFDT, 1999, pages 62 and 63.

concerned, it is estimated that in the second half of the 1990s more than one-third of all 15- to 19-year-olds had experimented with drugs, mostly cannabis. Surveys also showed an important increase in the frequency of use of cannabis as "the share of young people who had used cannabis at least ten times during the year increased by over one-half from 1993 to 1997."[44] It was further found that boys are more likely than girls to use illicit substances and at much higher risk of repeated use. A 1998 survey indicated that 33% of the boys declared that they had experimented with cannabis, compared to 23% of the girls.[45] The 2002 report of the French Monitoring Centre for Drugs and Drug Addictions also notes an increase in the number of new health and social cases involving cannabis use: approximately 15 per cent of cases involved cannabis use. Those persons were generally younger than those involved in opiate use, more of them were entering the system for the first time and more had been referred by the courts.[46]

During the second half of the 1990s, the number of "problem" opiate users (drug use that may result in treatment in the health and social system and/or contact with law enforcement agencies) was estimated between 142,000 and 176,000.[47]

Offences

The report from the French Monitoring Centre indicates that the number of arrests for drug-related offences increased from 45,206 to 85,507 over the period 1993-1998. The most important increase was in the number of individuals arrested for cannabis use (30,344 in 1993 compared to 72,281 in 1998) whereas the number of arrests for heroin use had actually decreased (14,959 in 1993, 7,469 in 1998, following a peak at 17,356 in 1995). Cannabis, in fact, accounted for 85% of drug-related arrests in France in 1998 compared to 63% in 1993. However, it must be noted that a little less than half of the individuals arrested for using drugs (45%) were retained for questioning and the vast majority of persons (97.2%) held for questioning were freed in 1997.[48]

Studies in France have emphasized that the statistics on arrests of drug users should be used with caution as it is difficult to ascertain how much of noted changes reflect variations in the population of drug users and how much of these changes are linked to modifications of police and gendarmerie services. For example, data on arrests for use between 1993 and 1998 indicated a significant growth of 30% in use-related arrests in 1997 and 9% in 1998.[49] Many factors may explain such an increase including changes in the behaviour of police and gendarmerie services, the reorganization of

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44 *Ibid.*, page 83.
45 *Ibid.*, page 82-84.
46 OFDT, 2002, page 96.
47 OFDT, 1999, page 64.
48 *Ibid.*, page 112 and 113. It should be noted that release refers to many situations and does not imply that prosecution does not go forward. Some may subsequently be convicted upon being summoned to court.
49 *Ibid.*, page 112.

police departments, and the normalization of cannabis use. One explanation suggests that a circular letter on court-ordered treatment issued in 1995 by the Ministry of Justice has led public prosecutors to instruct the police and gendarmerie to "systematically report users." [50] It may be assumed that such instructions may have led to the notable increase in drug use-related arrests recorded in 1997.

With respect to trafficking, the number of arrests decreased between 1996 and 1998 from 8,412 to 5,541. Slightly more than half of dealers (52%) arrested in 1998 were trafficking cannabis, 24% were involved in dealing heroin, and 17% trafficked cocaine and crack. The main development was observed in the number of arrests of heroin traffickers which decreased from 3,395 in 1993 to 1,356 in 1998. Arrests for trafficking cocaine increased from 383 to 972 during the same period whereas arrest related to cannabis trafficking increased slightly from 2,456 to 2,920. [51]

The total number of convictions for drug use as the main offence went from 7,434 in 1992 to 6,530 in 1997, with a low of 4,670 convictions in 1995. In 1997, 3,368 convictions were for use only. Of these, 14% were sentenced to imprisonment with an average length of 2.4 months, 35% received a deferred sentence (often associated with probation and court-ordered treatment), 33% were fined, 7% were given an alternative sentence, and 6% were sentenced to an educational measure. The number of convictions for use and transporting increased from 761 in 1991 (6.6% of convictions) to 3,478 in 1997 (22.2%). Convictions for use and trafficking also increased from 475 in 1991 to 1,501 in 1997 (4.1% compared to 9.6% of convictions related to drug offences). In 21% of the convictions for use and other drug-related offences, a prison sentence was given out. In 37% of cases involving drug use and trafficking and 21% of drug use and transporting, individuals received a mixed sentence (prison time and deferred sentence). The average length of imprisonment was 16.8 months in 1997. [52]

In 1998, the number of cannabis seizures was 40,115, up from 27,320 seizures in 1996. However, the quantities seized were smaller in 1998 than in 1996 (55,698 kg compared to 66,861 kg).

Costs

In 1995, public funds devoted to implementing the French drug policy was 4.7 billion Francs. Out of the total expenses (specific budget and interdepartmental credits), approximately 1536.56 million Francs were spent on Justice, 1260.54 million F on police services, 469.55 million F on the gendarmerie, and 450.25 million F on customs expenses. The amount spent on enforcement was considerably higher than that spent on health (656.3 million F) and social affairs (28.58 million F).

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[50] *Ibid.*, page 114.

[51] *Ibid.*, page 164 and 165.

[52] OFDT, 1999, page 121-123.

More recent figures on interministerial credits indicated that for 1998, the expenditures of health and social affairs were set at 47.9 million F , those of Justice at 18.9 million F, the Ministry of the Interior (police) at 18.5 million F and Defence (gendarmerie) at 10.7 million F.

THE NETHERLANDS[53]

Much has been said about the Dutch approach to the drug issue. The following is one example:

> *In Holland, studies conducted in the early 1990s show the negative impact of tolerance of illegal drugs:*
>
> - *the number of "coffe shops" that have derived income from the sale of hashish since decriminalization in 1990 rose from 20 to 400 in Amsterdam in 1991 to more than 2,000 throughout all of Holland;*
> - *from 1984 to 1988, the number of hashish smokers 15 years of age or more doubled in Holland; from 1988 to 1992, the number of smokers 14 to 17 years of age doubled again, and the number of users 12 and 13 years old tripled;*
> - *the rate of violent crimes committed in Holland is the highest in Europe and is still rising.* [54]

> *In the Netherlands (you have to be careful because there are enormous social and cultural differences preventing any general comparison between Canada and that country), the harm-reduction-based drug policy draws a very clear distinction between cannabis and so-called hard drugs. Since the policy was adopted, cannabis has appeared to be less dangerous and its social approval has increased, particularly among young people whose cannabis use has quadrupled. Cannabis use in that country, as in most continental European countries, based on the statistics cited, remains below that of Canada. But that simply means that we must be even more vigilant. The tendency to have a problem situation and the probability that it will occur appear higher in the country.* [55]

Various witnesses cited the article by Larry Collins published in the prestigious *Foreign Affairs.* However, that article is full of errors of fact.

In view of the climate surrounding the drug policy debate, it is difficult to describe the Dutch approach without giving the impression that one is taking a position. First, we should recall a number of observations we made in Chapter 6, to which we will return in the comparative analysis in the next chapter. First of all, international comparison of use trends must be carefully drawn because of the different methodologies used in the surveys. Second, international comparisons tend to show

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53 This section draws largely on the research report prepared for the Committee by the Library of Parliament: B. Dolin, (2001) *National Drug Policy: The Netherlands.* Ottawa: Library of Parliament, prepared for the Senate Special Committee on Illegal Drugs; available online at www.parl.gc.ca/illegaldrugs.asp.

54 Canadian Police Association, Brief to the Senate Special Committee on Illegal Drugs, May 28, 2001.

55 Brief of Dr. Colin Mangham, *Consequences of the Liberalization of Cannabis Drug Policy*, September 17, 2001.

that "*the relationship between the figures measuring cannabis use levels and the legislative model in effect in a country is not obvious or systematic*."[56]

As was the case for France, we begin with a brief overview of drug legislation in the Netherlands, then describe the broad outlines of the current Dutch policy and the tools used to implement it. We then present current legislation in a more detailed manner and the reports on which it is based, then, lastly, provide some figures on drug use and repression.

Dutch pragmatism?

Like the other colonial powers, the Netherlands maintained opium production authorities and trading posts in their colonies, a system that generated significant tax revenues: between 1816 and 1915, net profits from the sale of opium represented approximately 10 per cent of total revenue from the colonies for the Dutch treasury. The country was also the largest producer of cocaine for medical purposes. It was not until the end of World War II and the independence of Indonesia that the Netherlands terminated the opium monopoly.

> *Vested economic interests in the production and trade of drugs may explain the Dutch reluctance to endorse strong international drug control. Clearly, the Netherlands attempted to protect these interests at the conferences and did so successfully, at least temporarily. (…) Incidentally, the Netherlands also objected to the inclusion of marihuana in the convention.* [57]

During the 1920s and 1930s, the country came under criticism from the League of Nations and the United States in particular over its extensive drug trade. The Netherlands was one of the main heroin producers and the principal producer of cocaine. However, the Dutch negotiators at the international conferences on the various conventions, as well as a portion of the Dutch population itself, did not believe in a system based on prohibition and, already at the turn of the century, felt that a system of government control would be more effective.

It was this attitude that led a number of analysts to represent the Dutch approach to drugs as pragmatic.

> *Dutch society is a pragmatic society. It is a nation of traders, going back to the XVIIth century. Traders are more pragmatic than other people. The pragmatism finds its roots in Dutch history, which is characterized by its fight against the sea, the natural enemy of the Netherlands since the Middle Ages. The Netherlands is roughly the size of Vancouver Island, and today one-half of the country is at sea level.*

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[56] H. Martineau and É. Gomart, *Politiques et expérimentations sur les drogues aux Pays-Bas.* Rapport de synthèse. Paris: OFDT, 2000, page 44.

[57] M. De Kort, "A Short History of Drugs in the Netherlands", in E Leuw and I. Haen Marshall, eds., *Between prohibition and legalization. The Dutch experiment in drug policy.* Amsterdam: Kugler, 1994, page 11.

> *A system of dykes was built to protect the country. Centuries ago, everyone in Dutch society, from the aristocracy to the farmers worked together to prevent seawater from flowing into the country. The pragmatic attitude comes from that. It is impossible to completely eliminate the problem of the water. It is better to control it with canals.* [58]

However, other factors beyond pragmatism are at work. One Dutch government publication suggests that the nature of Dutch society is the reason for its approach:

> *Some knowledge of the characteristics of Dutch society is required to appreciate the Dutch approach to the drug problem. The Netherlands is one of the most densely populated urbanized countries in the world. Its population of 15.5 million inhabitants occupies an area of 41,526 square kilometers. The Netherlands has always been a transit country: Rotterdam is the largest seaport in the world and the country has a highly developed transportation sector. The Dutch firmly believe in individual freedom and expect the state to be reserved in its approach to religious and moral questions. Free and open debate on such questions is one of the characteristics of Dutch society. Considerable value is attached to the well-being of society as a whole, as may be seen from the extensive social security system and universal access to health care and education.* [59]

It follows that, by tradition, the Dutch are not accustomed to using criminal law to address social problems.[60] Furthermore, the Netherlands is a country of consensus, where there is a long tradition of cooperation between local, regional and national authorities, and between the various sectors of the government.

Whatever the reasons, the Dutch experience has received considerable media coverage, surprisingly, much more than the Spanish approach, which, in many respects, is even more liberal. Being called upon to defend it in Europe and in other international forums, the Dutch have often presented it as a position of compromise between that of the "hawks" of the war on drugs and that of the "doves" of legalisation.[61] It is unlikely that the approach is the result of specific cultural factors and that the Dutch experience cannot apply to other countries. On the contrary, it appears to be the rational solution to a problem by politicians, and that cannot be claimed to be an exclusively Dutch characteristic.

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[58] Tim Boekhout van Solinge, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, 19 November 2001, Issue 11, page 53-54.

[59] "Drug Policy in the Netherlands", Government of the Netherlands, available online at: http://www.netherlands-embassy.org/c_hltdru.html.

[60] Boekhout van Solinge, "La Politique de drogue aux Pays-Bas: un essai de changement", *Déviance et Société*, Vol. 22, page 69-71.

[61] C.D. Kaplan *et al.*, "Is Dutch Drug Policy an Example to the World?" in Leuw and Marshall, eds., *op. cit*.

Essential expert reports

Unlike most other countries where commissions of inquiry produced reports in the 1970s, the Netherlands is the only country that has implemented the recommendations of its commission.

The Hulsman Commission(1968-1971)

In 1968, the National Federation of Mental Health Organizations[62] established a commission with a broad mandate to "clarify factors associated with the use of drugs" and "to suggest proposals for a rational policy."[63] Chaired by criminal law professor Louk Hulsman, the Commission had a diverse membership including law enforcement officials, alcohol treatment experts, psychiatrists, a drug use researcher and a sociologist.

The commission's final report, presented in 1971, provided an analysis of drug use and the social mechanisms behind drug problems. New approaches were suggested, including:

- The use of cannabis and the possession of small quantities should be taken out of the criminal law immediately. For the time being, production and distribution should remain within criminal law, but as misdemeanours.
- The use and possession of other drugs should temporarily remain in the realm of criminal law, as misdemeanours, but in the long run all should be decriminalized.
- People who have problems with their drug use should have adequate treatment facilities at their disposal.

In recommending the gradual decriminalization of all drugs, the report noted that illicit drugs can be used in a controlled and limited way and that marginalizing drug-using subcultures has significant negative repercussions. Specifically, becoming a member of the "drug scene" may familiarize a cannabis user with other drugs and patterns of use. Although the commission found no evidence of a "stepping stone" sequence of drug use – what in other contexts has been referred to as "gateways" – it accepted the notion that one kind of drug user (e.g., heroin user) will contaminate another kind of drug user (e.g., cannabis user) when the two kinds of drug use are forced into one marginalized subculture.

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[62] In the Netherlands, public and private agencies have jurisdiction over mental health based on political affiliation and religious denomination. The National Federation of Mental Health Organizations was a coordination agency.

[63] Louk Hulsman, *Ruimte in het drugbeleid*, Boom Meppel, 1971, page 5, mentioned in Peter Cohen, "The case of the two Dutch drug policy commissions: An exercise in harm reduction 1968-1976" (1994, revised in 1996), Article presented to the 5th International Conference on Drug Harm Reduction, March 7-11, 1994, Addiction Research Foundation, Toronto, available online at: www.cedro-uva.org/lib/cohen.case.html.

With respect to the issue of law enforcement, the commission concluded that once started, drug policing would have to be constantly enlarged to keep pace with the never-ending escalation of drug use. It referred to the criminal law option of opposing drug use as inadequate and "extremely dangerous":

> *Time after time it will show that the means will fall short, upon which those who favour punishment will plead for increase of law enforcement, until it will be amplified a hundred fold from the present situation…This will boost polarization between the different parts of our society and can result in increased violence.* [64]

Although it had no immediate impact, the Hulsman report nevertheless influenced the government report of the Baan Commission.

The Baan Commission (1968-1972)[65]

A State Commission was also established in 1968 by the Under Secretary of Health. This commission contained some members of the Hulsman Commission, as well as officials from the Ministry of Justice, the Amsterdam Chief of Police, and additional psychiatrists and sociologists. In 1970, Pieter Baan, the Chief Inspector of Mental Health, assumed the chairmanship of the commission and a final report was presented in 1972.

The report suggested dividing drugs into those with acceptable and those with unacceptable risks. Further research would be needed to create a greater consensus among the experts as to how some individual drugs should be classified, but the report described cannabis products as relatively benign with limited health risks. However, even for those drugs that pose unacceptable risks, the report concluded that use of the criminal law is not an adequate approach. The Commission suggested the long-term goal of complete decriminalization once a good treatment system had been created. In the interim, the justice system should just be used as a tool for manoeuvring heavy users into treatment.

Other notable findings include:

- The special characteristics of youth culture are important determinants of drug use and if so-called deviant behaviour is stigmatized by punitive measures, the probability of intensification of this behaviour is a serious danger. This will initiate a spiral that will make the return of the individual to a socially accepted lifestyle increasingly difficult.
- Much drug use is short-lasting experimentation by young people.
- Cannabis use does not lead to other drug use, but as noted in the Hulsman report, the criminalization of cannabis promotes contact between cannabis users and the users of "harder" drugs.

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64 In Peter Cohen, "The case of the two Dutch drug policy commissions", *supra*, page 3.

65 *Working Party*, Department of Justice, The Hague, 1972.

- Drug users are better served by drug information and prevention efforts than by prosecution.
- The sometimes unusual behaviour of cannabis-consuming youth is more a result of specific subculture norms and ideologies rather than pharmacology.
- Cannabis use when driving or operating machines in factories is not responsible conduct, and the consumption of cannabis should be restricted to times of leisure in order to limit the risks to the individual or society .

The Baan report formed the basis of what was to become the system of tolerance toward cannabis in the Netherlands as part of a concern for public health and the separation of drug markets.

The Engelsman Report (1985)[66]

Taking notice of the limits of a public health policy essentially based on young people (the principal cannabis users) and of the evolution of heroin use, as well as the declining condition of users, the Engelsman report proposed to extend the Baan Commission's tolerance approach to other drugs. It also went further than the Baan report on the need to rely on the experience and word of users in determining policies, proposing in particular to exclude non-users from the circle of experts. In Engelsman's view, drugs and drug use were no longer the only factors involved in explaining the problems of drugs - hard drugs in this case - and that new factors included the perverse effects of repressive action (care and police) on users. Public policy proposals should therefore not be based on the panic reactions of society and should aim to integrate users and "normalize" their drug use. The state should therefore arbitrate between users and non-users with a view to protecting users. The Engelsman report, which was considered too radical in certain circles, remained a dead letter.

"Continuity and Change" Report – 1995[67]

In 1995, the Dutch government published a report entitled *Drugs Policy in the Netherlands: Continuity and Change*. This policy document was sponsored by: the Minister of Justice; the Minister of Health, Welfare and Sport; and the Secretary of State for the Interior. To some extent, this report was the Dutch response to international pressure (from both neighbouring countries and the USA) as well as an opportunity to make its cannabis policy clearer and to some extent stricter.

The report begins by noting that the Netherlands has always attempted a pragmatic approach to drug use, recalling that prohibitionist policies throughout the

66 Interdepartmental Task Force on Drugs and Alcohol, The Hague: Department of Justice, 1985.

67 Department of Foreign Affairs (1995), *Continuity and Change.* 1995. The report is available online at: www.drugtext.org/reports/wvc/drugnota/0/drugall.htm.

world have proven to have a limited effect. Thus, the modest objective in Holland is to limit the health and social problems that result from the use of dangerous drugs. This harm reduction approach has led the Dutch government to distinguish between "hard drugs," i.e., those that pose an unacceptable risk to health, and "soft drugs" such as cannabis products, which although still considered "risky" do not present similar concerns. The underlying assumption made in the Netherlands with respect to cannabis is that people are more likely to make a transition from soft to hard drugs as a result of social factors, not physiological ones. Separating the markets by allowing people to purchase soft drugs in a setting where they are not exposed to the criminal subculture surrounding hard drugs is intended to create a social barrier that prevents people experimenting with more dangerous drugs.

The report goes on to review the effects of the Dutch drug policy, the treatment of addiction in the Netherlands, and enforcement under the *Opium Act.* Key conclusions and findings include:

- Decriminalization of the possession of soft drugs for personal use and the toleration of sales in controlled circumstances has not resulted in a worryingly high level of consumption among young people. The extent and nature of the use of soft drugs does not differ from the pattern in other Western countries. As for hard drugs, the report states that the number of addicts in the Netherlands is low compared with the rest of Europe and considerably lower than that in France, the United Kingdom, Italy, Spain and Switzerland.
- The number of heroin users under the age of 21 has continued to fall in the Netherlands.
- The use of cheaper forms of cocaine (i.e., crack) has not made significant inroads in Holland as had been feared as a result of developments in the United States.
- The tone of public debate in Holland is different than in other countries because drug use is no longer seen as an acute health threat but rather as a source of nuisance. Policies focusing on addiction and care have resulted in less HIV infection; in fact, levels continue to fall. As well, the mortality rate among addicts is low and is not increasing, as it is in other European countries.
- With respect to the legalization debate, the report concludes that, with a state monopoly or licensing system, the disadvantages would outweigh the practical advantages. Although the role of criminal organizations would be reduced, such a system would impose a considerable burden in implementation and monitoring, and would probably attract even more "drug tourists" and the nuisance they sometimes cause. Furthermore, the report suggests that this is not something that could be done by the Netherlands in isolation. The international conventions preclude outright

legalization and would have to be renegotiated or denounced. As well, even if just soft drugs were legal in Holland but not in the rest of Europe, the Dutch criminal organizations that export drugs would continue to exist and would still require significant law enforcement activity.

- Foreign concerns about the Dutch coffee shop policy have centred not on the use of cannabis in the establishments, but on drug tourists who take cannabis back to their home countries, something that has been particularly easy since the abolition of border controls under the Schengen Agreement. The report confirms the government's plan to reduce the purchase limit to 5 grams from 30 grams to see what impact this will have on illegal exports.[68]
- Given the lack of sufficient scientific data, the report endorses the 1995 recommendation of the Dutch Health Council that a medical trial into the effectiveness of prescribing heroin to addicts be undertaken.[69]

The report also notes three negative implications that need to be addressed: the nuisance caused by hard and soft drug users; the increasing presence of organized crime in the Netherlands; and the effect of Dutch policy on other countries.

- The criminal and general nuisance caused by Dutch and foreign hard drug users may have the effect of undermining public support for the policy of social integration of addicts. A small proportion of hard drug users commit a large number of property offences in order to buy their drugs. Contrary to expectations, the fact that methadone is easily obtained has scarcely improved the situation. Drug-related crime and anti-social behaviour, such as discarding used needles in public places, has affected the tolerance levels of residents in some socially disadvantaged neighbourhoods in the larger Dutch cities. Nuisance caused by the presence of coffee shops selling soft drugs has also been problematic in some municipalities.[70]
- Another complication has been the rise of criminal organizations involved in the supply and sale of drugs in Holland which has necessitated increased criminal law measures. The prosecution of drug traffickers will continue to be a top priority for the Dutch police and judicial authorities.
- Although the "ideological nature" of some foreign criticism suggests a lack of understanding of Dutch policy and is often based on purported health risks that are not supported in the scientific literature, there are problems in the Netherlands that have international implications. The Dutch, for example, are responsible for more than their proportional share of

[68] As noted in the section on current legislation, this reduced limit is now in effect.

[69] As noted in the section on current legislation, trials began in 1998.

[70] This concern was addressed subsequent to the Report by the "Damocles bill" of 1999, discussed herein, which provides greater powers to municipalities to shut down coffee shops that are a local nuisance.

trafficking in soft drugs, and drug tourists routinely purchase soft drugs in Holland with the intent of transporting them back to their home country. The report suggests that combating these problems will involve continuing and reinforcing current law enforcement activities that prioritize trafficking. As noted, the issue of soft drug tourists taking home their coffee shop purchases is to be addressed by decreasing the amount permitted for sale.

Three major principles have characterized the Dutch approach since 1976:

- Harm reduction: attenuation of risks and dangers related to drug use rather than prohibition of all drugs, the key elements of which are:
  - prevention or alleviation of social and individual risks caused by drug use;
  - a rational relationship between those risks and policy measures;
  - a differentiation of policy measures based on the risks associated with drugs;
  - repressive measures against drug trafficking are a priority; and
  - the inadequacy of criminal law with respect to other aspects apart from drug trafficking.[71]
- Policy of normalization: social control is achieved through depolarization and the integration of deviant behaviour rather than isolation and removal, as is typical of the deterrence model. This paradigm also suggests that drug problems should be seen as normal social problems rather than unusual concerns requiring extraordinary treatment.
- Market separation: by classifying drugs according to the risks posed and then pursuing policies that serve to isolate each market, it is felt that users of soft drugs are less likely to come into contact with users of hard drugs. Thus, the theory goes, users of soft drugs are less likely to try hard drugs.

Legislation

In 1919, the Netherlands passed its first law on opium under the influence of the international conventions, including the Hague Convention in 1912. That legislation prohibited the manufacture, sale, processing, transportation, supply, import, export and possession of cocaine, opium and its derivatives. The law was amended in 1928 to include cocaine derivatives and cannabis in the list of controlled substances. However, only the import, expert and transfer of those substances were prohibited. The offences

[71] M. Grapendaal, E. Leuw and H. Nelen, *A World of Opportunities: Life-Style and Economic Behaviour of Heroin Addicts in Amsterdam*. New York, S.U.N.Y. Press, 1995, mentioned in T. Boekhout van Solinge, "Dutch Drug Policy in a European Context", *Journal of Drug Issues* Vol. 29, No 3, 1999, page 511. Available online at: www.cedro-uva.org/lib/boekhout.dutch.html.

of possession and producing cannabis and cannabis derivatives were not punishable until 1953.

The *Opium Act*–also referred to as the *Narcotics Act*–is the Netherlands' main drug legislation. The *Act* criminalizes possession, cultivation, trafficking and importing or exporting. The 1976 Amendments establishes two classes of drugs: Schedule I drugs are deemed to present an unacceptable risk to Dutch society and include heroin, cocaine, amphetamines and LSD; Schedule II drugs include "traditional hemp products" such as marijuana and hashish.

Offences

The *Act* has three characteristic features:

- it criminalizes possession, trafficking, cultivation, transportation, manufacturing, import and export of drugs, **including cannabis and cannabis derivatives**;
- it draws a clear distinction between suppliers and users; the act punishes possession for the purpose of use, not use as such;
- differentiated penalties based on the substances involved.

The possession of all scheduled drugs is an offence, but possession of a small quantity of "soft" drugs for personal use is a minor offence. Generally, it is tolerated by law enforcement, particularly within the regulated coffee shop system, discussed in the following section. Importing and exporting are the most serious offences under the *Act.*

Penalties

The maximum penalty for importing or exporting hard drugs is 12 years' imprisonment and a fine of 100,000 Dutch florins.[72] Anyone found in possession of a quantity of hard drugs for personal use is liable to a penalty of one year's imprisonment and a fine of 10,000 florins. The maximum penalty for importing or exporting soft drugs is four years' imprisonment and a fine of 100,000 florins. Repeat offenders are liable to a maximum penalty of 16 years' imprisonment and a fine of 100,000 florins. Offenders may also be deprived of any money or property gained from their offence. The Netherlands also has guidelines for sanctions that the Public Prosecutor is directed to seek, based on: the type of drug involved, the amount of the drug and the specific offence. The following tables set out the current guidelines (1996).[73]

[72] 100,000 Dutch florins = approximately C$63,000.

[73] Source: Staatscourant (1996) in D.J. Korf and H. Riper, "Windmills in Their Minds? Drug Policy and Drug Research in the Netherlands", *Journal of Drug Issues* , Vol. 29, No. 3, 1999, page 451, Table 2.

SCHEDULE I SUBSTANCES ("HARD DRUGS")		
Offence	Amount	Sanction to be Sought[74]
Possession	< 0.5 g or < 1 user unit	Police Dismissal
	0.5-5 g or 1-10 user units	1 week - 2 months
Possession with Dealer Indication (i.e., intent to sell)	< 15 g or < 30 user units	Up to 6 months
	15-300 g or 30-600 user units	6-18 months
	> 300 g or > 600 user units	18 months - 4 years
Street or Home Dealing	< 1 g	Up to 6 months
	1-3 g	6-18 months
	> 3 g	18 months - 4 years
Middle-level Dealing	< 1 kg	1-2 years
	> 1 kg	2+ years
Wholesale Trade	> 5 kg	6-8 years
Import and Export	< 1 kg	Up to 3 years
	> 1 kg	3-12 years

SCHEDULE II ("SOFT DRUGS")		
Offence	Amount	Sanction to be Sought (75)
Possession, Preparing, Processing, Sale, Delivery, Supply, Transporting or Manufacturing	Up to 5 g	Police Dismissal
	5-30 g	Fine of Dfl. 50-150
	30 g-1 kg	Fine of Dfl. 5-10 per g
	1-5 kg[76]	Fine of Dfl. 5,000-10,000 and 2 weeks per kg
	5-25 kg	Max. fine of Dfl. 25,000 and 3-6 months
	25-100 kg	Max. fine of Dfl. 25,000 and 6-12 months
	> 100 kg	Max. fine of Dfl. 25,000 and 1-2 years

[74] In addition to imprisonment, penalties sometimes include fines and property seizures (except for possession).

[75] For repeat offences within five years, the required penalty is increased by one-quarter. As to sales to "vulnerable groups" (that is to say to minors, psychiatric patients), a minimum fine of approximately Cdn $475 is also levied.

[76] Quantities greater than 1 kg are considered as suggesting drug trafficking.

SCHEDULE II ("SOFT DRUGS")		
Offence	Amount	Sanction to be Sought (75)
Cultivation	Up to 5 plants	Police Dismissal
	5-10 plants	Dfl. 50 par plant (repeat offenders: Dfl. 75 per plant)
	10-100 plants	Dfl. 25 per plant and/or ½ day per plant
	100-1 000 plants	Max. fine of Dfl. 25,000 and 2-6 months
	>1 000 plants	Max. fine of Dfl. 25,000 and 6 months – 2 years
Import and Export	The *Act* does not distinguish between quantities, but in practice the prosecutor's sentence recommendation will correspond to the quantity divisions for possession.	Sanctions for possession may be doubled to a maximum of 4 years and a maximum fine of Dfl. 100,000

The coffee shop system

Contrary to several stereotypes, cannabis possession is not decriminalized; strictly speaking, it is still a criminal offence. However, based on the principle of expediency, which is part of the criminal law tradition in the Netherlands, the possession of small amounts of cannabis for personal use has been decriminalized. The sale of cannabis is technically an offence under the *Opium Act*, but prosecutorial guidelines provide that proceedings will only be instituted in certain situations.

Without legalizing the sale of cannabis and cannabis derivatives, the municipalities may permit the establishment of coffee shops which are authorized to sell cannabis under certain conditions. An operator or owner of a coffee shop (which is not permitted to sell alcohol) will avoid prosecution if he or she meets the following criteria:

- no more than 5 grams per person may be sold in any one transaction;
- no hard drugs may be sold;
- drugs may not be advertised;
- the coffee shop must not cause any nuisance;
- no drugs may be sold to minor (under 18), nor may minors enter the premises;
- the municipality has not ordered the establishment closed.

> *The idea behind the Netherlands' policy towards the* coffee shops *is that of harm limitation. This is based on the argument that if we do not prosecute small-scale cannabis dealing and use under certain conditions, the users – who are mainly young people experimenting with the drug – are not criminalized (they do not get a criminal record) and they are not forced to move in criminal circles, where the risk that they will be pressed to try more dangerous drugs such as heroin is much greater.* [77]

It is common for municipalities to have a coffee shop policy to prevent or combat the public nuisance sometimes associated with these establishments. For example, suspicion of selling hard drugs or locating a coffee shop near a school or in a residential district may result in closure. In April 1999, the "Damocles Bill" amended the *Narcotics Act* by expanding municipal powers regarding coffee shops and permitting local mayors to close such places if they contravened local coffee shop rules, even if no nuisance was being caused. As a result of strict enforcement and various administrative and judicial measures, the number of coffee shops decreased from nearly 1,200 in 1995 to 846 in November 1999. [78]

There appears to be three types of policies on coffee shops:

- tolerance without condition as to the number of coffee shops, which is determined by market mechanisms; this situation is the most rare;
- conditional tolerance, setting a maximum number of coffee shops;
- zero tolerance: no coffee shop; this is the case in approximately 50 per cent of Dutch cities.

To determine the ideal number of coffee shops, the association of municipalities recommends that demographic factors (number of inhabitants, age groups) and urban development factors (role of the city with respect to the region; number of centres in the city) be considered, as well as any nuisance caused by the use of soft drugs.

> *Thus, in most municipalities, coffee shops are accepted on in the downtown area, and a maximum number is determined in accordance with criteria of distance – distance of the establishments from one another and distance between the coffee shops and certain institutions such as schools and psychiatric hospitals. (…) The difficulties encountered by certain mayors with regard to administrative judges have come from the fact that the absence of any complaints or contraventions has been considered by certain judges as an absence of any concrete evidence of nuisance. A "substantiated" policy is ultimately a policy based on a procedure for consulting drug addiction and public health experts, police experts and, in certain instances, the public itself (including users). This is also a balanced policy in the sense that it accommodates the interests not only of "average" citizens irritated by public nuisances, but also those of soft drug users.* [79]

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[77] Dr. Robert Keizer, *The Netherlands' Drug Policy*. Brief to the Senate Special Committee on Illegal Drugs, November 19, 2001.

[78] National Drug Monitor, "Fact Sheet: Cannabis Policy, Update 2000", Trimbos Institute, 2000.

[79] Martineau and Gomart, *op.cit.*, page 85, for the quotation and preceding information.

Since the memo on public nuisances was issued in 1993 and stricter conditions were set for the issuing of permits in 1999, municipal authorities have in fact been able to issue "nuisance permits", which are thus used to monitor the number of coffee shops, without moreover violating the fundamental orientations of the Dutch system.

Data on use

Despite the Dutch "pragmatism", there are ultimately few reliable historical data on use trends. It therefore cannot be asserted that use trends significantly increased after the coffee shop system was introduced, nor can it be stated that they declined. The creation of the Trimbos Institute and its designation as a focal point in the OEDT's European network are correcting this situation.

The following tables contain data from the most reliable surveys.

CANNABIS USE IN THE NETHERLANDS BY PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Has ever used	16%
Has used recently	2.5%
Has used for the first time in the past year	1%
Mean age of current users	28 years

CANNABIS USE IN THE FOUR LARGE CITIES AND IN SMALLER TOWNS AMONG PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

	Ever use	Recent use
Amsterdam	**37%**	**8%**
Utrecht	**27%**	**4%**
The Hague	**20%**	**4%**
Rotterdam	**19%**	**3%**
Smaller towns[(a)]	**11%**	

(a) Definition: Towns with less than 500 addresses per square kilometre.

CANNABIS USE BY PEOPLE AGED 16 AND ABOVE IN THREE URBAN AREAS. SURVEY YEAR 1999

	Ever use[(a)]	Recent use[(b)]
Utrecht	**30%**	**7%**
Rotterdam	**19%**	**6%**
Parkstad Limburg[(c)]	**13%**	**5%**

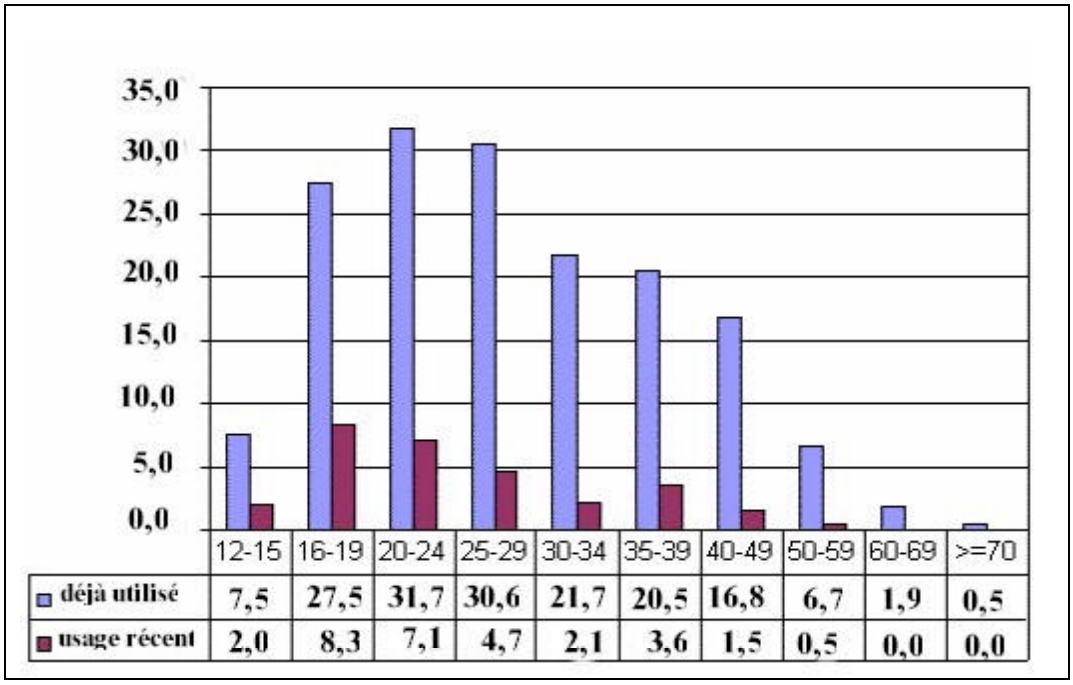
Percentage of users: [(a)] 16 to 70 years, [(b)] 16 to 55 years. Recent use: last month.

LEVEL OF CANNABIS CONSUMPTION IN THE NETHERLANDS BY RECENT USERS AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Days of use in the last month	*Percentage among recent users[(4)]*
1-4	**45%**
5-8	**14%**
9-20	**15%**
More than 20 days	**26%**

[(a)] Adds up to 100%.

CANNABIS USERS IN THE NETHERLANDS PER AGE GROUP. SURVEY YEAR 1997[80]



	12-15	16-19	20-24	25-29	30-34	35-39	40-49	50-59	60-69	>=70
déjà utilisé	7,5	27,5	31,7	30,6	21,7	20,5	16,8	6,7	1,9	0,5
usage récent	2,0	8,3	7,1	4,7	2,1	3,6	1,5	0,5	0,0	0,0

[80] We have reproduced this table in its original format, thus we do not have the capacity to change text to English ; "déjà utilisé" means ever used, and "usage récent" means recent use.

WHERE DO YOUNG PEOPLE PROCURE THEIR CANNABIS?

	1996	1999
Obtain cannabis from friends	41%	47%
Purchase cannabis in coffee shops	41%	32%
Purchase cannabis from a dealer	11%	11%
Receive cannabis from others	5%	8%
Purchase cannabis at school	3%	1%
Grow it themselves[a]	-	2%

Pupils aged twelve and above in secondary schools (recent users)
[a] Only measured in 1999.

RECENT CANNABIS USE IN SPECIAL GROUPS

Young persons in	*Survey Year*	*Age*	*Recent Use*
Special schools for secondary education	1997	12-18	14%
Truancy projects	1997	12-18	35%
Judicial institutions	1995	-	53%
Youth care institutions	1996	10-19	55%
Young drifters	1999	15-22	76%

As seen in Chapter 6, the available data on the Netherlands place the country somewhere in the middle of the field, behind Australia, the United States, the United Kingdom, Spain and Denmark, and far ahead of Sweden and Finland.

Whatever the case may be, and despite what some analysts refer to as a disastrous situation, the Dutch experience poses fewer problems in relation to drug use in the Dutch population than internal difficulties in connection with the nuisances caused by the coffee shops for Dutch citizens and neighbouring countries, Germany, France and Belgium, as a result of narco-tourism. Even more significant, the Dutch system, with its half measures, is faced with the problem of supplying coffee shops with cannabis and cannabis derivatives, which is still entirely illegal.

> *Holland does not escape criticism any more than other countries. From a theoretical standpoint, the very principle of de facto legalization is debatable. It fosters arbitrary action and, in particular, leaves the field open to trafficking. As much as the legalization of drug use has made it possible to get a handle on the phenomenon and make it visible so that it can be more effectively addressed, the legalization of trafficking prevents any control. (…) In practical terms, the criticisms are equally fundamental. The main criticism is that the Dutch policy has not reduced the use of drugs, hard or soft. (…) Nor has the Dutch policy eliminated the risks associated with drug abuse. (...) But it must also be recognized, and it is to the credit*

of the Dutch policy that, while the Netherlands has not actually done better than the prohibitionist countries in the fight against drug use, it has not done worse.[81]

Ultimately, the most remarkable thing is the ability of the Dutch stakeholders themselves, as may be seen from their testimony before our committee, to admit the weaknesses and errors of their approach, while constantly seeking ways to correct them.

[81] Caballero and Bisiou (2000), *op. cit.*, page 770-772.

UNITED KINGDOM[82]

Ten-year strategy to battle drugs

In 1998, at the same time as the newly elected Labour government announced an imposing crime reduction program, it adopted a 10-year strategy, based on a similar model, to combat drug abuse in the UK.[83] The strategy has four objectives:

- To help young people resist drug misuse in order to allow them to achieve their full potential. The key objective is to reduce the number of people under age 25 reporting use of illegal drugs in the past month and previous year. The program relies on education in schools and prevention efforts focusing on young people at risk.
- To reduce levels of repeat offending among drug-misusing offenders, by giving them the opportunity to take appropriate treatment. To do this, various treatment options were added to the stages of arrest, probation and court appearance. In addition, new drug treatment and testing orders will be made available in all courts in England and Wales. This scheme allows a court, with the offender's consent, to make an order requiring the offender to undergo treatment either in parallel with another community order, or as a sentence in its own right. In addition, the program known as *Carats* (*Counselling, Assessment, Referral, Advice and Throughcare*) is available in all England and Wales prisons, and additional prison-based rehabilitation programs are planned.
- Acknowledging that waiting times are one of the main problems for people requiring treatment and that the supply of treatment services is well below demand, the government plan provides for the creation of a National Treatment Agency which will be responsible for the provision of drug treatment and the delivery of high-quality services. Harm reduction strategies will also be increased.
- To reduce access to drugs among five-to-16-year old children, increase the seizure of Class A drugs and increase assets seized from traffickers.

Ambitious targets relating to the drug strategy have been set out in the Anti-Drugs Co-ordinator's First Annual Report and National Plan, including:

- halving the numbers of young people using illegal drugs (especially heroin and cocaine);

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[82] This section draws largely on the research report prepared for the Committee by the Library of Parliament: G. Lafrenière, (2001) *National Drug Policy: United Kingdom.* Ottawa: Library of Parliament, prepared for the Senate Special Committee on Illegal Drugs; available online at www.parl.gc.ca/illegaldrugs.asp.

[83] *Tackling Drugs to Build a Better Britain.*

- halving the levels of re-offending by drug-misusing offenders;
- doubling the numbers of drug misusers in treatment; and
- halving the availability of drugs on the streets (especially heroin and cocaine).

Although the 10-year strategy is supposed to focus on the most harmful drugs (heroin and cocaine), the number of people fined, cautioned and in some cases jailed for possession of cannabis still exceeds 100,000 a year.[84]

Legislative framework

The main illicit drug legislation in the UK is the Misuse of Drugs Act 1971 (MDA) (which is equivalent to Canada's *Controlled Drugs and Substances Act*). This legislation and its regulations (Misuse of Drugs Regulations 1985) control the use of listed drugs (including both medical drugs and drugs with no medicinal use). They set out the circumstances in which it is lawful to import, produce, supply, possess with intent to supply, and possess controlled drugs.

Under Schedule 2 of this Act, drugs are classified as either A, B or C in theory to reflect the degree of harm they are considered to cause to the individual or society when misused. Each class has different maximum penalties that apply to prohibited activities in relation to drugs.

- *Class A* is reserved for the more harmful drugs to which more severe penalties apply. This class includes, among others, heroin, morphine, methadone, cocaine, opium and hallucinogens such as Ecstasy and LSD. Also included are liquid cannabis (hashish oil), cannabinol and cannabinol derivatives and any class B drug prepared for injection.
- *Class B* includes cannabis, cannabis resin, less potent opioids (codeine), strong synthetic stimulants (oral amphetamines) and sedatives (barbiturates).
- *Class C* is reserved for drugs that are considered the least harmful such as tranquillzers, some less potent stimulants and mild opioid analgesics.

The Home Secretary can change the classification of drugs through delegated legislation as was just recently done for cannabis. This modification means that possession of cannabis for personal use will not be an arrestable offence but obtain a police caution.

Sections 3 to 6 set out which activities in relation to drugs are prohibited. They include importation and exportation (the actual offences are contained in and prosecuted under the Customs and Excise Management Act 1979), production, supply,

[84] "Drug Laws: the debate nobody wants", *The Guardian*, May 14, 2001.

possession, and possession with intent to supply. Cultivation of cannabis is a separate offence but is also considered production. Under section 8, it is prohibited for the occupier knowingly to permit premises to be used for: production; the supply of any controlled drug; the preparation of opium for smoking; or the smoking of cannabis, cannabis resin or prepared opium. Section 9 provides a series of offences related to opium, including smoking or otherwise using opium. Section 9A prohibits the supply of any article which may be used in the unlawful administration of drugs (hypodermic syringes are excluded from this prohibition for the purpose of needle exchange programs). Sections 18 to 21 create other offences mainly dealing with incitement to commit an offence under the *MDA*.

Penalties are set out in sections 25 and 26. Section 27 deals with forfeiture.

- For class A drugs, the maximum penalties are as follows: seven years and/or unlimited fine for possession; life and/or unlimited fine for production or trafficking with a mandatory seven-year sentence for a third conviction for trafficking. The mandatory sentence for a third conviction of trafficking is found in the Criminal Sentences Act 1997.
- For class B drugs, the maximum penalties are: five years and/or unlimited fine for possession; and fourteen years and/or unlimited fine for production or trafficking.
- For class C drugs, the maximum penalties are: two years and/or unlimited fine for possession; and five years and/or unlimited fine for trafficking.

In addition, producers and traffickers are also liable to confiscation of assets under the Drug Trafficking Act 1994. As stated above, growers of cannabis may be prosecuted under section 4 (production) of the MDA rather than under section 6 (cultivation) of this Act. This is significant because production (but not cultivation of cannabis) is designated a trafficking offence for the purposes of the Drug Trafficking Act 1994. In 1997, a total of 4,168 people were dealt with for production offences of which 92% involved production of cannabis (25% of these offenders were cautioned and 18% of those who were found guilty were sentenced to immediate custody). Offences that are designated as trafficking offences for the purposes of the Drug Trafficking Act 1994 include production, supply, and possession with intent to supply as well as importation offences under the Customs and Excise Management Act 1979. In the UK, most drug offences may be tried summarily by magistrates or on indictment with a jury at a Crown Court. If tried summarily, the maximum cannot exceed six months and/or £5000 fine or three months and/or fine for less serious offences.

Section 7 allows for regulations to be made to exempt certain activities from the offence provisions. This allows for the use of drugs for medicine and for scientific research. The Misuse of Drugs Regulations 1985 divide drugs into five schedules. The regulations set out the classes of persons who are authorized to handle controlled drugs while acting in their professional capacities and lay down the conditions under which certain activities may be carried out. More severe rules regarding importing, exporting,

production, supply, possession, prescribing and record-keeping apply to Schedule 1 drugs with a gradual loosening of the rules for other schedules. For example, the most restricted Schedule 1 drugs (such as LSD and cannabis) can be supplied or possessed only for research or other special purpose by licensed individuals and are not available for normal medical uses and cannot be prescribed by doctors who do not have a licence. Schedule 2 drugs–which must be prescribed–are subject to a number of controls relating to prescriptions, secure storage and the need to keep records. Schedule 5 drugs, meanwhile, are subject to the least administrative controls and may be freely imported, exported or possessed for personal use.

Cannabis and certain psychoactive cannabinoids and derivatives are classified under Schedule 1 as having no therapeutic benefit. Thus, they cannot be prescribed and can only be possessed for research purposes by someone who is licensed to do so. Nabilone (a synthetic cannabinoid) is licensed for prescription to patients with nausea or vomiting resulting from cancer chemotherapy, which has proved unresponsive to other drugs. Dronabinol (a cannabinoid) has been rescheduled from Schedule 1 to Schedule 2 and can be prescribed. However, it remains unlicensed in the UK and has to be prescribed on a "named patient basis."

Section 10 allows the making of regulations dealing with safe custody, documentation of transactions, record-keeping, packaging and labelling, transport, methods of destruction, prescriptions, the supply of information on prescriptions to a central authority, the licensing of doctors to supply controlled drugs to addicted patients, and the notification by doctors of their addicted patients.

The Misuse of Drugs (Supply to Addicts) Regulations 1997 restrict to a few specially licensed doctors the ability to prescribe heroin, dipipanone and cocaine for the treatment of addiction.

Other relevant legislation in the field of drug misuse

The Medicines Act 1968 (equivalent to Canada's *Food and Drugs Act*) regulates the production and distribution of medicinal drugs and other medicinal products in the UK. It generally requires a marketing authorization or licence before a product may be distributed. The Act deals with the testing, sale, supply, packaging, labelling, prescribing, dispensing by pharmacists, and selling in shops of medicinal products. Many controlled drugs are also medicinal products and must thus satisfy the requirements of both the MDA and the Medicines Act 1968.

The MDA prohibits the importation or exportation of a controlled drug unless it is exempted by regulation or it takes place under the proper licence. The offences, however, are actually under the Customs and Excise Management Act 1979 which acts together with the MDA to prohibit unauthorized importation or exportation of controlled drugs. The offences under the Customs and Excise Management Act 1979 are usually charged and prosecuted by H.M. Customs and Excise rather than by the police and Crown prosecutors. In 1997, a total of 1,741 people were dealt with for

these offences, 68% of which involved cannabis (31% were dealt with by compounding and of those found guilty by the courts, 79% were sentenced to immediate custody).

Part II of the Criminal Justice (International Co-operation) Act 1990 controls the manufacture and supply of certain precursor chemicals which can be used in the manufacture of illicit drugs. Manufacture or supply contrary to the Act is a trafficking offence for the purposes of the Drugs Trafficking Act 1994. Regulations may be made dealing with notification of exports, record-keeping and the supply of information.

The Drug Trafficking Act 1994 was adopted to enable the UK to meet its obligations under the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1998 (The Vienna Convention). It creates offences in connection with laundering and handling of the proceeds of drug trafficking, and introduces confiscation measures. The burden of proof is placed on the defendant to prove that the assets were lawfully acquired and applies the civil standard of proof on the balance of probabilities. The MDA does not distinguish between trafficking and non-trafficking offences. Rather, this distinction is made in the Drug Trafficking Act 1994; the main consequence of designating an offence as a trafficking offence is that the confiscation provisions apply. In addition, an offender is liable for a third trafficking offence involving a Class A drug to a minimum penalty of seven years imprisonment under the Crime Sentences Act 1997.

Debate in the UK

As in Canada, the debate in the UK regarding cannabis would appear to revolve around two issues: (1) decriminalization or legalization of cannabis for recreational use; and (2) the medicinal use of cannabis.

Although cannabis is now a Class C drug, its recreational use is still prohibited in the UK. Under the MDA, it is illegal to grow, produce, possess, or supply cannabis to another person. It is also an offence to allow premises to be used for growing, preparing, supplying or smoking it. Maximum penalties for cannabis offences in the UK are fairly severe (these vary throughout the EU). As in Canada, there is considerable discretion in how the law is applied and in many cases the police caution those found in possession of small amounts of cannabis. In the *Report of the Independent Inquiry into the Misuse of Drugs Act 1971, Drugs and the Law*, the following was stated regarding the use of discretion, particularly with respect to cannabis:

> *Many cases are kept away from the courts by cautioning and compounding and, in Scotland, warning letters and fiscal fines. By far the largest increase in police cautioning in England and Wales has been for cannabis offenders, from 41% in 1990 to 55% in 1997. This has meant in practice a tripling in the number of cannabis offenders for which a caution was given, from 16,500 to 47,000. Cautions are part of an offender's criminal record. There is no provision at present for these records to expire under the Rehabilitation of Offenders Act 1974. The Government has recently issued a consultation paper proposing that this anomaly should be corrected and that cautions should be immediately spent. This*

would also apply to reprimands and warnings, which are to replace cautions for young people under 18 under the Crime and Disorder Act 1998.
Cautioning is not used by H.M. Customs and Excise or in Scotland. For importation and exportation offences, compounding – a monetary penalty in lieu of prosecution – may be used in cases involving cannabis not exceeding 10 grams in weight. While compounding does not necessarily become part of an offender's criminal record, it may be mentioned in subsequent court proceedings Its use for cannabis importation offenders fell between 1990 and 1997 from 58% to 45%.
…This discretion in the implementation of the MDA is desirable but produces anomalies in the differing regimes of cautioning and compounding, and inconsistencies in the cautioning rates between police forces. More than half of the arrests for cannabis offences result in a caution. We do not criticise the police for their extensive use of cautioning. It is currently the only realistic and proportional response. Without it, the courts would have ground to a halt. However, the use of discretion does not lessen the disproportionate attention that the law and the implementation of the law unavoidably give to cannabis and cannabis possession in particular.[85]

The use of cannabis for medicinal purposes has a long history in the UK. It was prescribed as a medicine in the UK until 1973. At that time, it became a drug that could not be legally used as a medicine and today its medicinal use remains prohibited. As will be discussed in the next section, the Science and Technology Committee of the House of Lords recommended that cannabis be made available for medicinal purposes in a 1998 report. This recommendation was rejected by the government, which indicated that before such a change could be considered, the safety and efficacy of cannabis would have to be demonstrated. G.W. Pharmaceuticals has been given permission to grow cannabis with the aim of developing a cannabis-based medicine; clinical trials have commenced in the UK.

Recent key reports and studies

Science and Technology Committee of the House of Lords

In 1998, the Science and Technology Committee of the House of Lords studied the issue of medicinal use of cannabis and tabled a report entitled Cannabis: The Scientific and Medical Evidence. The purpose was to examine the scientific and medical evidence with respect to the medicinal use of cannabis and determine whether current restrictions were appropriate. In addition, the Committee considered whether the prohibition on recreational use was justified based on the scientific evidence of adverse effects. However, the mandate did not include other issues such as the social and legal aspects of cannabis use.

The Committee discussed the long history of cannabis use both as a medicine (usually in the form of a tincture) and an intoxicant. The Committee noted that the

[85] Police Foundation (2000) *Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, "Drugs and the Law", Chapter 7, paragraphs 28, 29 and 31.

"*advent of a host of new and better synthetic drugs led to the abandonment of many ancient herbal remedies, including cannabis*."[86] The *Medicines Act 1968* allowed the government to licence pharmaceutical companies and products, and cannabis was still able to be prescribed under certain conditions. In 1973, cannabis's licence of right was not renewed and the regulations under the *Misuse of Drugs Act 1971* prohibited medical use altogether (by listing cannabis in what is now Schedule 1).

The Committee then went on to review the pharmacology of cannabis and the different ways it may be administered, the toxic effects of cannabis, including: the short and long-term effects of it; whether the user develops tolerance to the drug; and whether it causes dependence. The Committee found that although cannabis "*is not in the premier league of dangerous substances, new research tends to suggest that it may be more hazardous to health than might have been thought only a few years ago*."[87]

Concerning the current medical use of cannabis in the UK (quite widespread even though it is illegal) as well as the current medical uses of cannabinoids (certain cannabinoids are legally in current use in UK medicine), the Committee proposed new indications for cannabis-based medicines (including alleviating certain symptoms related to multiple sclerosis). The Committee stated that it "*is important to distinguish the different substances and preparations; for instance, cannabis leaf must be distinguished from cannabis extract, and whole cannabis from THC. It is also important, although not always easy, to distinguish the various possible routes of administration, e.g. by smoking and by mouth.*"[88]

Based on evidence that cannabis can be effective in relieving the symptoms of multiple sclerosis and against certain forms of pain, the Committee recommended that clinical trials of cannabis for these conditions "be mounted as a matter of urgency." The Committee members did indicate that if a medicine became licensed (after clinical trials), they did not envisage smoking being used to administer it. Thus, they called for research into alternative delivery systems. The Committee also recommended that cannabis should be reclassified as a Schedule 2 drug so that doctors would be permitted to prescribe an appropriate preparation of cannabis, "*albeit as an unlicensed medicine and on the named-drug basis*"; this would also allow research without a special licence.

Compassion was the main reason for recommending the change to the law (a law under which patients risk prosecution to get help). Another reason was the inconsistent way in which the law was enforced, which brought it and Parliament into disrepute.

The Committee did note that cannabis-based medicine would not be appropriate for certain groups of patients such as pregnant women, people predisposed to schizophrenic illness or those with cardiovascular conditions. In addition, users would have to be warned of possible side-effects. The risk of addiction would have to be considered when deciding whether to prescribe. Thus, the Committee recommended that "*if doctors are permitted to prescribe cannabis on an unlicensed basis, the medical professional*

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[86] House of Lords, Select Committee on Science and Technology, Ninth Report, Session 1997-98, *Cannabis: The Scientific and Medical Evidence*, para. 2.6.

[87] *Ibid*., par. 4.1.

[88] *Ibid*., par. 5.1.

bodies should provide firm guidance on how to do so responsibly"[89] and that "*safeguards must be put in place by the professional regulatory bodies to prevent diversion to improper purposes*."[90]

With respect to the recreational use of cannabis, the Committee added that although the harms must not be overstated, there was enough evidence of toxic effects of cannabis to justify maintaining the current prohibition.

The government rejected the recommendation to reclassify cannabis. It indicated that before cannabis should be available for prescription, its safety, quality and efficacy would have to be demonstrated and a marketing authorization issued by the Medicines Control Agency. In addition, the government indicated that allowing prescriptions of cannabis would reduce momentum in research. The government was also concerned with the possibility of prescribed cannabis being used for improper purposes.

In March 2001, the Science and Technology Committee of the House of Lords presented another report dealing with the current state of research into the therapeutic uses of cannabis, the roles of the Home Office and the Medicines Control Agency in the licensing of cannabis-based medicines, and more recent issues relating to the prosecution of therapeutic cannabis users. The Committee reiterated that cannabis should remain a controlled drug and that the legalization debate should maintain a clear distinction between therapeutic and non-therapeutic use.

With respect to the current state of research, the Committee noted trials recently approved for funding by the Medical Research Council. The Committee was concerned about the long timeframe for developing usable therapeutic preparations from these trials. It was more encouraged with the progress being made by G.W. Pharmaceuticals, both with respect to establishing the efficacy of a cannabis-based medicine and in developing suitable medical preparations (e.g., a sub-lingual spray).

The Committee also discussed the prosecution of therapeutic users of cannabis. They noted that the decision to prosecute varies from region to region and that, in some cases, juries have acquitted therapeutic users who do not deny the offence but plead therapeutic use in mitigation while others are found guilty. The Committee believed that the acquittal of cannabis users by juries on compassionate grounds brings the law into disrepute. According to the Committee, this problem underlines the need to legalize cannabis preparations for therapeutic use.

The Committee noted that the decisions made by the Medicines Control Agency appear to be inconsistent. For example, although it is satisfied that the information on the toxicological profile of delta-9-tetrahydrocannabinol is adequate, it is not satisfied with the toxicology data of cannabidiol. The Committee was of the view that the Medicines Control Agency had "*not adopted a positive approach towards the licensing of a cannabis-based medicine.*" The Committee was concerned that the Medicines Control Agency's approach places "*the requirements of safety and the needs of patients in an unacceptable*

[89] *Ibid.*, par. 8.16.
[90] *Ibid.*, par. 8.17.

balance." The Committee concluded that the Agency's attitude "*means that cannabis-based medicines are not being dealt with in the same impartial manner as other medicines*."

> *We believe that a thorough and impartial reappraisal of the published scientific literature on the safety of CBD and cannabis extracts should lead the MCA to reconsider their present overly cautious stance. We are at least encouraged that the MCA state that they are conducting a more detailed review of existing literature reports on cannabis and CBD.* [91]

The Runciman Report

In August 1997, The Police Foundation set up an independent inquiry (chaired by Viscountess Runciman) to assess the UK's legislation on the misuse of drugs. The main goal was to determine whether the legislation needed to be revised in order to be more effective and more responsive to the changes that had taken place in the 30 years since the original law was passed.

The report recognizes that the goal of drug legislation must be to control and limit the demand for and the supply of illicit drugs because eradication of drug misuse is not a realistic goal. The report also stated that the law must fulfil UK's international obligations and noted that international agreements – while restricting some options – allow for room to manoeuvre, particularly in the areas of drug use and possession.[92] The report discussed different approaches towards drug use and possession and towards minor acts of supply taken by some other European countries and found that the UK had a comparatively more severe regime of control of possession offences.

The report indicated that the law should be based on the following principles:

- as a means of reducing demand, the law is only one aspect of a broader agenda of health, prevention and education;
- it should reflect the latest scientific understanding and the social and cultural attitudes of modern British society;
- it should be realistically enforceable;
- it should infringe personal freedom only to the degree necessary to restrain serious levels of harm to users or others;
- it should target the drugs that cause the most harm;
- it should reflect the relative harmfulness of activities connected with each illicit drug or category of drugs, and provide for sanctions proportionate to that harm; and
- in its operation, the law should be accepted by the public as fair, consistent, enforceable, flexible and just.

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[91] House of Lords, Select Committee on Science and Technology, *Therapeutic Uses of Cannabis*, Second Report, March 14, 2001, par. 29.

[92] *Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, Drugs and the Law, Mars 2000, page 74.

The report noted a steady increase in the prevalence of both problem drug use (including injecting among problem drug users) and casual drug use in the UK over the past 30 years. Cannabis is the most widely used illegal drug, with age 30 being the big divide in drug use. Despite there being a steady rise in drug offences and seizures (including amounts seized) over the years, the report concluded that efforts to limit supply have in the most part failed. The report found that the public views health-related dangers of drugs as more of a deterrent than their illegality, availability or price. In addition, public attitudes to cannabis compared to other drugs were significantly different (cannabis was seen as the least harmful drug, its possession should be the lowest of priorities for police, and a number of people – a third to half – believe that the laws should be relaxed).[93] All age groups shared these views, although support for legalization was not as strong among older age groups. With respect to other drugs, strong drug laws were fully supported despite concern with health risks resulting from drug use. The public was much more concerned with trafficking than with possession offences. The inquiry found that there was a lack of data on drug use and the absence of detailed cost information about drug use (e.g., health care, enforcement and other social services costs). Thus, it was difficult to do any type of assessment of drug control and prevention strategies

The UK's drug classification was reviewed and the report recommended keeping the current three-tier drug classification system (class A, B and C). This classification enables authorities to distinguish between the relative risks of different drugs and allows sanctions to be applied that are proportionate to a drug's harm. However, the report found that the criteria by which drugs are classified should be clearly described. The classification should take into account modern developments in medical, scientific and sociological knowledge; as well, the main criteria should be dangerousness of the drug to the individual and to society. The report set out factors to consider, including: the risks of the drug itself (acute and chronic toxicity); risks due to the route of use; extent to which the drug controls behaviour (addictiveness/dependency) and ease of stopping; and social risks (costs to society in terms of crime, medical costs, social harm through intoxication, etc.). Based on these factors, the report recommended some changes to the drug classes to counteract what the members felt was a dangerous message, i.e., that all drugs are equally dangerous. The members of the inquiry believed that these changes would enhance the law's credibility and that education and attention should be refocused on the more harmful drugs such as heroin and cocaine. The report recommended the following changes:

- cannabis should be reclassified from a class B drug to a class C drug and cannabinols from class A to class C;
- heroin and cocaine would remain in class A (the most dangerous drug category) while Ecstacy and LSD would move to class B; and
- buprenorphine would move from class C to class B.

[93] *Ibid*., Chapter 2, par. 64.

It is interesting to note that the members of the inquiry would have classified alcohol as a class B drug bordering on A, while tobacco would have been on the borderline between B and C, if these substances were controlled under the MDA.

The report found that possession offences should remain, even if for personal use. However, the law should minimize the harmful consequences of a contravention in appropriate cases. The report concluded that for the majority of possession offences, imprisonment was neither proportionate nor effective. It recommended that imprisonment no longer be available for possession of class B or class C drugs. Imprisonment should remain a possibility for possession of class A drugs, although the maximum would be shorter than what is currently set out. This would reflect what the courts are currently doing; the average possession sentence is fairly short compared to the maximum available. In addition, the report recommends lowering the maximum fines for all classes of drugs. According to the report, imprisonment for possession would be rare. Non-custodial responses would include fines, probation orders, probation orders with treatment conditions attached, and conditional discharges. These sanctions would be most suitable for possession of class B and class C drugs where a caution was not appropriate. The report noted that in over 50% of cases, police use cautioning. This approach was supported but the report felt that this discretion needed a proper framework. Thus, cautions should become a statutory sanction with guidelines set out in regulations. This would allow the enforcement of conditions attached to a caution. Finally, the report recommended that a caution should not carry a criminal record. If the recommendation to reclassify cannabis as a class C drug were carried out, it would have certain consequences, including that police would no longer be allowed to arrest for possession of cannabis. For arrestable offences, the police have powers to insist that suspects accompany them to the police station and to search their premises without a warrant. Police would still have the power to stop and search for all drugs, however.

With respect to trafficking, the report mentioned that there should be an attempt to differentiate between acts of different gravity with respect to supply offences (for example, supply between friends versus as part of an organized criminal group and supply of class A drugs versus other drugs). The report recommended a separate offence of dealing, the main ingredient of which would be the pattern of activity of illicitly transacting business in drugs. The offence would be a trafficking offence for the purposes of the Drugs Trafficking Act 1994. The report also recommended that the maximum penalty for trafficking in class A drugs be lowered to 20 years and that the maximum for class C drugs (including cannabis) be raised to seven years. The report also recommended the adoption of sentencing guidelines, for trafficking offences in particular. The report also mentioned the ineffectiveness of the laws dealing with confiscation of assets (in their view, a pragmatic problem rather than a legislative one). The report recommended improving the effectiveness of the current system by setting up a new national confiscation agency and making several other changes.

Although the inquiry members believed that the drug legislation in general did not need radical change, the legislation's application to cannabis was the exception. Thus, many of the more significant changes apply to this drug. The report noted that it was the drug most widely used and most likely to bring people in contact with the justice system. The report also noticed the gap between how the law is written and how it is practised with respect to cannabis (due to the use of discretion). The members of the inquiry were of the view that cannabis was less harmful to the individual and society than other illicit drugs (although not harmless). With respect to cannabis, it was felt that the current law produces more harms than it prevents and that the law's response is disproportionate to the drug's harm. The report, thus, recommended penalties for cannabis possession for personal use be decreased and that imprisonment not be an option (normal sanctions for possession and cultivation for personal use would be out-of-court disposals, including informal warnings, statutory cautions or a fixed out-of-court fine). In addition, the report stated that cultivation of small amounts of cannabis should be prosecuted under section 6 (cultivation of cannabis) rather than section 4 (production) so that it not be considered a trafficking offence. The cultivation offence should be treated in the same way as possession of cannabis. In addition, permitting people to smoke cannabis on their premises would no longer be an offence. The members of the inquiry were of the view that the benefits of such a strategy outweigh the risks and that this would promote the targeting of enforcement on those drugs and activities that cause the most harm.

The report concluded that demand is not significantly reduced by the deterrent effect of the law. Education and treatment can be successful, however. Thus, the members recommended a less punitive approach to possession offences and a more punitive approach to trafficking (particularly with respect to profits obtained from drugs). The members believed that harm could be reduced with credible education and treatment when needed. They indicated that treatment is cost-effective in reducing problem drug use and associated criminal activity and recommended a substantial reallocation of resources from enforcement (currently 62%) to treatment (currently 13%).

With respect to the medicinal use of cannabis, the report concluded that the therapeutic benefits of cannabis for certain serious illnesses outweighed any potential harm. They endorsed the view of the House of Lords report that cannabis and cannabis resin should be moved to Schedule 2 (thus permitting possession and supply for medical purposes). Because the House of Lords recommendation was rejected by the government and because it would be years before a licensed cannabis product becomes available, the report recommended a new defence in law: duress of circumstance on medical grounds for those accused of the possession, cultivation or supply of cannabis for the relief of certain medical conditions.

In its reply to the report, the government rejected or referred for further consideration many of the recommendations made by the inquiry. On the key issues of reclassifying cannabis and the depenalization of cannabis, the government did not

support the inquiry's recommendations. With respect to the reclassification of cannabis, the government was mainly concerned with the health risks associated with its use. With regard to depenalization, the government rejected removing imprisonment as a possible sanction. In addition, they did not want the police powers of arrest to be abolished for these offences. In dealing with the medicinal use of cannabis, the government indicated that the quality, efficacy and safety of a medicinal form of the drug must be established before prescribing should be allowed.

As we now know, the government has since reclassified cannabis and abolished prison terms for possession for personal use.

Other reports

A Working Party of the Royal College of Psychiatrists and the Royal College of Physicians also published a report in 2000. Entitled *Drugs: Dilemmas and Choices*, the report examined key issues in preventing drug misuse. In particular, it states:

> *Spending on prevention: Three-quarters of UK expenditure is devoted to enforcement and international supply reduction. There is little evidence that this is money well-spent. The proven cost-effectiveness of methadone maintenance and abstinence-based programmes for heroin addicts suggests that more of the available budget should go to treatment programmes. New money for treatment announced by the Government is welcome, but calls for expansion of unproven and untested treatments must be resisted.*
> *Research: Current UK expenditure on drugs research does not begin to match the magnitude of the problem. Just one per cent of the annual drugs prevention budget would inject £14 million into research – over double the current spent.*
> *Improving the value of treatment: Systematic investment in staff training, monitoring of patients and essential support services is needed to bring improvement rates achieved by UK treatment programmes closer to those in the United States. In particular, more extensive drug treatment facilities are needed for adolescents.*
> *Private prescribing: Private prescribing of substitute drugs leaves scope for malpractice that comes close to 'buying a prescription'. Doctors treating drug-users outside the health service are not currently required to have extra training in addictions and receive little monitoring or regulation.*
> *Drug-testing by employers: Although expensive and surrounded by legal and ethical issues, the technology exists for drug-testing of employees using hair samples. This provides a record of drug-use over the previous three months and could, therefore, have a major impact on the prevalence of drug-use in future.*
> *Ecstasy: Many young people use Ecstasy, and some drugs education campaigns may have proved counter-productive. Any advice given to young people should take account of the likely impact on those who continue to use drugs as well those who will be deterred.*
> *Amphetamine: Dependence on amphetamine, especially when injected, probably carries more risk to users and public health than heroin. Little research has been carried out into dependence or treatment.*
> *Cannabis: Cannabis is not a harmless drug, but its ill-effects on health are almost certainly less than those of tobacco or alcohol, which are legal. More research is needed into the medicinal benefits and long-term ill-effects of the drug. Legislative experiments, as in the Netherlands, should be encouraged. People requiring cannabis to relieve disabling medical conditions, such as multiple sclerosis, should not be prosecuted.*

Future policy: The Government's Ten-Year Strategy for Tackling Drug Misuse recognises the need for greater investment in treatment. But there are no easy answers, and ambitious targets for reducing the proportion of young people using heroin and cocaine by 50 per cent by 2008 are unlikely to be achieved by the modest initiatives announced so far. Attempts to curb the illegal international drugs trade have consistently failed and will probably continue to do so. If the prevalence of drug-use and drug-related crime continues to rise, the pressure on the UK and other governments to change policies that are clearly failing is bound to increase. [94]

Administration

Because of the complexity of the drug problem, many different departments and organizations are involved in implementing the UK drug strategy. The key organizations in the UK's drug strategy are the drug action teams at the local level, which are responsible for ensuring that the strategy is translated into concrete action.

Costs

Public costs

In 1997/1998, most of the costs were directed at enforcement. The total expenditure of £1.4 billion was spent on the following activities:

- *drug misuse, enforcement and international supply reduction* accounted for 75% (enforcement includes police, court, probation, and prisons – 62%; international supply, which encompasses customs and excise, Foreign and Commonwealth Officer – 13%);
- *treatment and rehabilitation*–13%; and
- *education and prevention*–12%.[95]

Following a comprehensive spending review in 1998, an additional £217 million were to be allocated over a three-year period to drug activities. "A substantial share of these new funds will be directed at initiatives designed to break the link between drug misuse and crime, including Arrest Referral Schemes and Drug Treatment and Testing Orders. The idea is to provide every drug misusing offender entering a police station or prison with a chance to seek treatment by the year 2002."[96] The extra funds were to be spent as follows:

- £133 million for the implementation of the strategy to tackle drug misuse in the criminal justice system.

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[94] Joseph Rowntree Foundation, *Drugs: dilemmas, choices and the law*, November 2000. This article may be found at http://www.jrf.org.uk/knowledge/findings/foundations/N70.asp.

[95] *Tackling Drugs to Build a Better Britain, The Government's Ten-Year Strategy for Tackling Drugs Misuse*, April 1998, in the chapter entitled: "Resourcing and Managing the Work".

[96] DrugScope, *UK Drug Situation 2000*. The UK Report to the European Monitoring Centre for Drugs and Drug Addiction, November 2000, page 7.

- Prisons would receive £60 million for treatment services and £12 million for voluntary drug testing in prisons.
- £61 million for the piloting and implementation of Drug Treatment & Testing Orders.
- £70.5 million would be allocated to health and local authorities to fund new treatment services and to improve community care for drug misusers.
- Health Authorities would receive £50 million for treatment services and for young people at risk.
- Local Authorities would receive £20.5 million to improve access to services and increase numbers in treatment programs.
- £10.5 million would be allocated to support Drug Action Teams across the country and for national research into effectiveness of anti-drugs activity.
- £3 million would be allocated to support cross-departmental development of more effective drugs education.
- £6 million over 3 years would be provided for a major new research program.
- An extra £3 million would be available from the Confiscated Assets Fund in 1999/2000, to be increased to £5 million and £7 million in subsequent years.[97]

Social costs

The UK Anti-Drugs Co-ordinator's Annual Report 1999/2000 stated that drug misuse costs Britain over £4 billion per year in crime, sickness and absenteeism. In addition, it was estimated that one-third of property crime is related to drugs.

Statistics

The Office for National Statistics estimates that the illegal drugs market alone accounts for nearly 1% of national output, equivalent to £8.5 billion a year.[98]

Despite the criticisms made in certain reports, the UK has an impressive database on drug use trends. Every two years since 1983, the Home Office has conducted the national British Crime Survey, which includes a series of questions on illegal drug use. The Home Office also keeps detailed data on arrests, convictions and sentences. The *DrugScope* organization is the British correspondent for the OEDT.

Use

In the 16-59 age group, 32% in England and Wales say they have "ever used a drug" (1996 = 29% and 1994 = 28%). This rises to 50% for the 16-24 age group.

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97 *Ibid.*, page 11-12.

98 "The Untouchables", *Economist*, April 21, 2001, Vol. 359, No. 8218, page 49.

Recent drug use was less common, however. For example, in the 1994, 1996 and 1998 surveys, 10%-11% reported drug use in the last year and 6% reported drug use in the last month. Drug use does change with age: 30% of 16- to 24 year olds reported drug use in the last year and 20% in the last 30 days (this compares to 3% and 1.5% for 45-to 54 year olds). In addition, there is a higher prevalence of drug use in males than in females. With respect to children, surveys in England show that 13% of respondents aged 11 to 15 reported ever taking a drug. For children, prevalence increases with age. For example, 3% of 11- to 12-year-olds, 13% of 13- to 14-year-olds, and 31% of 15 year-olds reported ever using drugs.

Cannabis is the most widely cultivated, trafficked and used illicit drug in the UK. The young use it most commonly, with usage declining with age. Almost half of 16- to 24 year olds in England and Wales report ever using cannabis, with 17% using it in the last month. Only 5% of adults aged 55 to 59 report ever using this drug.

Offences

As stated, people arrested in the UK may be dealt with in different ways including cautioning by police or prosecution (except in Scotland where other procedures are available). Under the Customs and Excise Act 1979, compounding (the payment of a monetary sum in lieu of prosecution) is available in cases of importation of small quantities of cannabis (10 grams or less). In addition, the authorities may use their discretion and take no further action. This last option would not appear in criminal statistics.

The total number of people dealt with for drug offences went from 35,000 in 1988 to 153,000 in 1998. Of these, 127,840 were found guilty, cautioned, fined or settled with by compounding. In 1997, the number was 113,150. The most common drug was cannabis at 76%. Almost 90% of MDA offences are possession offences and, generally, three-quarters of all possession offences involve cannabis. The number of people who receive cautions has increased dramatically over the years and of the people found guilty, cautioned, fined or settled with by compounding, cautioning now accounts for almost 50%. Thus, many of the cases are dealt with outside the courts.

In 1998, the number of drug seizures was 149,900, an 8% increase over 1997. Cannabis was involved in 76% of the cases. Between 1995 and 1999, the average price of most drugs remained relatively stable.

SWEDEN[99]

When contrasting a successful model with the Dutch "failure", the witnesses we heard invariably mentioned Sweden. In Sweden, the drug phenomenon is considered one of the most serious social problems (if not the most serious), and drugs are viewed as an external threat to the country.[100] Drug addiction is often viewed as the cause of other social problems and the drug problem itself as jeopardizing Sweden's traditional values. These concerns have intensified since Sweden became a member of the European Union (EU) in 1995, since most of the other members of the EU have adopted a more liberal attitude on drug issues. In comparison to other western European countries, Swedish drug policy is regarded as restrictive. One of the aims of the policy is to make it clear that drugs are not tolerated in society, and its overall goal is a drug-free society. In particular, we observe that:

- harm reduction programs are available in a limited fashion only;
- treatment is based on obtaining complete abstinence and it is possible to force people into treatment;
- drug use is an offence, and urine and blood tests are used to detect those suspected of drug use;
- drug legislation is strictly enforced;
- discussions regarding the medical value of cannabis are almost non-existent;
- Swedish legislation strictly adheres to, and even exceeds, the requirements set out in the three United Nations drug conventions.

While Swedish drug policy is currently very restrictive, this was not always the case. In fact in the 1960s, its policy was fairly liberal, basically reflecting a harm reduction approach.[101] For example, from 1965 to 1967, it was possible for severe drug abusers to obtain prescriptions for morphine and amphetamines. This non-scientific experiment (involving approximately 120 people) was used by Nils Bejerot, a police doctor and very influential figure in Swedish drug policy, in his study of the relationship between drug use and drug policy in the period between 1965-1970. Some of his

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99 This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: G. Lafrenière, (2001) *National Drug Policy: Sweden.* Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp. For more information, see also T. Boekhout van Solinge, (1997) *The Swedish Drug Control System: An in-depth review and analysis*, Centre for Drug Research, University of Amsterdam, Amsterdam, 1997.

100 European NGO Council on Drugs and Development, *A Snapshot of European Drug Policies : Report on the state of drug policies in 12 European countries*, October 2001, page 27.

101 United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile : Sweden*, 1998, page 1.

findings included: that changes from restrictive to permissive policy and vice versa was reflected in the rates of intravenous drug use; that this experiment was the origin of the Swedish drug epidemic; and that the experiment did not have the desired effect of crime reduction. His findings are still widely accepted in Sweden even though they have been criticised.[102]

With increased drug use in 1965, the Committee on the Treatment of Drug Abuse was established: it published four reports from 1967 to 1969. The first report dealt with treatment and the second with repressive measures. It is this second report which led to the adoption of the *Narcotic Drugs Act* in 1968. The Committee's reports indicated that the drug problem was on the increase. This finding, in conjunction with the findings of Bejerot, are partly responsible for the more restrictive approach adopted by Sweden in the late 1960s. In addition, since 1968, the government organized a massive media and school campaign against drugs. This led to a generation growing up with messages based on the gateway theory, among others.[103] This theory is used as a justification for being restrictive in relation to cannabis and "*Swedish drug policy actually focuses on cannabis, since it is alleged 'drug careers' start with this substance*."[104] In addition, the dangers caused by cannabis itself (psychosis, addictive character, higher risk of suicide, etc.) are seen as reasons for having a restrictive policy.

Over time, Swedish policy became more restrictive and repressive, resulting in the strengthening of penalties, criminalizing of use, and allowing of urine and blood tests for those suspected of use. Although the original goal of the urine and blood tests was to detect new users and provide them with appropriate treatment, it would appear that the tests are no longer being used for this sole purpose as known drug users are also being targeted.[105]

Some authors have drawn a link between Sweden's restrictive drug policy and its restrictive alcohol policy. The temperance movement has a long history in Sweden and the country has developed a fairly restrictive alcohol policy, including a state monopoly on the sale of alcohol.

> *Swedish attitudes towards alcohol are relevant since a restrictive alcohol policy makes a restrictive drug policy a logical option. Moreover, the total consumption model on which the alcohol policy is based, is thought to be valid for illicit drugs as well. By limiting the total consumption of drugs, the total harm caused by drugs is alleged to be lower as well. However, it was shown that this correlation is far from clear when it comes to (different) illicit drugs.* [106]

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102 Boekhout van Solinge, *op. cit.*, page 45.
103 European NGO Council on Drugs and Development, *op. cit.*, page 27.
104 Boekhout van Solinge, *op. cit.*, page 88.
105 *Ibid.*, page 116-117.
106 *Ibid.*, page 103.

National strategy

Following the creation of a Commission on Narcotic Drugs, the Swedish government presented a new action plan in January 2002, which is to be valid until 2004. A total of SKR 325 million (approximately $50 million Canadian) has been allocated over the three-year period to combat illegal drug use. The action plan was presented as a means to reverse the disturbing trend in drug abuse. [107]

The policy's objectives are to:

- reduce the number of new recruits to drug abuse (mainly through prevention directed at young people);
- encourage more drug users to give up the habit (through care and treatment); and
- reduce the supply of drugs (through criminal measures).

One of the key new features of the drug strategy is the creation of a national anti-drugs coordinator position. The position was created to have clear leadership in the drug policy area, make it possible to follow up on the plan's goals, and determine whether new initiatives are required to combat new problems. The key tasks for the new anti-drugs coordinator are to:

- develop cooperation with authorities, municipal and county councils, NGOs, etc.;
- shape public opinion;
- undertake a supporting function for municipal and county councils in the development of local strategies;
- initiate methods development and research;
- serve as the Government spokesperson on drugs issues;
- evaluate the action plan; and
- report regularly to the Government (at least once a year).

Of the SKR 325 million, 100 million (approximately $15 million Canadian) has been allocated to a special drugs initiative within the Swedish Prison and Probation Service. The goal is to offer care and treatment to all drug abusers in this system. In addition, the National Prison and Probation Administration is required to:

- develop methods for preventing drugs being brought into institutions and detention centres;
- investigate the obstacles to treatment outside institutions; and
- produce special programmes for contract care, i.e. care in accordance with a contract between the person convicted and the community.

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[107] Ministry of Health and Social Affairs, *National Action Plan on Narcotic Drugs*, Fact Sheet, February 2002.

With respect to the police, the National Police Board and the National Council for Crime Prevention will be required to carry out their own review of police efforts to combat drug-related crime.

In Sweden, while the national policy is created at the national level, much of the responsibility for implementing the goals of the action plan remains with the municipalities. For example, they have responsibility for the care of drug abusers pursuant to the *Social Services Act.* In addition, prevention initiatives are also carried out at the local level. Thus, strategies in municipalities will be based on local concerns. Enforcement of the legislation remains at the national level, however, through the police and customs services.

Treatment is one of the three pillars of Sweden's drug policy. One of the stated goals of Swedish drug policy is to rehabilitate the user rather than to punish them by way of the criminal justice system. Since 1982, it has been possible to force people into drug treatment (also applies to alcohol and other products) for a period of up to six months. The main reason for this type of treatment is to protect the user or others in cases of life threatening situations and to motivate the user to continue treatment on a voluntary basis. The use of compulsory treatment appears to be uncommon and its effectiveness has been questioned.[108] In the last several years, there has been a shift from compulsory treatment and institutional treatment towards out-patient treatment. It would appear, however, that treatment is less easily available today than it was 10 to 15 years ago. In addition, the time a user spends in treatment has shortened. These changes are due to cutbacks in social service spending at the municipal level that occurred in the 1990s. "*Whereas in 1989 there were 19,000 people in treatment centres (for both alcohol and drugs), in 1994 this number had dropped to 13,000. In the same period, the number of people in compulsory care dropped from 1,500 to 900. Due to the budget cuts, 90 treatment homes were closed between 1991 to 1993.*"[109]

Methadone substitution programs have been available in Sweden since the end of the 1960s. Currently, approximately 600 people are involved in methadone substitution programs in Stockholm, Uppsala, Malmo and Lund. The programs are strictly regulated and are officially viewed as being experimental. Some of the conditions for participation include that: the patient must be aged over 20 and demonstrate at least four years of intravenous opiate abuse; he or she must have tried several forms of drug-free treatment; the person in question must have entered the program on a voluntary basis (for example, the person must not be detained, under arrest, sentenced to a term of imprisonment or be an inmate of a correctional facility). For those participating in methadone substitution programs, other drugs are not permitted and the patient must visit the clinic on a daily basis. At this time, the maximum number of people that may be in the program at one time is 800. Pilot projects are under way with Subutex.

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[108] Boekhout van Solinge, *op. cit.,* page 165.

[109] *Ibid*., p 125.

While Sweden has spent large sums of money on treatment, few of its programs have been properly evaluated. Therefore, it is difficult to provide details of their effectiveness. "*The official aim is to rehabilitate drug addicts and a lot of effort and financial means are allocated to achieve this; much more than in many other European countries. However, despite all these good intentions, the reality is that the effectiveness of these very expansive programmes is relatively low. In the long run, the Swedish drug treatment programmes do not show better results than what is found internationally.*"[110]

With respect to harm reduction initiatives, there are few low threshold services in Sweden and most are staffed by voluntary organizations. They offer a series of services, but no prescriptions. Needle exchange programs are operated at clinics for infectious diseases in hospitals in Lund and Malmo, and are thus fairly limited. Harm reduction initiatives, such as needle exchange programs, are difficult to promote under a vision of a drug-free society where drug use is not accepted. A proposal in the late 1980s to introduce needle exchange programs throughout Sweden was quashed by Parliament because it "*was felt that a higher availability of needles would not stop the spread of HIV, on the contrary, it was thought to increase intravenous drug use*."[111]

The criminal justice system also plays a role with respect to treatment. In 2000, more than 5,000 drug users were placed in prison. While in prison, offenders have access to treatment programs for drug abuse and some offenders are transferred outside prison for treatment. There are also initiatives to keep drugs out of prisons, for example by conducting searches and urine tests. While in prison, the offender is not offered syringes and substitution treatments are not available.

Swedish legislation allows, under certain conditions, that a sentence may be served outside prison. The necessity of drug treatment is one of the reasons that is often given. Another alternative to imprisonment is a probationary sentence combined with institutional drug treatment. An example of an alternative to prison is the following:

> *Since 1998, persons with drug addiction problems who have committed a drug offence can access treatment signing a 'treatment contract.' It is a real contract between the drug addict and the Court in which the two parties have rights and obligations like in all contracts. However, certain conditions must be fulfilled by the drug addict: the person must need treatment and he must be motivated to undergo treatment; he/she is a misuser of drugs; and the drug habit contributed to the drugs crime, which should not be serious (less than 2 years foreseen as penalty). The person is not sent to prison and a personalised plan of treatment is established. The health authorities are responsible for the treatment and shall report to the local prison and probation administration and to the public prosecutor if the probationer seriously neglects the obligations stated in the personal plan.* [112]

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[110] *Ibid*., page 162.

[111] *Ibid*., page 129.

[112] European Monitoring Centre for Drugs and Drug Addiction, *Country Profiles – Sweden*, European Legal Database on Drugs, 2001.

With respect to prevention, drug education programs start early and regularly appear throughout the school curriculum. "*Without exaggeration, this opinion-forming could be described as a process of indoctrination. Considering the magnitude of these programmes, the contents of them have gradually become something indisputable and conclusive that one incorporates them into one's own value system*."[113]

With respect to cannabis, it is viewed as a dangerous drug "*and its use is regarded as the beginning of a career in drugs.*"[114] This is one of the reasons that prevention measures pay specific attention to cannabis as this should lead to less experimenting with the drug and thus prevent new recruits from joining the drug scene.

Legislative framework

Classes of drugs

The main drug legislation in Sweden is the *Narcotic Drugs Criminal Act 1968*. The term "narcotic drugs" is defined in section 8. They include medicinal products or substances hazardous to health with addictive properties and which are subject to control under an international agreement to which Sweden is a party or which the government has declared to be 'narcotic drugs' within the meaning of the Act. No distinction is made between soft and hard drugs. As will be discussed later, the nature of the substance is, however, among the criteria to determine the seriousness of an offence. Narcotic drugs are set out in five lists. List I deals with illegal drugs without medical use; lists II to IV deal with narcotic substances with medical usage and regulation of its import/export; and list V deals with narcotic substances outside international controls. Pursuant to the legislation, narcotic medicines may only be supplied on prescription from a doctor, dentist or veterinarian.

Offences

In Sweden, almost all forms of involvement with narcotics are prohibited pursuant to the *Narcotic Drugs Criminal Act.* This Act lists the behaviours and practices which constitute drug offences and includes possession for personal use, supply (which is fairly broadly defined), manufacture, etc. Even consumption (drug use) has been prohibited since 1988. In this case, "*it is not addiction which is a criminal offence according to this law, but the act of adding a drug to the human body*."[115] The police are entitled to conduct urine or blood tests in the case of people suspected of having used drugs.

The *Smuggling Criminal Act 2000* regulates illegal import and export of drugs. Other relevant legislation includes: the *Doping Criminal Act 1991* which regulates the importation, supply, possession of performance enhancing drugs for example; the *Act*

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113 *Ibid*., page 177.

114 Boekhout van Solinge, *op. cit.*, page 15.

115 N. Dorn and A. Jamieson, *European Drug Laws: the Room for Manoeuvre*, London: DrugScope, 2001, page 188.

on Prohibition of Certain Substances which are Dangerous to the Health 1999 which regulates possession and supply of substances that entail danger to life or health and are being used, or can be used, for the purpose of intoxication – this legislation does not regulate substances regulated by other Acts.

The other relevant laws are: the *Social Service Act 1980*, which covers the possible forms of care for drug users; the *Act on the Forced Treatment of Abusers*, which provides that an addict who is dangerous to himself or to others may be ordered by a court to undergo compulsory treatment (which involves deprivation of liberty for up to six months for adults and even longer for those up to the age of 20). Other legislation deals with possible expulsion from school for students who abuse drugs, revocation of a driving licence for drug addiction, etc. There is zero-tolerance with respect to driving under the influence of drugs.

Penalties

Punishment is determined by rules contained in the Swedish *Penal Code*. There are three degrees of penalties for drug offences: minor, ordinary and serious. Penalties for minor drug offences consist of fines or up to six months' imprisonment, for ordinary drug offences, up to three years, and for serious offences, two to ten years imprisonment. The penalties regulated under the *Smuggling Criminal Act*, are identical to the penalties listed above.

The seriousness of the offence is based on the nature and quantity of drugs and other circumstances. The government has stated that the term "minor drug offence" is to be reserved for the very mildest of offences. For example, it should generally only involve personal use or possession for personal use of very small amounts. In these cases, a fine may be warranted. The fine is based on the offender's income. Minor offences involve: amphetamine up to 6 g, cannabis up to 50 g, cocaine up to 0.5 g and heroin up to 0.39 g; ordinary offences involve: amphetamine from 6.1 g to 250 g, cannabis from 51 g to 2 kg, cocaine from 0.6 g to 50 g and heroin from .04 g to 25 g; and serious offences involve: amphetamine 250 g or more, cannabis 2 kg or more, cocaine 51 g or more and heroin 25 g or more. The trafficking of drugs generally leads to imprisonment.

With respect to smuggling, the determination of the seriousness of the offence considers whether it formed part of an activity pursued on a large scale or on a commercial basis, involved particularly large quantities of drugs or was otherwise of a particularly dangerous or ruthless nature.

In 1996, of the 5,862 people sentenced for drug-related offences, 3,760 were sentenced for minor offences, 1,708 for ordinary offences and 391 for serious offences. Of the 1,274 who were sentenced to imprisonment, 54 were for minor offences, 893 for ordinary offences and 326 for serious offences.[116]

[116] *Ibid*., page 206.

As in other countries, there are several alternatives to imprisonment. For example, the court can choose other sanctions including probation, conditional sentence or compulsory treatment. These sanctions appear to be used frequently in drug cases.[117]

> *Generally a drug addict who is found guilty of any type of crime can in certain circumstances be ordered to undergo detoxification treatment. Treatment can take place in conjunction with a prison sentence or else together with probation, a conditional sentence or conditional release from prison. The consent of a convicted person to undergo treatment under certain conditions may constitute a reason for ordering probation instead of imprisonment (so-called* contract treatment*). In practice, probation and conditional sentencing in connection with compulsory treatment are usually used for drug offences of* normal *severity, that is in cases where imprisonment would otherwise be imposed.*[118]

Swedish legislation also allows for the forfeiture of any drugs used in the commission of an offence, any gains made, the property used as an aid in an offence, etc.

Prosecutorial discretion

The prosecutor has an absolute duty to prosecute, but there are a number of exceptions. In the Circular of the Prosecutor-General on Certain Questions regarding the Handling of Narcotics Cases, the Prosecutor-General stated that the dropping of prosecutions for narcotic drug offences should be limited to cases involving only possession for personal use of indivisible amounts or corresponding to at most a roll-up of cannabis resin or a dose of some stimulant of the central nervous system, with the exception of cocaine, i.e. such a small amount of a narcotic substance that it would not normally be further divided and sold. Having regard to the difficulties in individual cases of determining the magnitude of this quantity, prosecutions should go ahead in cases of doubt. If circumstances give grounds for assuming that the possession, despite the small amount, is not intended for personal use, the prosecution should not be dropped. As a consequence of these remarks, prosecutions should also not be dropped where an abuser is found in possession of narcotic drugs amounting to personal use for a certain period. In addition, it is of great importance that the dropping of prosecutions should be mainly limited to occurrences of the nature of first offences.[119]

Debate in Sweden

The Swedish vision of a drug-free society is so widely accepted that it is not questioned in the political arena or the media. The drug policy has support from all political parties and, according to the opinion surveys, the restrictive approach receives broad support from the public. For example, a survey in 2001 revealed that 96% were

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117 *Ibid*., page 190.
118 *Ibid*., page 191.
119 European Monitoring Centre for Drugs and Drug Addiction, *op. cit.*

opposed to legalizing any drug that is classified. In addition, another survey in 2000 revealed that 91% were against decriminalizing cannabis use.[120]

> *The role of public opinion is central to understanding the attitude of the different political parties. Opinion polls show that a large majority of the people subscribe to a restrictive drug policy. The same polls indicate that drugs are perceived as one of society's main social problems. The moral panic surrounding drugs is such, that no political party dares to speak out against any measures that may appear to move in the direction of a more liberal drug policy. Supporting the restrictive policy, or even asking for more restrictive measures to curb increase in the drug problem are essential for a political party to win votes. Saying the contrary, to back a more liberal approach, is not an option for a political party and would almost mean its political death. It has been pointed out that anti-drug pressure groups have been the driving forces behind influencing public opinion, and through them the political parties. It has also been shown that besides the social movements, the media have also contributed to the drug scare that exists today and the defining of drugs as a major social problem.* [121]

Thus, the Swedish population in general has a negative view of drug use and is convinced that drugs pose a major threat to society. These themes have been advanced by government, the media and other organizations in Sweden, and others do not often criticize them. Scientists are generally the only group that raises doubts with respect to the current policy.

Recent reports

In 1998, the government created a Commission on Narcotic Drugs. Its mandate was to evaluate Sweden's drug policy and to propose, within the concept of a restrictive drug policy, measures for its strengthening and streamlining. The Commission was not to deviate from the overall aim of a drug-free society. The terms of reference were to:

- propose improvements of methods and systems to assess the drug situation and to evaluate the goal of a drug-free society;
- evaluate and propose measures to strengthen and streamline drug prevention measures;
- analyse the development of treatment programmes, including those in the prison and probation system, and propose measures to improve treatment and rehabilitation of drug abusers;
- evaluate the extent and focus of national funds for the development of treatment and of measures to prevent drug-related crime,
- analyse the need for changes in the working methods in the judicial system and in penal and criminal procedural legislation;

[120] National Institute of Public Health, *National Report: Sweden 2001*, Stockholm, December 2001, page 14.
[121] Boekhout van Solinge, *op. cit.*, page 172-173.

- review existing research, propose how research can be stimulated, strengthened and organized and identify important but neglected areas for research in the drug field;
- frame strategies for targeted information measures and for the formation of opinion.

The Commission recently published a report entitled *The Crossroads* (referring to one direction that calls for a significant increase of resources in the form of commitment, direction, competence and funding and another that implies a lowering of goals and considerable acceptance of drug abuse).

The Commission noted that the drugs issue was not a political priority in recent years. This situation has led to reduced funding for all sectors involved, while the drug problem has become more severe and widespread. The following are some of the Commission's main findings and recommendations.[122]

Leadership: The Commission noted that there is a need for stronger priorization, clearer control and better follow-up of drug policy and of concrete initiatives at all levels of government.

Demand reduction: The Commission noted that there are no hard boundaries between preventive measures, care and treatment, and the restriction of supply. For preventive measures to succeed, they must be "*included in a system of measures restricting availability, and there must be clear rules which include society's norms and values, as well as effective care and treatment.*"[123] The Commission viewed care and treatment as an essential element of drug policy measures as they help reduce drug abuse and also the harm to drug abusers. In addition, the Commission found a need for improving the competence of those in the field of care and treatment. It set out the following guiding principles regarding care and treatment:

- all drug abusers shall be reached by an offer of help and, if necessary, the abuse treated.
- advice, support and assistance shall reach people at an early stage of abuse.
- measures of care shall be aimed at achieving a life free from substance abuse and illegal drugs.
- care and other measures on behalf of substance abusers shall be of good quality.
- measures to combat substance abuse shall be sustainable and long-term.

[122] The Swedish Commission on Narcotic Drugs, *Summary of the report The Crossroads from the Swedish Commission of Narcotic Drugs*, Sweden, 2000.
[123] *Ibid.*

Supply reduction: The Commission did not find any real deficiencies in the legislation or the working methods used by drug authorities, although it was vital that these authorities be allocated more resources. Police and customs have not gained control over the illegal market. In fact, indicators show that supply is more generous, prices are lower than in the past and the variety of drugs has expanded. With respect to combating illegal drug trade, the Commission recommended that the organizational structure of the police be examined (for example, the way in which the dissolution of specialized drug squads has affected the quality of police investigations) and that any shortcomings be followed up. The Commission also recommended that special investigation methods (such as controlled deliveries) be reviewed and that the findings lead to the drafting of guidelines on the subject.

Competence development and research: Competence development and research: The Commission was of the view that it was important to improve knowledge concerning different aspects of narcotic drugs, measures used to combat drug abuse and the effect of drug policy.

Costs[124]

As in other countries, systematic figures on drug-related costs are not readily available.

Public costs

Treatment for alcohol and drug abuse has been estimated to cost municipalities SKR 3.7 billion (over $500 million Canadian) per year (55% of which is for institutional care). The police used 6% of its budget to combat drugs during 2000 (for a total of SKR 702 million–over $100 million Canadian). The police had 869 people involved in drug issues while customs had 1,080 involved in border defence. No costs were available for customs.

Social costs

The Commission on Narcotic Drugs estimated the social costs at SKR 7.7 billion per year (does not take into account prevention, training and evaluation).

[124] The following information is based on the European Monitoring Centre for Drugs and Drug Addiction, *National Report – Sweden 2001*, *op. cit.*, page 15.

Administration[125]

As discussed above, the coordinator will now be responsible for coordinating the national drug policy. In the past, this role had been played by the Ministry of Health and Social Affairs. With respect to the legal distribution of narcotic drugs and psychotropic substances, the Medical Products Agency is responsible for issuing authorizations for the import and export of drugs. This Agency also provides drug related statistics to the UNDCP.

The Swedish National Police have responsibility for drug enforcement. The Drug Offences Division of the National Police Board conducts criminal investigations in relation to organized crime, or other drug-related offences, on a national or international scale. The Swedish Customs Service is responsible for points of entry.

The National Institute of Public Health coordinates demand reduction activities. It is also the National Focal Point in the REITOX network. Operational activities are coordinated at the regional and municipal level. There is also local coordination with the participation of social services, the police, prison and probation services, medical services, schools and other concerned parties. Thus, in prevention and care and treatment, local groups and municipalities play a key role.

Because of its encompassing nature, the drug issue also involves many other ministries, for example the Ministry of Justice and the Ministry of Foreign Affairs.

Statistics

Use[126]

Pursuant to surveys among youths in the 9th grade (15-year-olds) and among 18-year-old military conscripts, an obvious trend seen in the 1990s was the increase in lifetime prevalence use of drugs among teenagers, particularly older teenagers. There was also been an increase in recent use (last year, last 30 days) among teenagers and younger adults. For example, the percentage of 15 year olds who had tried drugs rose from 4% to 9% from 1992 to 2000. It is interesting to note that the number was 14% in the beginning of the 1970s and had decreased to around 8% in 1982. With respect to military conscripts, the trend was similar. According to these surveys, consumption of illegal drugs was low compared to other European countries, although the trend pointed to an increase in use. It should be noted that these numbers have been criticized. First, they are applicable to only 15-16 year old students and 18-year-old conscripts. Thus, these prevalence rates did not consider older groups where some first-time experimentation with drugs will occur. In addition, it has been argued that drug use is under-reported when drugs are viewed in such a negative light and the

125 The information in the following section is based on the United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile – Sweden, op. cit.*, page 12.

126 OEDT, *National Report – Sweden 2001, op. cit.*

questionnaires are filled out at school (where some will feel they are being observed by their teachers).[127]

In 2000, the running three-year average of lifetime prevalence for the 15-64 age group was 12% (with the highest at 17% for the 24-44 age group). Since 1988, last year prevalence has never been over 1%. Overall, males are twice as likely to have used drugs than females although the difference is not as high in lower age groups.

Most who have experimented with drugs have tried cannabis, and the majority of these have tried only cannabis (in Sweden, cannabis is usually taken in the form of hashish). The second most popular drug in Sweden are amphetamines. Cocaine would be the third most popular drug for older people, while for youths it would be ecstasy and LSD. During the 1990s, the availability of drugs increased, in particular amphetamine and heroin. It would appear, however, that heroin use is on the increase in Sweden.

In general, the surveys indicate that overall drug use is fairly low in Sweden. With respect to severe drug abusers (defined as intravenous or daily drug use), it would appear that Sweden has a fairly serious problem with a range of between 14,000 and 20,000 people in this class. This is close to the European Union average.[128]

Offences

The number of suspected people reported increased from 6,567 in 1985 to 12,470 in 1999. The police registered 32,423 violations of the *Narcotic Drugs Criminal Act* in 2000, a figure which is similar to the numbers in the previous decade. The number of violations to the *Goods Smuggling Act* has decreased by 85% since 1980, to 350.

In 1998, 92% of these offenders were suspected for use or possession (from 76% in 1975). In addition, the number of those suspected of selling or manufacturing is now 19% (from 40% in 1975).

The number of sentences for violations of the *Narcotic Drugs Criminal Act* or the *Goods Smuggling Act* was 12,470 in 1999 (up from 2,601 in 1975). Cannabis was involved in 51% of sentences in 1998. In 1998, the sentences were divided in the following fashion: 38% were fines; 27% were prison terms; 14% were prosecution waivers; 14% were probation; and, 8%, other sanctions. Imprisonment was generally from two to six months.[129]

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127 Boekhout van Solinge, *op. cit.*, page 138.
128 United Nations Office for Drug Control and Crime Prevention, *op. cit.*, page 9.
129 National Report 2001, page 27.

SWITZERLAND[130]

Switzerland's drug policy has attracted considerable attention in recent years. As a result of widely distributed pictures of the open drug scene in Zurich, the country's injection clinics and heroin prescriptions for drug "addicts" are now known around the world. More recently, Switzerland's Parliament introduced a bill to regulate the production and sale of cannabis, and that bill is currently under study.

Switzerland is a Confederation[131] consisting of 26 cantons and half-cantons and has a population of slightly more than seven million inhabitants. The cantons are currently subdivided into 2,904 political communes. The federal Constitution, which was passed in 1848, is the legal basis of the federal state. It guarantees the fundamental rights of individuals and the people's participation in the country's political life, divides jurisdictions between the Confederation and the cantons and defines the powers of the federal authorities. Switzerland is made up of various linguistic, ethnic and denominational communities. Under Article 4 of the Constitution, German, French, Italian and Romansch are the country's four national languages. German is the language spoken by the majority of Swiss (63.7 per cent). All the cantons have their own constitution, parliament, government and courts. The cantons have certain legislative powers which have been conferred on them by the federal Constitution.

Switzerland's political structure is important to our understanding of that country's drug policy. In fact, some writers[132] argue that there are in fact 26 drugs policies in Switzerland, one for each canton and half-canton. This diversity is often overlooked, since the media and drug literature have focused in particular on the "open drug scenes" in Zurich and on the medical prescription of heroin for severally dependent persons, a practice endorsed by the Swiss Confederation.[133]

A harm reduction policy

The recent history of Switzerland's drug policy began towards the end of the 1960s with the increase in psychoactive drug use. As a result, the cantons developed a first drug policy, which was based on three pillars, namely:

- the repression of drug use and trafficking;
- prevention measures aimed at young people;

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130 This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: C. Collin, (2002) *National Drug Policy: Switzerland*. Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

131 This term is used to designate the federal state.

132 Yan Boggio *et al.*, (1997) *Apprendre à gérer : La politique suisse en matière de drogue*, Geneva: Georg, 1997.

133 *Ibid.*, page 38.

- treatment based on abstinence, which at the time already included methadone programs.[134]

At the beginning of the 1980s, the HIV-AIDS epidemic hit many countries, including Switzerland. There were "open drug scenes" in several Swiss cities, such as Zurich, Bern, Olten and Solothurn. As a consequence, the miserable state of drug dependent persons was becoming increasingly visible contributing to growing concern over the situation. Public and social services were created to help the "addicts" and protect them against HIV and AIDS. Needle exchange programs were set up and "addicts" were encouraged to be vaccinated against hepatitis. The Swiss Federal Office of Public Health (SFOPH) supported many of these services and still does so today, arguing that they help prevent the spread of AIDS. However, the main pillars of Switzerland's official drug policy remained prevention, treatment and law enforcement.

In the 1990s, Switzerland introduced new measures to reduce the problems associated with drug use and adopted a new national drug strategy. The new strategy introduced another pillar, namely harm reduction, which led to the creation of a four-pillar approach. The role of the Confederation in the area of drug policy becomes more defined and aims to support the efforts made by cantons, cities and communes and by private organizations by providing them with reference material, scientific data and training for professionals.

On February 20, 1991, the Swiss government adopted a program of federal measures to reduce the problems related to drug use,[135] currently known as "ProMeDro,"[136] and which was based on the concept of harm reduction. The objectives of the program were as follows:

- to decrease the number of new drug users and to prevent people from becoming drug dependent;
- to help users overcome their addiction (through treatment and social reintegration);
- to improve the living conditions and the health of drug users, to reduce harm and to maintain their social integration.[137]

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[134] Swiss Federal Office of Public Health, *The Swiss Drug Policy*, September 2000, available online at http://www.bag.admin.ch/sucht/f/index.htm.

[135] Swiss Federal Office of Public Health, *Mesures fédérales pour réduire les problèmes de la drogue*, Basic document of the Federal Office of Public Health, decision of the Federal Council of February 20, 1991, Doc. no. 3.4.1f.

[136] The acronym "MaPaDro" was used to refer to the program of federal measures for the period 1990-1996. The acronym "ProMeDro" is used to refer to the program of federal measures for the period 1997-2002. To avoid confusion, "ProMeDro" is used throughout.

[137] Swiss Federal Office of Public Health, *Programme de mesures de santé publique de la Confédération en vue de réduire les problèmes de drogue (ProMeDro) 1998-2002*, October 1998.

To achieve these goals, the following measures were introduced:

- primary and secondary prevention measures aimed at young people and awareness campaigns to prevent them from experimenting with drugs;
- patient management and treatment to help users overcome their addiction;
- harm reduction, AIDS prevention and social reintegration measures to help addicts cope with their dependency in the best possible health conditions and to ensure that the door to a drug-free life remains open;
- ongoing training and development programs for professionals (including those working in the areas of sentencing, programs and social services, as well as hospital workers, pharmacists and family doctors) and for people acting as mediators (such as teachers, youth group facilitators, business personnel and parents);
- the development, co-ordination and regular publication of scientific research on drugs;
- the evaluation of projects and measures in the fields of prevention, patient management and treatment to help identify any gaps or shortcomings, but also to pinpoint and highlight any progress achieved;
- the development of new documentation and information services normally provided by the Swiss Confederation; and
- the co-ordination of measures adopted by the Confederation.

These measures mark the beginning of Switzerland's drug policy, based on a four-pillar approach: prevention, law enforcement, treatment and harm reduction. Between 1991 and 1999, the SFOPH initiated and/or supported approximately 300 projects and programs under the "ProMeDro" initiative at the cost of 15 million francs per year.

Among other activities, the Federal Council asked for a study on heroin-assisted treatment for severely dependent heroin addicts who had failed at other treatment programs. In 1992, the Council passed an order authorizing clinical trials with the medical prescription of heroin, along with a strict scientific evaluation of the trials. The trials began in 1994 and ended on December 31, 1996. The final evaluation report was published in July 1997 and concluded that:

- heroin-assisted treatment for severely dependent heroin addicts improved their physical and/or psychic health, as well as their quality of life (in terms of housing, work and other areas);
- participants' illegal use of heroin and cocaine decreased;
- the users involved in the program committed fewer crimes (the incidence of theft and property and drug trafficking offences fell sharply).[138]

[138] M.F. Aebi, Martin Killias and Denis Ribeau, "Prescription médicale de stupéfiants et délinquance : Résultats des essais suisses", *Criminologie*, Vol. 32, no. 2, 1999, page 127-148; see also the testimony of

The Federal Council followed the report's recommendations, and on March 8, 1999, passed the *Ordinance governing the medical prescription of heroin* authorizing heroin assisted treatment, setting objectives, eligibility criteria, administrative measures and providing for such treatment.

Over the same period in 1993 and 1994, two people's initiatives were presented with opposite objectives. The first initiative called for a strict, abstinence-oriented drug policy ("Youth Without Drugs"),[139] and the second proposed the legalization of drug use ("DroLeg").[140] The federal government and Parliament found both initiatives too extreme and recommended their rejection. On September 28, 1997, Swiss voters rejected the initiative "Youth Without Drugs" by a majority of over 70%. On November 29, 1998, Swiss voters rejected the "DroLeg" initiative with a majority of over 74%. By rejecting both initiatives, the Swiss population showed its massive support for the Confederation's more measured approach to drug policy.

Between the time that these popular initiatives were launched and subsequently voted down, some major events influenced the evolution of Swiss drug policy. In 1994, the violence occurring on the "open drug scenes," from Letten to Zurich, made headlines in the international media. Certain government parties (Socialist, Christian Democrat and Radical) clamoured for decriminalization of drug use, increased access to heroin-assisted treatment, stronger prevention measures and stiffer sentences for drug traffickers.[141] The open drug scene in Zurich was shut down in 1995,[142] resulting in new co-operation between the Federal Council, canton representatives and the city of Zurich. A joint task force, called the Drug Delegation, was established. This unusual co-operation made it possible to implement measures that would never have got off the ground under more traditional circumstances: the creation of prison spaces in Zurich for drug traffickers, the adoption of emergency federal measures allowing for more drug addicts to participate in heroin-assisted treatment and the creation of centres for the treatment of hard core users.[143] Today the "open drug scenes" are a thing of the past.

Finally, in October 1998, the program of federal measures to reduce the problems related to drug use (ProMeDro) was renewed for a four-year period. The Confederation set a budget of 18 million francs per year to run this program and staffed it with 15

Professor Ambros Uchtenhagen, Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

[139] For more information on this initiative, see the Youth Without Drugs Web site at http://www.jod.ch/f_fr_index.htm.

[140] For more information on this initiative, see the DroLeg Web site at www.droleg.ch.

[141] Swiss Federal Office of Public Health (2000), *op. cit.*, page 10.

[142] See the testimony of the Chief of the Zurich Criminal Police, Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

[143] Boggio *et al.*, 1997, *op. cit.*, page 75-80.

positions from the Federal Office of Public Health.[144] The main priorities for ProMeDro from 1998 to 2002 are as follows:

- to strengthen the Confederation's commitment to primary and secondary prevention and early intervention to prevent addiction;
- to consolidate the range of treatments in a co-ordinated system, thereby increasing the likelihood that addiction can be overcome;
- to consolidate harm reduction and social integration measures;
- to establish and operate effectively a national epidemiological monitoring centre based on the focal points REITOX model of the European Monitoring Centre for Drugs and Drug Addiction;[145]
- to forward, in an effective manner, the findings of epidemiological studies, scientific research and evaluations to experts and decision makers;
- to implement a process to foster quality management throughout the entire ProMeDro program, tailored to the needs of the different fields, useful to and used by more than half of the addiction agencies and decision makers concerned (Confederation, cantons, communes, private institutions);
- to ensure optimum co-ordination and organization for various commissions and forums, mainly for the Conference of Canton Delegates on Drug Addiction Problems and the National Drug Liaison Committee.[146], [147]

The Confederation has thus set itself up as a political hub for drug policy and national co-operation

First pillar: prevention

Prevention measures are aimed primarily at achieving three objectives:

- to prevent drug use among individuals, especially children and youth;
- to prevent the problems and harmful effects related to drug use from spilling over onto the individual and society;

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[144] Federal Office of Public Health (1998), *op. cit.*, page 5.

[145] The EMCDDA coordinates a network of 15 information centres, or national focal points, located in each of the member states. For more information, visit the EMCDDA Web site at http://www.emcdda.org/mlp/ms_fr-4.shtml.

[146] The Conference of Canton Delegates usually meets four times a year. It coordinates drug addiction measures, establishes an annual program and priority catalogue, ensures the exchange of information, debates and adopts positions and responds to consultations, defines and discusses related issues and provides development sessions. See http://www.infoset.ch/inst/kkbs/f-statuten.html (in French). The National Committee consists of representatives from the cities, cantons and the Confederation. Its role is to provide follow-up on implemented measures and ensure that those measures are harmonized.

[147] Federal Office of Public Health (1998), *op. cit.*, page 6-7.

- to prevent individuals from going from casual drug use to harmful use and addiction, with all of its known consequences.

It should be pointed out that the most notable change in prevention has been a transition from the concept that prevention was a matter of preventing someone from ever trying drugs to today's concept of preventing the health and social problems related to drug use, thereby integrating the person's social network and environment as well.

Second pillar: treatment

In Switzerland, there are many types of in-patient and out-patient treatment available to people suffering from drug addiction. The objectives sought through treatment include:

- breaking drug "addicts" of their habit;
- social reintegration;
- better physical and mental health.[148]

As mentioned earlier, heroin assisted treatment has been a recognized type of therapy in Switzerland since 1999. By the end of 1999, there were already 1,650 treatment spaces reserved for hard-core heroin dependent persons in 16 treatment centres. In addition, during the same period, approximately 50% of opiate addicts (estimated to be 30,000) were being treated with medically prescribed methadone, compared to 728 individuals who were receiving this type of therapy in 1979. Those individuals addicted to one or more drugs also have access to in-patient treatment based on abstinence, to a limited number of spaces in transition centres, specialized withdrawal units or clinics, and treatment institutions, as well as out-patient consultation centres.[149] In March 1999, there were 100 institutions providing in-patient withdrawal and rehabilitation treatment in Switzerland, for a total of 1,750 spaces.[150]

Third pillar: harm reduction

The first so-called "low threshold" coping skills institutions made their appearance in Switzerland in the mid 80s. Their purpose was to reduce the health and social risks and consequences of addiction. First and foremost, these institutions gave drug dependent persons a roof over their heads and were often equipped with cafeterias, showers and laundry facilities. They provided addicts with someone who would listen and talk to them. These facilities have evolved over the past ten years and now incorporate medical support for harm reduction (for example, prevention of AIDS and other infections, needle exchange, out-patient medical care, etc.) and social support

[148] *Ibid.*, page16.
[149] *Ibid.*, page 16-17.
[150] Federal Office of Public Health, *The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics*, 1999, page 7.

(street work, soup kitchens, emergency shelters, low threshold centres, etc.). The Swiss Federal Office of Public Health supports many harm reduction projects as part of ProMeDro. Such projects include:

- needle exchanges for drug addicts and inmates;
- injection sites (a statutory notice makes such sites legal);
- offers of employment and housing;
- support for women who prostitute themselves to buy drugs;
- consultation services for the children of drug-addicted parents.[151]

Furthermore, the cantons, communes and private institutions also provide such programs. In 1995, the SFOPH established a central service to support certain social assistance agencies, particularly those with low thresholds, and to advise the cantons, communes and private institutions on planning and funding harm reduction programs. Drug "addicts" have access to such programs without having to meet any particular prerequisites. The objective of these harm reduction services is to limit as much as possible the negative consequences of addiction so that the "addict" is able to resume a normal existence. In addition, these measures are aimed at safeguarding and even increasing the addict's chances of breaking the drug habit.[152]

Fourth pillar: enforcement

The primary goal of enforcement is to reduce supply and to fight the trafficking of narcotics, the illegal financial transactions related to such trafficking (for example, money laundering) and organized crime. Users are not the number one target of police operations in Switzerland. Enforcement of the federal *Narcotics Act* is, to a large extent, the responsibility of the cantons, although the Confederation does monitor the situation closely and can call for and carry out police investigations into drug trafficking. It should be noted that canton and commune laws on policing differ and sometimes result in varying interventions. Furthermore, the drug milieu changes quickly and the methods used to fight drug-related problems are improving and adapting to this milieu.[153] These methods include:

- focussing enforcement activities on the manufacturing of drugs, trafficking and money laundering;
- assigning more officers to the "drug police" and making greater use of specialists from other sectors (finance professionals);
- intercantonal and international cooperation (agreements with police forces from neighbouring countries);

[151] Boggio *et al.*, 1997, *op. cit.*, page 19.
[152] *Ibid.*, page 18-19.
[153] *Ibid.*, page 20-21.

- accelerating and improving the processing of information (networking systems and access to the police department networks from many European countries);
- improving cooperation between the police and the private sector (banks, chemical industries, etc.);
- improving police effectiveness and making greater use of front-line liaison workers;
- strengthening the legal structure (for example, policing legislation, witness protection).[154]

The legal framework

Narcotics legislation in Switzerland has, as is the case in many other countries, been closely tied to the evolution of international conventions. For instance, the 1924 *Narcotics Act* was implemented to enable Switzerland to fulfil the commitments it had made by signing the International Opium Convention of 1912. This law prohibited certain narcotics such as opium, coca leaves, morphine, heroin, cocaine and their derivatives. As a result of Switzerland's signing other conventions and of experience gained from enforcing the 1924 *Act*, the federal *Narcotics Act* was totally revamped and a new law adopted on October 3, 1951. This legislation prohibited the growing, manufacture, sale, distribution and possession of opiates, coca derivatives and cannabis. The purpose of the *Act* was, on the one hand, to regulate the use of narcotics for medical purposes and, on the other hand, to fight against both the abuse and illicit trafficking of narcotics. The *Act* was amended slightly in 1970 when Switzerland signed the Single Convention on Narcotic Drugs of 1961.

Indeed, up until the 1960s, the *Act* was primarily a response to Switzerland's commitments under international conventions because narcotic use was relatively marginal and there was not any real narcotics abuse problem per se to warrant specialized legislation. Moreover, the Federal Council had recognized as early as 1951 that drug addiction was a serious pathology that should not be prosecuted as a crime or an offence. When drug-related problems emerged in the early 1970s, the *Act* was revised in 1975 to provide for medico-social and assistance measures for drug addicts, differentiated punishment for drug use and tougher criminal provisions for illegal drug trafficking.[155]

Following Switzerland's accession to the 1971 UN Convention on Psychotropic Substances, the 1972 amendment to the Single Convention and the adoption of the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (Switzerland has not yet ratified this convention), the *Narcotics Act* was revised in 1996 to provide for the control of narcotic raw materials. Since then, dependence-producing

[154] *Ibid.*, page 21.

[155] Swiss Federal Council, *Message concernant la révision de la loi sur les stupéfiants*, March 9, 2001.

substances and preparations with morphine-, cocaine- or cannabis-like effects have been considered narcotics under this legislation (*Narcotics Act*, s. 1).[156] The list of substances is currently compiled by the Swiss Agency for Therapeutic Products.[157]

With respect to the production, distribution, acquisition and use of narcotics, the current legislation provides that narcotics and psychotropic substances cannot be cultivated, manufactured, prepared or sold without cantonal authorization, in accordance with conditions set by the Federal Council (*Narcotics Act*, s. 4). In addition, a special permit from the Federal Office of Public Health is required for the importation or exportation of controlled narcotics (*Narcotics Act*, s. 5). Furthermore, under section 8 of the *Narcotics Act*, the following narcotics cannot be cultivated, imported, manufactured or sold: smoking opium, heroin, hallucinogens (such as LSD) and hemp for the extraction of narcotics or hash. Section 8 also sets out the conditions governing the treatment of addicts with medical prescription of certain narcotics.

The current legislation also contains criminal provisions that apply to: anyone who unlawfully cultivates, manufactures, extracts, processes or prepares narcotics; anyone who, unless authorized, stores, ships, transports, imports, exports, provides, distributes, sells, etc., or buys, holds, possesses or otherwise acquires narcotics; and anyone who finances illicit traffic in narcotics, acts as an intermediary or encourages consumption (*Narcotics Act*, s. 19). Section 19 offenders are liable to imprisonment or a fine depending on the seriousness, according to the *Narcotics Act*, of the act committed. The intentional consumption of narcotics or the commission of a section 19 offence for personal use is punishable by detention or a fine (*Narcotics Act*, s. 19a). For petty offences, the appropriate authority may stay the proceedings or waive punishment and may issue a reprimand (*Narcotics Act*, s. 19a(2)). However, preparing narcotics for personal use or for shared use with others at no charge is not punishable where the quantities involved are minimal (*Narcotics Act*, s. 19b). Finally, anyone who persuades or attempts to persuade someone to use narcotics is also punishable by detention or a fine (*Narcotics Act*, s. 19c).

A bill to decriminalize cannabis[158]

The Swiss Federal Council recently submitted a major bill to Parliament, the cantons and the public for a fundamental revision of the *Narcotics Act*. That bill, which is set to go through the various stages of canton and national consultation, is based on the observation, similar to our own findings, that:

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156 *Loi fédérale sur les stupéfiants et les substances psychotropes*, October 3, 1951 (as of November 27, 2001) available on line at http://www.admin.ch/ch/f/rs/812_121/index.html#fn1.

157 New name of the therapeutic products agency, in effect since January 1, 2002.

158 See testimony of Ms. Diane Steber Büchli, Swiss Federal Office of Public Health, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

(…) with regard to cannabis, the gap is too great between the actual situation, the statutory provisions and their implementation. As the Federal Commission on Drug Issues states in its report on cannabis, the prohibitionist system does not prevent cannabis use and cannabis users no longer tend to consider themselves drug users. The risks that cannabis represents for public health must be assessed differently from the way the legislator did it in 1975.

At the time, cannabis was considered a gateway drug. It was felt that the pharmacological properties of cannabis led young cannabis users to opiate or amphetamine use. That view was refuted with the 1989 report of the Sub-commission of the Federal Commission on Narcotics.

The most recent research supports current findings that the effects of cannabis are less hazardous to health than the effects of alcoholism or tobacco abuse. (…)

(…)

The number of users of cannabis derivatives has increased. In 1992, according to the Swiss Health Survey of the Federal Statistics Office, 16.3 per cent of young Swiss citizens aged 15 to 35 said they had previously used hash at least once in their lives. In 1997, 26.7 per cent gave the same answer. All OECD countries have observed the same trend. In the United States, for example, the life prevalence of cannabis use in individuals 18 years of age increased from 32.6 per cent in 1992 to 49.6 per cent in 1997. [159]

The cannabis revision bill is also based on the observation, **in which we wholeheartedly concur**, that "*the available scientific literature establishes no relationship between severity of legislation and life prevalence of cannabis use*."[160] It further emphasizes that:

The weaknesses of the present act are apparent when it comes to fighting the cultivation of hemp used to produce narcotics and the production and sale of cannabis-based products. Enforcing the act in this area is a highly heterogeneous and costly enterprise; the result is a large market that is very difficult to control and has expanded beyond our borders. Moreover, the need to revise statutory provisions in this area is virtually undisputed. [161]

The purpose of the revision of the act is thus, in particular, to:

- adapt the Act to the actual situation;
- decriminalize cannabis use and acts leading thereto;
- reinforce youth protection;
- regulate the cultivation, manufacture and trafficking of cannabis;
- restrict the obligation to prosecute;
- reinforce repression in certain areas in a targeted manner.[162]

More specifically, the bill would provide (art. 19c) for the decriminalization of the use of cannabis-related products. In addition, preparatory acts to personal use of cannabis-related products would be decriminalized if committed without affording a

159 Swiss Federal Council, *Message concernant la révision de la loi sur les stupéfiants,* 2001, page 3554-3555.
160 *Ibid.,* page 3560. We further discuss this issue in Chapter 21.
161 *Ibid.,* page 3540.
162 *Ibid.,* page 3556.

third party the opportunity to use drugs. While the bill does not set out specific limits on quantity–as it would be left to the courts to determine whether it was related to personal consumption - the government publication explaining the bill mentions that as a principle, it does related to personal consumption if the quantity does not exceed what is needed for weekly use. In general, this would mean quantities of 30 grams for possession and 10 average-size plants for cultivation. The publication states that these quantities would vary depending on the person, the way it is consumed, etc.[163]

Article 19d would confer on the Federal Council the power – and not the obligation – to determine priorities in criminal prosecutions. Under this power, the Federal Council could, after consultations with the cantons, set out the conditions under which the prosecution and criminalization of certain offences would be waived, if they are conducted under the legal framework discussed in the next paragraph.[164]

If the Federal Council uses its power under article 19d, article 19f sets out conditions under which the cultivation, production and distribution of cannabis and its derivatives would be allowed. Distribution would not be prosecuted under certain conditions: selling to persons under 18 years of age would not be permitted; the product must not represent a significant risk to health; public order must not be disturbed, advertising would be prohibited, etc. Producers must also submit to a set of strict rules: they may produce solely for point of sale located in Switzerland, notify authorities regarding all crops (species, cultivation area, location, etc.), and specify THC levels. The Federal Council can establish a series of rules such as size and lay out of cultivation areas, the number of distribution centres, etc. In addition, cantons would be able to set out more restrictive rules, particularly with respect to cultivated areas and distribution centres.[165]

The Council did request legal opinions on whether its proposals satisfied the three international conventions.[166] The two opinions concurred that the decriminilization of personal use and related acts would not contravene international conventions. In addition, the waiver of prosecution (or limitation of criminal prosecution) for cultivation, production and distribution would also be consistent with the three conventions. The Federal Council concludes in its *Message* that:

> *In their essential points, the two legal opinions come to the same conclusions. The only difference is in the matter of whether, in cases where a waiver of criminal prosecution in matters pertaining to the cultivation of cannabis and the manufacture and distribution of cannabis products would be introduced, the provisions are sufficient or whether they should be supplemented by a licensing system.*

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163 *Ibid.,* pp. 3596-3597.
164 *Ibid.,* p. 3598.
165 *Ibid.,* p. 3600.
166 The findings of one of the experts consulted are presented in Chapter 19 above.

It should be noted on this point that the Netherlands also has a partial limitation on the obligation to prosecute in the areas referred to and that it has not introduced a licensing system. Nevertheless, the principle of the Dutch system has never been disputed as being inconsistent with the UN conventions.[167]

Administration of Swiss drug policy

The Confederation is the hub of Swiss drug policy and co-ordination and harmonization of the various policies and measures put in place by cantons, cities, local authorities and private institutions. Under section 15c of the *Narcotics Act,* the Confederation is responsible for the following tasks [translation]:

- Through grants or other measures, the Confederation shall encourage scientific research on the effects of narcotics, the causes and consequences of narcotics abuse and ways to combat that abuse.
- The Federal Council shall establish the procedures for awarding and calculating grants and shall determine grant amounts.
- The Confederation shall assist cantons and private organizations in the administration of the *Act.* The Confederation shall, *inter alia*, set up a documentation, information and co-ordination office and encourage the training of staff specialized in the treatment of addicts?. The Federal Council shall establish the relevant procedures.

Under section 15a of the *Narcotics Act,* the cantons are responsible for the following tasks [translation]:

- To prevent narcotics abuse, the cantons shall promote information and consultation and set up the institutions needed to do so.
- The cantons shall provide for the protection of those in need of medical treatment or other assistance on account of narcotics abuse and shall assist their return to work and society.
- The appropriate authorities may delegate certain tasks and responsibilities to private organizations.
- The cantons may prohibit the acquisition of narcotics. They shall give notice of their decisions to the Federal Office of Public Health, which shall relay those decisions to health officials in the other cantons for the information of physicians and pharmacists.
- Prescribing, dispensing and administering narcotics for the treatment of addicts shall be subject to special cantonal authorization.

[167] Federal Council, *ibid.,* page 3621.

- Where, owing to addiction, a person might constitute a danger to traffic circulation, the service with knowledge of that danger shall advise the appropriate authority.

In principle, the administration of the *Narcotics Act* falls under cantonal jurisdiction, as the cantons have authority for criminal procedure. There are usually a number of stages in cantonal criminal proceedings: police investigation, preliminary hearing, dismissal or referral to court and court decision. In minor cases punishable by fine or detention–and this is the case for a number of offences under the *Narcotics Act*– a penalty can be imposed by an administrative authority (for example, a prefect). The subject, however, is entitled to object and be tried by a court, usually a police court composed of a single, legally trained judge. Cases of moderate seriousness are usually tried by a district court (correctional court) over which a legally trained judge presides, assisted by lay judges. Finally, the most serious offences are heard by assize courts made up of at least one legally trained presiding judge and a jury of citizens. However, because this type of procedure is lengthy, elaborate and costly, most cantons tend to replace assize courts with either district courts or a higher court made up of permanent judges (criminal court).[168]

The Confederation also plays a role in combating drug trafficking; under section 29 of the *Narcotics Act*, the Federal Office of Police (FOP) is the central Swiss agency responsible for controlling illicit traffic in narcotics. The FOP gathers information for the prevention of offences under the *Act* and to facilitate the prosecution of offenders. In order to do so, the Office maintains contact with other federal government agencies involved (Office of Public Health, Customs Administration, the Swiss Post Office administration, cantonal police authorities, central agencies in other countries and the International Criminal Police Organization (Interpol)). To its cantonal and international partners, the FOP is a focal point for information, co-ordination and analysis in the area of Swiss internal security.[169] Since 1996, after a trial period, the Office has operated a drug database called DOSIS. This database is an invaluable tool for the cantons. Cantonal narcotics squads are connected to the system and have direct access to DOSIS because they are required, as is the FOP, to enter information into the database. This system thus promotes co-operation between the FOP and cantonal police authorities. Only information on the illicit narcotics trade is entered into the system; information on those who only use drugs is excluded.[170]

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168 Federal Court, *L'organisation judiciaire en Suisse*, available online in French at: http://www.bger.ch/index.cfm?language=french&area=Federal&theme=system&page=content&maskid=195

169 Federal Office of Police, *Un aperçu de l'OFP*, available online in French at http://www.bap.admin.ch/f/index.htm.

170 Federal Office of Police, *Exploitation définitive de la banque de données en matière de drogue DOSIS*, June 26, 1996, available online in French at http://www.bap.admin.ch/f/index.htm.

Statistics on narcotics use and offences under the Narcotics Act

This section summarizes parts of a Federal Office of Police publication entitled *Situation Suisse: Rapport de Situation 2000* [2000 Situation Report on Switzerland],[171] prepared by the Analysis and Prevention Service as an interim document, given that a comprehensive report is to be published in 2002. It should be noted that the statistics in the report are distorted by methodological deficiencies. Switzerland is a federal state with 26 cantonal entities (cantons and half-cantons) and offences are not recorded based on the same criteria in every canton. Furthermore, the statistics do not make it possible to control double or multiple entries; some suspects may appear repeatedly in the same year or in different cantons. Finally, only some of the criminal acts under the criminal code are taken into account.[172]

Use

The report found the following trends in 2000:

- a sharp rise in marijuana use;
- a sharp rise in cocaine use;
- a sharp rise in multiple addictions (use of various kinds of narcotics);
- a sharp rise in synthetic drug use (amphetamines and methamphetamines) – Thai pills[173] have become the "in" drug;
- a downward trend in injection heroin use;
- virtually no open drug scenes in Swiss cities;
- 205 deaths due to drugs and recorded by the police (as compared to 405 in 1991) – those over 27 were the most affected age group, for men and for women, and Zurich and Bern were the most affected cantons, with 50 and 36 deaths due to drugs, respectively;
- 18- to 24-year-olds remain the most frequent users of marijuana, hash and hallucinogens, while those over 30 are the most frequent users of cocaine and heroin.[174]

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[171] Federal Office of Police, *Situation Suisse : Rapport de situation 2000*, Analysis and Prevention Service, 2001, available online in French at http://www.bap.admin.ch/f/index.htm.

[172] *Ibid.*, page 7.

[173] According to the Federal Office of Police press release, Thai pills contain metamphetamine, and their structure closely resembles that of ecstasy. They come from Thailand, where they go by the name of "Yaba" (drug that makes you go crazy). The tablets bear the letters "WY" and smell like vanilla. The substance is usually smoked, using a sheet of aluminium, or absorbed. The risk of addiction among people absorbing the product by smoking it is at least three times greater than among ecstasy users. This drug is a powerful stimulant with effects comparable to those of crack, but longer lasting. These pills may result in irreparable physical and mental damage (loss of memory, depression). They may also cause paranoid hallucinations and violent fits and create psychological dependence faster than ecstasy.

[174] Federal Office of Public Health, 2000, *op. cit.*, page 17-37.

Offences

Federal *Narcotics Act* drug-related offences reported cases rose from 44,307 in 1999 to 46,558 in 2000. This represents a significant increase over the 18,800 reported cases in 1990. A comparison of the number of reported cases per offence type in 1997 and 2000 reveals a downward trend in drug trafficking, smuggling, dual offences and an overall increase – with the exception of 1999[175] – in drug use cases.

The number of reported cases of drug dealing in 2000 fell to 3,021 from 3,711 in 1999. This represented a drop of 18.5%. However, some cantons posted a major hike in reported cases. A case in point was the city of Basel, which recorded an increase of 31%. The report urges caution in interpreting these figures, suggesting that the major drop in the number of reported cases is not in fact due to an improved situation in these specific cantons, but rather to a decrease in the number of cases reported by the police as investigation capacity and officers are deployed in other areas. It should be noted that of a total of 3,021 drug trafficking cases, 78% involved foreigners and 22% Swiss citizens. With respect to the sex of offenders, 82% were men and 7% were women. The sex of the remaining 11% was unknown. The largest percentage (45%) of male offenders were aged between 18 and 24, whereas the majority of female offenders were over 30 (56%), followed by the 18-to-24 age group (27%).[176]

[175] *Ibid.*, page 18-19.
[176] *Ibid.*, page 20-23.

AUSTRALIA[177]

Cannabis was generally little known or used in Australia before the 1960s. However, the drug legislation that was passed in the majority of states and territories in the late 1800s and early 1900s (mainly because of the large number of Chinese who smoked opium) provided a framework that lent itself well to the prohibition of cannabis. The first Australian measures designed to control cannabis use were part of an act passed in 1928 in the state of Victoria to penalize the unauthorized use of Indian hemp and Indian hemp resin. Similar acts were subsequently passed in the other states of the Commonwealth. Penalties for the cultivation, possession and use of cannabis were generally quite harsh in the 1960s and 1970s.[178]

The incentive to revise the laws on cannabis use in South Australia came from the recommendations made in 1979 in the *Report of the South Australian Royal Commission into the Non-Medical Use of Drugs.*[179] One of those recommendations was that small-scale cannabis use not be considered a criminal offence. In support of that recommendation, the Royal Commission cited a number of overseas states, including 10 American states, where such a measure had yielded good results.

National drug strategy[180]

The National Campaign Against Drug Abuse (1985-1992)

The inception of the National Campaign Against Drug Abuse (NCADA) in 1985 was a watershed in Australian drug policy and introduced a focus on public health and harm minimization. The NCADA emphasized that drug use should be treated primarily as a health issue. The decision was made deliberately to situate the program within the Federal Department of Health rather than the Federal Attorney General's Department, due at least in part to the emergence of HIV/AIDS. But the program from the start involved a strong partnership between the Commonwealth (or federal government), States and Territories. It also intended to foster a partnership between health and law enforcement in a comprehensive strategy involving an integrated approach to licit as well as illicit drugs.

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177 This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: R. MacKay, (2001) *National Drug Policy: Australia*. Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

178 For a history of the laws relating to cannabis in Australia, see: McDonald *et al.*, *Legislative Options for Cannabis Use in Australia*, Commonwealth of Australia, 1994, available online at: http://www.druglibrary.org/schaffer/Library/studies/aus/cannabis.htm.

179 South Australian Government, Royal Commission of Inquiry into the Non-Medical Use of Drugs South Australia 1979, *Final Report* (Chairperson: Sackville).

180 For an outline of the National Drug Strategy from 1985 to the present, see: http://www.aic.gov.au/research/drugs/strategy/index.html.

The philosophy of harm minimization includes the strategies of supply, demand and harm reduction. The mission of Australia's drug strategy is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs.

The National Drug Strategy (1993-1997)

A further principle underlying the new drug strategy was that reliable data, new approaches and evaluation of effort were required. As part of this new effort, the Ministerial Council on Drug Strategy (MCDS) commissioned two independent evaluations of the NCADA to assess progress and make appropriate recommendations. After these two evaluations, one released in 1988 and the other, *No Quick Fix*, in 1992, the campaign was relaunched as the National Drug Strategy (NDS). Incorporating the recommendations from the two evaluations, the National Drug Strategy continued to stress the importance of harm minimization principles. Some of the goals of the Strategy were to:

- Minimize the level of illness, disease, injury and premature death associated with the use of alcohol, tobacco, pharmaceutical and illicit drugs;
- Minimize the level and impact of criminal drug offences and other drug-related crime, violence and antisocial behaviour within the community;
- Minimize the level of personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the inappropriate use of alcohol and other drugs; and
- Prevent the spread of hepatitis, HIV/AIDS and other infectious diseases associated with the unsafe injection of illicit drugs.

The strategic plan identified six specific concepts which were to underpin the development and implementation of drug policy: harm minimization; social justice; maintenance of controls over the supply of drugs; an intersectoral approach; international cooperation; and evaluation and accountability.

Overall responsibility for the broad policy direction and operation of the NDS rests with the MCDS, which comprises both health and law enforcement ministers from each State and Territory as well as from the Commonwealth government. The council meets annually. The National Drug Strategy Committee (NDSC) provides administrative support for the MCDS. It is mandated to develop proposals for the NDS, implement the NDS, develop policy proposals relating to licit and illicit drugs and liaise with other governmental agencies on matters relating to the NDS. It consists of one health and one law enforcement representative from each jurisdiction. The MCDS and NDSC develop national policies and directions which individual jurisdictions then implement as appropriate within their social, political and economic environments.

Report on the National Drug Strategy (1997)[181]

In 1997 a report evaluating the National Drug Strategy (1993-1997) was produced. This report, entitled *The National Drug Strategy: Mapping the Future*, lauded the NDS for a unique combination of features which had brought it international attention and acclaim:

- The NDS recognizes the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options based on the concept of harm minimization. These range from abstinence-oriented interventions to programs aimed at ameliorating the consequences of drug use among those who cannot be reasonably expected to stop using drugs at the present time;
- The NDS adopts a comprehensive approach to drugs, which encompasses the misuse of licit as well as illicit drugs. Policies and programs to address the problems of illicit drugs, alcohol, tobacco and pharmaceuticals all fall under the aegis of the NDS;
- The NDS approach to drugs stresses the promotion of partnerships–between health, law enforcement, education, non-overnmental organizations, and private industry; and
- The NDS attempts to address drug issues in a balanced fashion. This refers to the appropriate balance of effort between the Commonwealth, States and Territories, a balance between supply and demand reduction strategies, and a balance between treatment, prevention, research and education.

Contrary to the fears of many that harm minimization policies might lead to increased public acceptance and use of illicit drugs, the evaluation found that there was no discernible trend in the use of drugs such as heroin, amphetamines and cocaine, although there was some increase in marijuana use. The NDS was also found to have contributed to the success of the National HIV/AIDS Strategy in reducing the spread of HIV, Hepatitis C and other infectious diseases among intravenous drug users.

The National Drug Strategic Framework (1998/1999-2002/2003)[182]

The National Drug Strategic Framework maintains the policy principles of the previous phases of the National Drug Strategy and adopts the recommendations of the

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181 See Eric Single and Timothy Rohl, *The National Drug Strategy: Mapping the Future*, A Report commissioned by the Ministerial Council on Drug Strategy, Canberra, April 1997. Available online at: http://www.health.gov.au/pubhlth/publicat/document/mapping.pdf.

182 Ministerial Council on Drug Strategy, *National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships*, Prepared for the Ministerial Council by a joint steering committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs, Canberra, November 1998. Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

report from the previous phase. Its focus remains on harm minimization and continues to seek a balance between supply-reduction, demand-reduction and harm-reduction strategies, emphasizing the need for integration of the various strategies. It also continues the emphasis on evidence-based practice, based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions.

This next phase of the NDS places emphasis on extending the partnership between health and law-enforcement agencies to take in a broader range of partners, as recommended in the evaluation report. Thus the Intergovernmental Committee on Drugs, which consists of health and law enforcement officers from each Australian jurisdiction, is expanding to include officers from the portfolios of customs and education. The MCDS will now be supported by the Australian National Council on Drugs, consisting of people with relevant expertise from the government, non-government and community-based sectors to provide policy advice. These bodies will develop a series of National Drug Action Plans which will specify priorities for reducing the harm arising from the use of licit and illicit drugs, strategies for taking action on these priorities, and performance indicators.

The National Illicit Drug Strategy (1998 –)[183]

In 1997, the Australian government launched the National Illicit Drug Strategy "Tough on Drugs" as the next major phase of the National Drug Strategy. Its implementation began in 1998. The Strategy encompasses a range of supply reduction and demand reduction measures at a total cost of AUD $516 million. Funding for the Strategy is split between demand-reduction strategies, which are being implemented by the Department of Health and Aged Care and the Department of Education, Training and Youth Affairs, and supply-reduction strategies, which are being implemented by the Attorney-General's Department, the Australian Federal Police and the Australian Customs Service. AUD$213 million has been allocated for a range of supply reduction measures to intercept more illicit drugs at borders and within Australia. Law enforcement efforts include funding for 10 new Federal Police anti-drug mobile strike teams to help dismantle drug syndicates within Australia as well as increased funding for the Australian Customs Service to enhance its capacity to intercept drug shipments.

The remaining AUD$303 million has been allocated for demand reduction initiatives which cover five priority areas:

- Treatment of users of illicit drugs, including identification of best practice,
- Prevention of illicit drug use,
- Training and skills development for front line workers who come into contact with drug users,
- Monitoring and evaluation, including data collection,
- Research.

[183] For further details on the National Illicit Drug Strategy, see the Australian Department of Health and Aged Care Web site: http://www.health.gov.au/pubhlth/strateg/drugs/illicit.

In conjunction with the new strategy, the Intergovernmental Committee on Drugs has been established to provide policy advice for government ministers on a full range of drug-related matters.

In June 1999, Commonwealth, State and Territory health and law enforcement Ministers agreed on a national approach to the development of a drug diversion initiative. This was designed to support the diversion of illicit drug users from the criminal justice system into education and treatment. Diversion involves a graduated series of interventions appropriate to the seriousness of the offence and the circumstances of the offender. Diversion is not considered appropriate for trafficking offences. Drug-involved offenders can be cautioned on the streets and provided with treatment referral information if their offence is possession of a small quantity of drugs. They can be sent for assessment or directly to treatment rather than prison, as long as the offence is not serious and they do not pose a threat to society. Courts and correctional systems can also use commitment or referral to community-based treatment as an adjunct to probation or parole from prison. There is also treatment within correctional facilities and corrections-operated or funded therapeutic communities and halfway houses.[184]

Assessment of the National Drug Strategy (2001)[185]

Based on the concept of harm minimization rather than the need to eliminate drug use, the NDS recognizes the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options. These options range from abstinence-oriented interventions to programs aimed at ameliorating the consequences of drug use among those who cannot reasonably be expected to stop using drugs immediately. The goals, strategies, guiding principles and performance indicators for the NDS are established by a National Drug Strategy Committee. This committee consists of high-level civil servants from health and law enforcement ministries of each state and territory as well as their counterparts from the federal government. This shared decision-making has been seen as a strength of the NDS since it enhances government co-operation and ensures a high level of visibility for the drug strategy.

Professor Eric Single noted that the Australian government had followed up on a number of the recommendations he had made to improve the NDS. For example, the NDS was renewed for five years, funding was increased, a specialized NDS unit was

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184 For further information, see: Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs, 2001 to 2002-03*, Prepared by the National Expert Advisory Committee on Illegal Drugs, Canberra, July 2001. Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

185 See testimony of Professor Eric Single before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, May 2001. Available online at: www.parl.gc.ca/drogues-illicites.asp.

created within the Commonwealth Ministry of Health, and action plans were developed with regard to other recommendations.[186]

Legislative framework

Under Australia's federal structure, criminal law– and responsibility for enforcing drug laws–is primarily the responsibility of state governments. Australia has ratified the three major international treaties on illicit drugs, and the obligations under those treaties are effected in three pieces of federal legislation: the *Narcotic Drugs Act 1967*, the *Psychotropic Substances Act 1976* and the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*.

The drug laws in Australian jurisdictions

The law relating to illicit drugs is made and enforced in Australia on a state and territorial level. It varies markedly between jurisdictions, but its structure is broadly similar. The key legislation from each jurisdiction is as follows:

New South Wales	*Drug Misuse and Trafficking Act 1985*; *Drug Court Act 1998*
Victoria	*Drugs, Poisons and Controlled Substances Act 1981*
Queensland	*Drugs Misuse Act 1986*; *Drug Rehabilitation (Court Diversion) Act 2000*
Western Australia	*Misuse of Drugs Act 1981*
South Australia	*Controlled Substances Act 1984*
Tasmania	*Poisons Act 1971*
Northern Territory	*Drugs of Dependence Act 1990*
Australian Capital Territory	*Drugs of Dependence Act 1989*
Commonwealth	*Customs Act 1901* *Narcotic Drugs Act 1967* *Psychotropic Substances Act 1976* *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*[187]

[186] *Ibid.*

[187] The illegal drug legislation in effect in the states and territories may be consulted online at: http://www.aic.gov.au/research/drugs/context/legislation.html.

Each act creates, in one form or another, the basic offences of possession, use, cultivation, production and trafficking, supplying and selling. The acts also contain lengthy schedules, derived from various international conventions, listing which drugs are prohibited, and defining various amounts, such as "traffickable" and "commercial" quantities. These quantities are used to determine maximum penalties for sentencing purposes.

The typical maximum penalties for the more serious offences, such as trafficking in "commercial quantities," are in the range of 25 years to life, although most jurisdictions apart from Queensland set lower maximums for offences involving cannabis. Most acts provide for persons who have been found guilty of simple possession and/or use offences to receive a term of imprisonment, but it is very uncommon now for this penalty to be imposed. Particularly for the less serious offences, there is often a very substantial gap in sentencing between the "law on the books" and the "law in practice." For example, in Queensland, where the offence of possession carries a notional maximum penalty of 15 years imprisonment and a maximum fine of AUD $300,000, the standard penalty applied in the Magistrates Court – where the overwhelming majority of possession charges are heard – is a fine of a few hundred dollars, often with no conviction being recorded.[188]

Since 1987 in South Australia, 1992 in the Australian Capital Territory, and 1996 in the Northern Territory, people detected committing "minor" cannabis offences have been able to avoid a court appearance altogether by paying a relatively modest "on-the-spot" fine. While cannabis possession is still prohibited, it is sanctioned by a civil, not a criminal, penalty. In addition, Victorian legislation provides for the imposition of pre-conviction bonds for first offenders charged with minor drug offences (*Drugs Poisons and Controlled Substances Act 1981*, s. 76). First offenders are given a bond, and no conviction is recorded if the bond conditions are complied with. But in Victoria, New South Wales, Tasmania, Queensland, and Western Australia all cannabis possession, use and supply is criminally prohibited with criminal penalties being imposed. In addition, in all jurisdictions the penalties imposed for commercial dealing are still very substantial, especially for offences at the upper end of the scale.

In the civil prohibitionist jurisdictions, the offences attracting a civil infringement notice include possession of small amounts of cannabis plant (up to 100g in South Australia, 25g in the Australian Capital Territory, and 50g in the Northern Territory) and cultivation of cannabis plants (up to three in South Australia, five in the Australian Capital Territory, and two in the Northern Territory). Failure to pay the fines may result in court appearances and subsequent conviction.

The criminal prohibitionist jurisdictions have also recently adopted "diversionary" cautioning procedures which allow first or second time cannabis possession/use

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[188] For more information on Australian drug laws, see David Brereton, "The History and Politics of Prohibition", in *Drugs and Democracy, supra.*

offenders to receive a caution or education/counselling session instead of the normal court appearance.

"Drug Courts" have been established in four Australian jurisdictions – Queensland, New South Wales, South Australia, and Victoria. In Queensland and New South Wales these "diversionary" courts have been established by legislation while in South Australia and Victoria they operate on a less formalized basis.[189]

A notable feature of Australian drug laws is the use of provisions which contravene the long-established principle that the burden of proof in criminal cases should be on the prosecution to prove each element of the offence beyond reasonable doubt. For example, the *Drugs Misuse Act 1986* (Queensland) contains a "deeming provision" for the offence of possession. This means that, if a prohibited drug is found on someone's premises, this will be regarded as conclusive evidence that the drug was in the possession of the occupier, unless he or she can persuade the court that they "neither knew nor had reason to suspect that the drug was in or on that place" (s. 57(c)). Another example is s. 235 of the Commonwealth *Customs Act 1901*. This provision requires a person who has more than a certain quantity of drugs in his or her possession to prove, on the balance of probabilities, that he or she did not intend to engage in commercial dealings in relation to those drugs. If the person cannot prove this, they will be sentenced on the basis that they had an intention to traffic.

Another aspect of Australian drug laws to note is the wide range of powers which are available to police and other law enforcement bodies to detect and investigate drug offences. Under the Queensland *Drugs Misuse Act 1986*, for example, police have had the power in relation to any quantity of any illegal drug to: stop, search, seize and remove motor vehicles; detain and search persons; order internal body searches; and enter and search premises with or without a warrant (s. 18). In addition, for offences such as drug trafficking, Queensland police are empowered to apply to a court to have listening devices installed on private premises.

For law enforcement bodies operating at the federal level, and in most states other than Queensland, telecommunications interception powers are also available for the investigation of serious drug offences under the Commonwealth *Telecommunications (Interception) Act 1979*.

Over the last decade, most jurisdictions have also passed confiscation of profits legislation which can be used to attack the assets of drug traffickers and producers. In most cases this action can be taken only after the person has been convicted, but in New South Wales a confiscation order can be made without requiring a conviction, where the Supreme Court is satisfied that "it is more probable than not" that the person has engaged in drug-related activities (*Criminal Assets Recovery Act 1990*).

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189 For further details on Australian drug courts, see:
http://www.aic.gov.au/research/drugs/context/courts.html

Decriminilization in Australia[190]

While the National Drug Strategy provides a general framework for responses to drug problems, drug offences and the associated penalties in Australia are a matter of state and territorial jurisdiction. Some Australian states and territories have adopted cannabis decriminilization measures while others have not.

The first Australian jurisdiction to adopt cannabis decriminilization measures was South Australia. The Cannabis Expiation Notice (CEN) scheme came into effect in South Australia on 30 April 1987. Under this scheme, adults coming to the attention of police for "simple cannabis offences" could be issued with an expiation notice. Offenders were able to avoid prosecution by paying the specified fee or fees (ranging from AUD $50 to AUD $150) within 60 days of the issue of the notice. Failure to pay the specified fees within 60 days could lead to prosecution in court, and the possibility of a conviction being recorded. Underlying the CEN scheme is the rationale that a clear distinction should be made between private users of cannabis and those who are involved in dealing, producing or trafficking in cannabis. This distinction was emphasized at the introduction of the CEN scheme by the simultaneous introduction of more severe penalties for offences relating to the manufacture, production, sale or supply of all drugs of dependence and prohibited substances, including offences relating to larger quantities of cannabis.

The CEN scheme was modified by the introduction of the *Expiation of Offences Act, 1996* which now provides those served with an expiation notice the option of choosing to be prosecuted in order to contest being given the notice. Previously those served with a notice had to let the payment of expiation fees lapse in order to secure a court appearance to contest the notice. In choosing to be prosecuted, however, people issued a notice have their alleged offence converted from one which can be expiated to one which still carries the possibility of a criminal conviction.

The Australian Capital Territory (in 1992) and the Northern Territory (in 1996) introduced similar expiation schemes. Victoria implemented a system of cautions for minor cannabis offenders in 1998 and Western Australia has followed with a similar scheme.

In all cases, cannabis possession remains a criminal offence. By their nature, these provisions reduce, as necessary, the prison term in which the possession of small quantities of cannabis for personal use would previously have resulted.[191]

Various evaluation studies since conducted have revealed significant savings and reduced negative social impact on persons convicted of minor cannabis offences. None

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190 For further details on this topic, see: Eric Single, Paul Christie and Robert Ali, "The Impact of Cannabis, Decriminilisation in Australia and the United States", *Journal of Public Health Policy*, 21,2, Summer 2000, page 157-186. Available online at: http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-f/ille-f/presentation-f/single-f.htm.

191 For a fuller discussion of the legislative possibilities concerning cannabis, see McDonald *et al.*., *Legislative Options for Cannabis Use in Australia, supra.*

of the studies upon levels and patterns of cannabis use in South Australia[192] have found an increase in cannabis use which is attributable to the introduction of the CEN scheme. Cannabis use did increase in South Australia over the period from 1985 to 1995 but this was so throughout Australia, including in jurisdictions with a total prohibition approach to cannabis. In fact, the largest increase in the rate of weekly cannabis use across all Australian jurisdictions occurred in Tasmania, a prohibitionist state.[193]

A comparative study of minor cannabis offenders in South Australia and Western Australia concluded that both the CEN scheme and the more punitive prohibition approach had little deterrent effect upon cannabis users. Offenders from both jurisdictions reported that an expiation notice or conviction had little or no impact upon subsequent cannabis and other drug use. However, the adverse social consequences of a cannabis conviction far outweighed those of receiving an expiation notice. A significantly higher proportion of those apprehended for cannabis use in Western Australia reported problems with employment, further involvement with the criminal justice system, as well as accommodation and relationship problems.[194]

In the law enforcement and criminal justice areas, the number of offences for which cannabis expiation notices were issued in South Australia increased from around 6,000 in 1987/88 to approximately 17,000 in 1993/94 and subsequent years. This appears to reflect the greater ease with which police can process minor cannabis offences and a shift away from the use of police discretion in giving offenders informal cautions to a process of formally recording all minor offences. Substantial numbers of offenders still received convictions due to their failure to pay expiation fees on time. This was due in large part to a poor understanding by cannabis users of the legal consequences of not clearing expiation offences and due to financial difficulties. Most CENs are issued for less than 25g of cannabis and half of all CENs issued were received by people in the 18- to 24- year-old age group.[195]

The scheme has proven to be relatively cost-effective and more cost-effective than prohibition would have been. The total costs associated with the CEN scheme in 1995/96 were estimated to be around AUD $1.24 million while total revenue from fees and fines was estimated to be around AUD $1.68 million. Had a prohibition approach

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[192] Single, Christie, and Ali, *supra*, Notes 3, 11, 12, 18, 19 and 50. See also Maurice Rickard, *Reforming the Old and Refining the New: A Critical Overview of Australian Approaches to Cannabis*, Department of the Parliamentary Library, Information and Research Services, Research Paper No. 6 2001-02, 2001, page 29. Available online at: http://www.aph.gov.au/library (listed under Research Papers).

[193] Rickard, *op. cit.*, page 30.

[194] National Drug Research Institute, Curtin University of Technology, *The Regulation of Cannabis Possession, Use and Supply*, A discussion document prepared for the Drugs and Crime Prevention Committee of the Parliament of Victoria, Perth, Western Australia, 2000, page xxxiv.

[195] *Ibid.*, page xxxiii.

been in place, it is estimated that the total cost would have been around AUD $2.01 million, with revenue from fines of around $1 million.[196]

A report on the CEN scheme[197] noted that it appeared to have numerous benefits for the community, not the least of which were cost savings for the community as a whole, reduced negative social impacts for offenders, and greater efficiency and ease in having minor cannabis offences dealt with, associated with less negative views of police held by offenders. Yet the rate of expiation of notices has remained low, compared with other types of infringement notices, at around 45%.

Administration

Public costs

In financial terms, Commonwealth and State Government expenditure in response to illicit drugs in 1992 was estimated at AUD $620 million. Of this sum, 84% was allocated to law enforcement, 6% to treatment, and 10% to prevention and research. Commonwealth and state expenditure on methadone programs has been estimated at AUD $30 million per year.

Based on various more recent estimates, it is likely that more than AUD $200 million is spent annually in the health and social welfare sectors by governments as a direct or indirect result of the illicit drugs trade.[198] It is estimated that AUD $450 to AUD $500 million is the annual cost to the criminal justice system incurred by illicit drugs.[199] It is estimated that more than AUD $312 million is raised each year by heroin users/dealers through property crime.[200] Law enforcement estimates suggest that drugs generate at least AUD $2 billion annually within Australia. In addition, it has been suggested that a significant proportion of the estimated AUD $3.5 billion laundered in and through Australia each year can be attributed to illicit drugs.[201]

The economic costs associated with the prevention and treatment of drug-related illness, loss of productivity in the workplace, property crime, theft, accidents and law enforcement activities are over AUD $18 billion annually.[202]

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196 Rickard, *op. cit.*,, page 33.

197 Robert Ali *et al.*, *The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia*, Department of Health and Aged Care, Canberra, May 1998. Available online at: http://www.health.gov.au/pubhlth/publicat/drugs.htm.

198 John Broome, "Impacts Upon Social and Political Life", in *Drugs and Democracy*, *op. cit.*, page 117.

199 *Ibid.*, page 117. See also: Adam Sutton and Stephen James, "Law Enforcement and Accountability", in *Drugs and Democracy*, *op. cit.*, page 163, where an estimate of AUD $404 million is given for the annual cost to the Commonwealth, States and Territories of enforcing laws against illicit drugs.

200 Broome, *supra*, page 117.

201 *Ibid.*, page 118.

202 This figure includes costs associated with the use of alcohol and tobacco. See Timothy Rohl, "Evaluating the National Drug Strategy", in *Drugs and Democracy*, *supra*, page 134.

Social costs

In a study of the social impacts of a conviction for a minor cannabis offence on first time offenders, a significant minority of the sample was shown to develop less favourable attitudes towards police, and there was evidence that many respondents had experienced adverse consequences in terms of employment difficulties, further problems with the law, and problems in relationships and accommodation.[203]

A cost of making cannabis illegal is the exposure of cannabis buyers to a range of other potentially more harmful illicit drugs which are available for sale. Another cost is the involvement of organized crime in large scale cannabis production and distribution in Australia. Finally, the illicit drug market generates a sizeable cash economy. It is not too surprising that some police officers become involved in corrupt activities such as drug use, drug dealing, protection of drug dealers, theft of drugs and/or money, and the presentation of false evidence in court.[204]

Statistics

Use[205]

The Australian Institute of Health and Welfare conducts a National Drug Strategy Household Survey (NDSHS) every 2-3 years. This survey has been conducted since 1985 with the seventh survey taking place in 2001. The last survey for which results are available took place in 1998.[206] 10,300 Australians aged 14 years and older participated in the NDSHS. Respondents were asked about their knowledge of drugs, their attitudes towards drugs, their drug consumption histories, and related behaviours.

The results from the NDSHS in 1998 indicate that approximately 46% of the Australian population had used an illicit drug at some time, while 23% of Australians reported using any illicit drug in the twelve months preceding the survey. Marijuana was the most common illicit drug used, with 39.1% of those aged 14 years and over having used the drug at some time in their lives and 17.9% having used it recently. Of those who had used marijuana, almost half had used it in the past 12 months. The prevalence of lifetime use of pain-killers/analgesics (for non-medical purposes) was 11.5%, followed by hallucinogens (9.9%) and amphetamines (8.8%). Only 2.2% of the Australian population had ever used heroin, with 0.8% reporting recent usage. The

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[203] The Regulation of Cannabis Possession, Use and Supply, *supra*, page 40.

[204] *Ibid.*, page 40-43.

[205] Megge Miller, and Glenn Draper, *Statistics on Drug Use in Australia 2000*, Australian Institute of Health and Welfare, Canberra, May 2001. Available online at: http://www.aihw.gov.au/publications/phe/sdua00/index.html.

[206] For detailed results of the 1998 NDSHS, see: Pramod Adhikari and Amber Summerill, *1998 National Drug Strategy Household Survey: Detailed Findings*, Australian Institute of Health and Welfare (Drug Statistics Series No. 6), Canberra, October 2000. Available online at: http://www.aihw.gov.au/publications/health/ndshs98d/index.html.

prevalence of cocaine use was slightly higher, with lifetime use in 4.3% of the respondents and recent use in 1.4%.

The second national survey on the use of over-the-counter and illicit substances by secondary students was conducted in 1999. The survey collected data from 25,480 students aged 12-17 years from 434 secondary schools throughout Australia. According to the survey, substance use increased with age for all substances except for inhalants and steroids. Across all ages, the most common substances used were analgesics (for medical and non-medical purposes), with at least 95% of those surveyed reporting the use of this substance. Marijuana use was also relatively high, particularly among those aged 16-17 years, who were more likely than the general community to use marijuana (47% versus 39%). Overall, a similar number of male and female students had tried the substances surveyed. However, slightly more males (32%) than females (29%) had used marijuana, while slightly more females than males had used analgesics for any purpose (98% versus 96%). Apart from these two substances, lifetime and recent illicit substance use was similar for both males and females.

Offences[207]

Marijuana/cannabis is consistently the most common drug for which people are arrested in Australia, accounting for 70% of all illicit drug arrests in 1998-99. However, the number of persons arrested for either the possession or supply of marijuana has fallen sharply from almost 79,000 in 1995-96 to approximately 58,000 in 1998-99.

The most common drug-related offence for which people were imprisoned was dealing/trafficking in drugs. Of the 1,663 people in prison in 1999 for drug-related offences, 78% were imprisoned for dealing/trafficking offences, with a further 11% imprisoned for possession/use of illicit drugs. The proportion of the total prison population imprisoned for drug-related offences has steadily declined, from 11% in 1995 to 9% in 1999. The proportion of people imprisoned for possession/use of drugs has remained stable over the past five years at 1%, while the proportion of those in prison for dealing/trafficking drugs and manufacturing/growing drugs is steadily decreasing.

Attitudes to drug use and drug legalization

The regular use of illicit drugs was not considered to be acceptable among the vast majority of the respondents in the 1998 NDSHS. Males were more likely to accept regular illicit drug use than were females. Marijuana was the most widely accepted illicit drug, with 30.5% of males and 20.6% of females supporting regular use.

Support for the legalization of illicit drugs follows a similar pattern to that of the acceptability of regular illicit drug use. The legalization of marijuana was supported by 33.8% of males and 25.1% of females. By contrast, support for the legalization of heroin, amphetamines and cocaine was less popular. Only 7% of males and 5.1% of

[207] Miller and Draper, *supra,* page 53-58.

females supported the legalization of cocaine. Those who supported the legalization of heroin, amphetamines and cocaine were generally aged 20-29 and 40-49 years.

THE UNITED STATES[208]

A proper description of the illegal drug policies, and even more so of drug practices, in the United States would in itself be long enough to fill a single report. Consider this: the research budget of the National Institute on Drug Abuse (NIDA) alone amounts to US $1 billion, approximately 80 per cent of funding allocated to illicit drug research worldwide; the budget of the Office for National Drug Control Policy (ONDCP) is more than US $18 billion, compared to that of the Canadian Drug Strategy, which is CDN $16 million, approximately one-half of one per cent of the US office's budget; and total expenses relating to illegal drugs are approximately US $35 billion. Furthermore, given the complexity of the American political system and the diversity of its population, one can only imagine the difficulty of accurately representing US drug policies.

What is more, the United States and illegal drugs are inextricably intertwined. As seen in the last chapter, the USA has played and continues to play a preponderant role in the negotiation and enforcement of international drug conventions. To think of drugs where the United States is involved is automatically to think of the "war on drugs" and the legions of statistics on incarceration, harsh sentences and the enormous economic and social costs that result therefrom.

In this section, we can only scratch the surface of this complex issue. Fortunately, in previous chapters, we have discussed various figures on the United States, use rates in Chapter 6 and research into effects in Chapter 7, for example. Our task was made even more difficult by the fact that we were unable to hear government representatives at the public hearings. In our single day of hearings in the United States, we heard from the Governor of New Mexico, Mr. Gary Johnson, and Mr. Ethan Nadelman of the Lindesmith Centre-Drug Policy Foundation. It was not until June 10 of this year that we were able to have a private meeting with Dr. Hanson, the director of NIDA and, on June 11, an *in camera* session with Mr. Walters, the director of the ONDCP.

The federal-state legislative framework

Historically, most criminal law and its enforcement was a matter under the jurisdiction of the states. Article I of the U.S. Constitution delineates the federal government's areas of legislative authority and the Tenth Amendment expressly provides that all powers not granted to the central government belong to the states. Criminal law is not among the powers specified as being within the federal

[208] This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: B. Dolin, *National Drug Policy: United States*. Ottawa: Library of Parliament, 2002, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

government's purview and in Congress' early days, federal criminal laws were restricted to acts injurious to the national government, such as treason and counterfeiting, or offences of an extra-territorial nature, such as piracy and felonies committed on the high seas.

Despite this, the U.S. Congress has managed to assume a significant role in the criminalization of drug use. Although the "Father of the Constitution," James Madison, had assured the states that their powers were "numerous and indefinite" and those of the central government "few and defined,"[209] judicial constitutional analysis subsequently provided a very wide interpretation of the sphere of congressional authority. Beginning with the 1819 case of *McCulloch v. Marlyland*[210] the U.S. Supreme Court has given a broad reading to the Article I provision that the federal government may enact all laws that are "necessary and proper" for executing its listed powers. Two of Congress' listed powers are taxation and the regulation of foreign and interstate commerce. As discussed below, the federal government has used these heads of power as the foothold for entering into the regulation of drug use.

Historical[211]

From the time of the U.S. Civil War (1861-1865) to the end of the 19th century, the use and sale of opium, morphine, cocaine and other psychoactive drugs were legal and common. Opium was available with or without a prescription and was an ingredient in many patent medicines, including various pain-killers, cough mixtures and teething syrups for infants. Cocaine was also used medicinally, as well as in soft drinks and wine.

Things started to change around the turn of the century. Heroin was first isolated in 1898 and was purported to convey the same benefits as opium or morphine, without the risk of addiction. The realization of heroin's addictive properties soon after its introduction coincided with racist appeals to protect American society from drugs. Initially, two drugs were targeted: Cocaine, associated mainly with Blacks who were said to go on violent rampages under its influence, and opium, the smoking of which was associated with the Chinese. Alcohol temperance societies and religious groups also played key roles in lobbying for prohibition.

Despite strong opposition from the patent medicine industry, the U.S. Congress passed the *Pure Food and Drug Act* in 1906. This legislation required over-the-counter medicines to list the amount of drugs contained in them in the hope that this would

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[209] In David P. Currie, *The Constitution of the United States: A Primer for the People*, Chicago: University of Chicago Press, page 26.

[210] 17 U.S. 316.

[211] See Steven R. Belenko, ed., *Drugs and Drug Policy in America: A Documentary History*, Westport: Greenwood Press, 2000; Joseph D. McNamara, "Commentary: Criminalization of Drug Use" *Psychiatric Times*; Vol. XVII(9) *Psychiatric Times*; Luna, Erik Grant, "Our Vietnam: The Prohibition Apocalypse", (1997) 46 Depaul L. Rev. 483**.** Stephen B. Duke, "Commentary: Drug Prohibition: An Unnatural Disaster", (1995) 27 Conn. L. Rev. 571).

reduce the use of such medicines. Soon to follow was the *Opium Smoking Act of 1909 (as Amended, 1914)* in which Congress banned the importation of the drug for non-medicinal purposes.

The *Harrison Narcotic Act* of 1914

The *Harrison Act* was a significant development in American drug policy. Earlier legislation enacted in 1909 had restricted the importation of opium in accordance with the international conventions against the use of the drug. Initially designed to medicalize cocaine and heroin by restricting their distribution to physicians, the *Harrison Act* was passed in 1914. Its stated purpose was soon altered by the influence of the prohibitionist fervour of the day and this legislation became the unusual model upon which the administration of American narcotics policy would develop. Constitutional limits, as perceived at the time, meant that federal laws had to focus on international controls, interstate transfer and taxation. The Act therefore addressed drug use by requiring anyone selling drugs to be licensed and to keep records of all sales, ostensibly for tax purposes. As part of this regulatory process, users had to obtain prescriptions. Even though the Act specifically provided that doctors could prescribe narcotics, they could only do so if it was in the course of their "professional practice."

There were court challenges to the legislation. However, the U.S. Supreme Court upheld the *Harrison Act* as a revenue act and not a policing measure.[212] It was subsequently held that the Act did not permit physicians to prescribe drugs to "addicts" to keep them physically comfortable or maintain their addiction.[213] The *Behrman* decision[214] of 1922 further restricted the ability of physicians to prescribe and the prosecution of pharmacists and physicians resulted in legal supplies of opiates and other drugs essentially becoming unavailable by the early 1920s.

Subsequent measures

In the Depression years, fears about "degenerate Mexicans" smoking marijuana also led to legislative action. Some suggest that this represents a common thread in American drug policy; that is, the determining factor in deciding whether a particular drug was criminalized was not its inherent properties or potential for social harm, but rather the kinds of people associated with its use.[215] By 1931, 29 states had outlawed marijuana and in 1937 Congress passed the *Marihuana Tax Act* which, like the *Harrison Act*, established federal control over marijuana pursuant to Congress' revenue authority. Although opposed by the American Medical Association at the time, the Act had the support of the country's top drug cop, the head of the Federal Bureau of Narcotics (FBN), Henry J. Anslinger.

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[212] *United States v. Doremus* (1919), 249 U.S. Reports 86. The *Harrison Act* was again upheld as a revenue measure in *United States v. Nigro* (1928), 276 U.S. Reports 332.

[213] *Webb et al. v. United States* (1919), 249 U.S. Reports 96.

[214] *United States v. Behrmann* (1922), 258 U.S. Reports 280.

[215] See Luna, *supra*, page 490-495.

Anslinger, a central figure in the history of American drug policy, had been named the commissioner of the FBN in 1930 and headed the organization through five presidential administrations, until 1962. Often compared to his contemporary J. Edgar Hoover, who controlled the FBI. with similar tenacity, Anslinger did not support a public health approach to drug policy and argued that jailing users was the only proper response. He often suggested that drugs were part of a foreign plot. During W.W.II, he accused the Japanese of using narcotics to sap America's will to fight; following the war, he asserted that it was the Communists who were attempting to do so.

Current legislation and enforcement

Federal law

The Controlled Substances Act

In 1970 the U.S. Congress enacted the federal Controlled Substances Act (the CSA) [216] pursuant to the federal authority to regulate interstate commerce.[217] This Act repealed most of the earlier federal legislation, including the *Harrison Act* and the *Marihuana Tax Act,* and is the foundation of U.S. federal drug law today. Based on a series of schedules, drugs are categorized and controlled to varying degrees. The most restrictions are placed on Schedule I drugs which cannot be possessed by anyone, except for the purpose of research that has been licensed by the federal government. This schedule includes drugs such as marijuana, heroin, MDMA, LSD and peyote which are deemed to have no medical use and a high abuse potential. Schedule II substances, which have an accepted medical use and are deemed to have an abuse potential less than those in Schedule I, are also subjected to tight controls. Included in Schedule II are cocaine, opium, morphine, meperidine (Demerol) and codeine.

The enactment of the CSA in 1970 represented a significant change in one key respect. Marijuana was differentiated from other drugs and federal penalties were reduced, not only for possession, but also for trafficking and distribution offences. This was to change, however, during the Reagan administration in the 1980s.

In 1982 President Reagan signed an executive order creating the post of White House Drug Policy Advisor. The *Comprehensive Crime Control Act* of 1984, the *Anti-Drug Abuse Act* of 1986 and the *Anti-Drug Abuse Amendment Act* of 1988 raised federal penalties for various drug-related offences (including marijuana offences), increased funding for drug control activities and sought to improve the coordination of federal drug control efforts. The *National Narcotics Leadership Act* of 1988 created the Office of

[216] Comprehensive Drug Abuse Prevention and Control Act of 1970, Title II, 21 U.S.C., ss. 800-966.

[217] Congress need merely find that a class of activity affects interstate commerce to enact criminal penalties; no proof is required that the conduct involved in a single prosecution has an effect on commerce: see Ehrlich, Susan, "The Increasing Federalization of Crime" (2000) 32 Ariz. St.L.J.825.

National Drug Control Policy, the director of which is commonly referred to as the "Drug Czar."[218]

Many commentators have suggested that these laws were passed during a time of extreme anti-drug hysteria resulting from the introduction of crack cocaine.[219] Propagated by politicians and embraced by the mainstream media, myths regarding crack likely had a significant impact on the increased use of mandatory minimum sentences and the expansion of the American "war on drugs" during the Reagan era.

Scheduling under the CSA–the example of marijuana

An examination of a petition to the Drug Enforcement Administration to reschedule marijuana is instructive of the scheduling process under the CSA.[220] In concluding that marijuana should remain in Schedule I, the Department of Justice considered eight factors:

- The drug's actual or relative potential for abuse;
- Scientific evidence of its pharmacological effects;
- The state of current scientific knowledge of the drug;
- Its history and current pattern of abuse;
- The scope, duration and significance of abuse;
- What, if any, risk there is to public health;
- The drug's psychic or physiological dependence liability; and,
- Whether the drug is an immediate precursor of a substance already controlled under the CSA.

The petition to reschedule was denied in part on the basis that marijuana has a high potential for abuse. While the term "abuse" is not defined in the CSA, the administration examined various factors in ascertaining the potential for abuse. Most important was its finding that individuals are taking the substance in amounts sufficient to create a hazard to their health or to the safety of other individuals or the community. It was determined that while marijuana has low levels of toxicity compared to other drugs of abuse, there are a number of risks resulting from both acute and chronic use, such as dizziness, nausea, time distortions, impaired judgement and short-term memory impairment. Also noted were studies from some authors who described a "marijuana withdrawal syndrome" consisting of restlessness, mild agitation, insomnia, nausea and cramping that resolves within days.

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[218] The Office's home page can b e found at www.whitehousedrugpolicy.gov.

[219] See, for example, Craig Reinarman and Harry G. Levine, eds., *Crack in America: Demon Drugs and Social Justice*, University of California Press, September 1997. The organization Human Rights Watch in a May 2000 report on the United States referred to the phenomenon as a "moral panic" (available online at www.hrw.org/reports/2000/usa).

[220] Department of Justice, Drug Enforcement Agency, "Notice: Denial of Petition", April 18, 2001, in Vol. 66, No. 75 of the Federal Register, page 20037-20076.

Another significant element of the analysis that precluded rescheduling marijuana was the fact that the drug has no currently accepted medical use in the United States. The Food and Drug Administration has not yet authorized treatment using marijuana. To do so would require that the following conditions be satisfied:

- The drug's chemistry must be known and reproducible;
- There must be adequate safety studies;
- There must be adequate and well-controlled studies proving efficacy;
- The drug must be accepted by qualified experts; and,
- The scientific evidence must be widely available.

Proposed legislation

The legislative war on drugs continues in the U.S. Congress. The proposed *Drug Dealer Liability Act of 1999* passed in the U.S. House of Representatives and was received in the Senate at the end of 2000. It would impose civil liability on drug dealers for the harm caused–either directly or indirectly–by the use of controlled substances. Even the drug users themselves would be permitted to sue for damages, although the statute requires that they first disclose to narcotics enforcement officers everything they know about the source of the illegal drugs. While it is not clear whether this bill will be made law, a model *Drug Dealer Liability Act* has so far been adopted by 13 states.[221]

Legislation entitled the *Protecting Our Children from Drugs Act of 2000* was passed by the House of Representatives on 17 October 2000. It would amend the *Controlled Substances Act* to further increase penalties for drug dealers who involve children in the drug trade. Mandatory minimum sentences would increase for dealers who use children under 18 to distribute drugs in or near schools or other "protected locations" such as playgrounds and video arcades. Other proposed initiatives include the *Drug Free America Act of 2001*, the *Domestic Narcotic Demand Reduction Act of 2001* and the *Drug Treatment and Research Enhancement Act of 2001.*

Federal penalties

The following charts provide a summary of the fines and the terms of imprisonment for selected violations of the federal *Controlled Substances Act* and related federal laws.[222] Note that for a third felony drug offence involving amounts constituting a top level offence, there is a mandatory life sentence without the possibility of release. Also note that the indicated weights refer to any mixture containing a detectable

[221] Arkansas, California, Colorado, Georgia, Hawaii, Illinois, Indiana, Louisiana, Michigan, Oklahoma, South Carolina, South Dakota, Utah and the U.S. Virgin Islands.

[222] Congress has passed various anti-crime bills that include drug-related provisions, including the *Crime Control Act* of 1984 (P.L. 98-473), the *Anti-Drug Abuse Act* of 1986 (P.L. 99-570), the *Anti-Drug Abuse Act* of 1988 (P.L. 100-690), the *Crime Control Act* of 1990 (P.L. 101-647) and the *Violent Crime Control and Law Enforcement Act* of 1994 (P.L. 103-322). Collectively, these Acts enhanced drug-related penalties and provided new funding for drug control activities.

amount of the illegal drug regardless of the substance in the mixture. "Conspiracy" and "attempt" offences carry the same penalties as the underlying offence.

Table 1[223]

Unlawful distribution, possession with intent to distribute, manufacture, importation and exportation				
Substance	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
Heroin	First Offence	1 kg or more	4-10 million	10 years to life
		100 g – 1 kg	2-5 million	5-40 years
		Less than 100 g	1-5 million	Up to 20 years
	Second Offence[224]	1 kg or more	8-20 million	20 years to life
		100 g – 1 kg	4-10 million	10 years to life
		Less than 100 g	2-10 million	Up to 30 years
Coca leaves, Cocaine or "Crack"	First Offence	50 g or more	4-10 million	10 years to life
		5-50 g	2-5 million	5-40 years
		Less than 5 g	1-5 million	Up to 20 years
	Second Offence	50 g or more	8-20 million	20 years to life
		5-50 g	4-10 million	10 years to life
		Less than 5 g	2-10 million	Up to 30 years
LSD	First Offence	10 g or more	4-10 million	10 years to life
		1-10 g	2-5 million	5-40 years
		Less than 10 g	1-5 million	Up to 20 years
	Second Offence	10 g or more	8-20 million	20 years to life
		1-10 g	4-10 million	10 years to life
		Less than 10 g	2-10 million	Up to 30 years
Marijuana	First Offence	1,000 kg or more or 1,000 plants or more	4-10 million	10 years to life
		100-1,000 kg or 100-1,000 plants	2-5 million	5-40 years
		50-100 kg or 100 plants	1-5 million	Up to 20 years
		Under 50 kg[225]	250,000-1 million	Up to 5 years
	Second Offence	1,000 kg or more or 1000 plants or more	8-20 million	20 years to life
		100-1,000 kg or 100-1,000 plants	4-10 million	10 years to life

[223] Source: Charles Doyle, *Drug Offences: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws*, Library of Congress Congressional Research Service, November 1, 2000.

[224] A second offence is one committed after a prior conviction for *any* felony drug offence under *any* federal, state or foreign drug law.

[225] Distribution of a small amount of marijuana for no remuneration is treated as simple possession, the penalties for which are contained in the second chart.

Unlawful distribution, possession with intent to distribute, manufacture, importation and exportation				
Substance	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
		50-100 kg or 100 plants	2-10 million	Up to 30 years
		Under 50 kg	500 000-2 million	Up to 10 years

Table 2

Simple possession				
Drug	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
Cocaine based	First	Over 5 g	Up to 250,000	5-20 years
	First	5 g or less	Minimum 1,000	Up to 1 year
All other	First	All amounts		
Cocaine based	Second[226]	Over 3 g	Up to 250,000	5-20 years
All other	Second	All amounts	Minimum 2,500	15 days to 2 years
Cocaine based	Third	Over 1 g	Up to 250,000	5-20 years
All other	Third	All amounts	Minimum 5,000	90 days to 3 years

State laws

General

In the U.S. a group called the National Conference of Commissioners on Uniform State Law has the task of drafting legislation that is to be recommended for adoption by all states in an effort to promote legislative consistency throughout the nation. The most recent Uniform Controlled Substances Act was drafted in 1994. The Act sets out the prohibited activities in detail but specific fines and sentencing are left to the discretion of the individual States. Most states have substantially adopted the major provisions of the Uniform Act[227] with the exception of New Hampshire and

[226] A prior conviction includes conviction of *any* offence under the *Controlled Substances Act* or any State drug law.

[227] The *Uniform Laws Annotated*, Master Edition, Volume 9, Parts II, III and IV, provides annotation materials for the adopting states. Under the heading "General Statutory Note", those jurisdictions that have based their drug legislation on the *Uniform Act* are stated to have substantially adopted the major provisions of the *Uniform Act*, but the official text of the State Act "departs from the official text in a such manner that the various instances of substitution, omission, and additional material cannot be clearly indicated by statutory notes." As such, it is recommended that recourse be had to the individual State legislation for specific details for the individual CSA. Another useful reference is Richard A. Leiter, ed., *National Survey of State Laws, 3d Ed.*, Detroit: Gale Group, 1999, which, at pages 152-188, provides charts that set out specific offences and penalties for cocaine, heroin and marijuana in all States.

Vermont where the state laws are not a substantial adoption of the Uniform CSA, although they contain some similar provisions and have the same general purpose. Also of note are the medical marijuana exemptions discussed below.

In terms of sentencing, there are significant discrepancies between states.[228] With respect to sentencing for other drug offences, some states have experimented with extremely harsh penalties. New York's "Rockefeller Laws," for example, are referred to herein in the section entitled "Key Reports and Studies." Other states that adopted similar "get-tough" penalties are now re-examining mandatory minimums, often as a result of fiscal considerations. For example, the state legislature in Louisiana overhauled its drug laws in June 2001. New legislation has cut drug sentences and repealed mandatory minimums for many non-violent crimes. As one republican legislator was quoted as saying, "*It's costing us too much to lock these people up and throw away the key*."

Medical marijuana

Since 1978, medical marijuana laws have been enacted in 35 states. Five have since expired or been repealed but the balance remain on the books. Of those remaining:

- 12 states have "Therapeutic Research Program" laws that purport to permit scientific research (although this is complicated by the federal prohibition).
- 10 states (and the District of Columbia) have symbolic laws that recognize the potential medicinal value of marijuana, but do not provide any protection from arrest.
- 8 states have laws that effectively allow patients to use medical marijuana despite federal law.

The following chart provides details of the eight states with effective medical marijuana laws. While marijuana possession is still a federal crime, most drug arrests are made by state and local officials. Since the federal government cannot force state and local police to enforce federal statutes, medical marijuana users are usually able to avoid prosecution in these states. However, since pharmacies do not sell marijuana, some distribution centres called "buyers' clubs" have emerged and these operations have been hampered by federal law enforcement.

Recently, the Supreme Court examined the issue of buyers' clubs in *Conant v. Oakland Cannabis Buyers' Cooperative*.[229] The court unanimously ruled that there is no medical necessity defence to the Controlled Substances Act's prohibitions on manufacturing and distributing marijuana. Because the CSA classifies marijuana as a Schedule I drug, marijuana has been deemed to have no medical benefits. While the decision in *Conant* does not render state laws regarding medical marijuana inoperative, it

[228] Appendix 2 of the report by B. Dolin, *op. cit.*, states the main alternatives.

[229] No. 00-151. Argued March 28, 2001 – Decided May 14, 2001. Cited as: 532 U.S. __ (2001).

does enhance the federal government's ability to prosecute under the CSA in all states. That said, federal enforcement efforts have not, thus far, targeted individuals who possess or cultivate small amounts for medical use. Only the buyers' clubs (also known as "compassion clubs") have been targeted.

In respect of the following chart, it should be noted that the quantity of marijuana a patient may possess varies from state to state. The provisions exempting caregivers from criminal liability may also vary.

State and Date Enacted	Protection provided to Patients	Documentation Required
Alaska – 3 Nov. 1998	Affirmative defence[230] provided to those registered with the state	Signed physician statement confirming that patient was examined, has a debilitating medical condition and other
California – 5 Nov. 1996	Exemption from prosecution if marijuana possession or cultivation is solely for the medical purposes of the patient	Written or oral approval by physician who has determined that the patient's health would benefit from marijuana in the treatment of a qualifying
Colorado – 7 Nov. 2000	Exemption from prosecution if in possession of a registry card; affirmative defence if no card, but in compliance with	Diagnosed prior to arrest as having a debilitating condition and advised by the physician that marijuana might benefit
Hawaii – 14 June 2000	Exemption from prosecution if in possession of a registry card; "choice of evils" defence also available[231]	Card obtained with medical records or a statement from a physician that there is a debilitating condition and the potential benefits of marijuana would "likely outweigh the
Maine – 2 Nov. 1999	Burden on state to prove that patient's medical use was not authorized by statute	Medical records or physician's letter showing that the patient has a qualifying condition, that the risks have been discussed and that the patient "might benefit" from medical marijuana
Nevada – 7 Nov. 2000	Exemption from prosecution	"Advice required"; specifics yet to be determined by legislature
Oregon – 3 Nov. 1998	Exemption from prosecution if in possession of registry card; affirmative defence if no card, but in compliance with the law; choice of evils	Diagnosed within 12 months of arrest with a qualifying condition and advised by attending physician that marijuana "may mitigate the

[230] An "affirmative defence" requires the defendant to prove on a balance of probabilities that he or she is in compliance with the statute.

[231] The "choice of evils" deference refers to the defence of medical necessity. Long recognized in common law, a defendant is provided the opportunity to prove in court that his or her violation of the law was necessary to avert a greater evil; the pain of a debilitating disease or condition in the case of medical marijuana. Certain states, as noted in the chart, have codified the defence.

State and Date Enacted	Protection provided to Patients	Documentation Required
Washington – 3 Nov. 1998	Exemption from prosecution if patient qualifies, has no more marijuana than necessary for personal medical use and presents valid documentation to law enforcement; affirmative defence if in compliance with	Signed physician statement or medical records that indicate that physician is of the opinion that the "potential benefits" of marijuana "would likely outweigh the health risks"

Federal drug policy goals and objectives

National drug-control policy in the United States purports to be based upon prevention, education, treatment and research, complemented by "supply reduction" activities.[232] To quote from the 2001 Annual Report of the Office of National Drug Control Policy ("ONDCP"):

> *Through a balanced array of demand-reduction and supply-reduction actions, we strive to reduce drug abuse and availability by half and the consequences of drug abuse by at least 25% by 2007.* [233]

Using the metaphor of cancer for the nation's drug problem, the ONDCP lists the following strategic goals and objectives as being the heart of American federal action in this area.[234]

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

Objective 1: Educate parents and other care givers, teachers, coaches, clergy, health professionals, and business and community leaders to help youth reject illegal drugs and underage alcohol and tobacco use.

Objective 2: Pursue a vigorous advertising and public communications program dealing with the dangers of illegal drugs, alcohol, and tobacco use by youth.

Objective 3: Promote zero tolerance policies for youth regarding the use of illegal drugs, alcohol, and tobacco within the family, school, workplace, and community.

Objective 4: Provide students in grades K-12 with alcohol, tobacco, and drug prevention programs and policies that are research based.

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[232] *National Drug Control Strategy: 2001 Annual Report*, Office of National Drug Control Policy, page 3.
[233] *Ibid.*, page 4.
[234] Available online at: http://www.whitehousedrugpolicy.gov/publications/policy/99ndcs/goals.html.

Objective 5: Support parents and adult mentors in encouraging youth to engage in positive, healthy lifestyles and modeling behavior to be emulated by young people.

Objective 6: Encourage and assist the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use.

Objective 7: Create partnerships with the media, entertainment industry, and professional sports organizations to avoid the glamorization, condoning, or normalization of illegal drugs and the use of alcohol and tobacco by youth.

Objective 8: Develop and implement a set of research-based principles upon which prevention programming can be based.

Objective 9: Support and highlight research, including the development of scientific information, to inform drug, alcohol, and tobacco prevention programs targeting young Americans.

Goal 2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.

Objective 1: Strengthen law enforcement – including federal, state, and local drug task forces – to combat drug-related violence, disrupt criminal organizations, and arrest and prosecute the leaders of illegal drug syndicates.

Objective 2: Improve the ability of High Intensity Drug Trafficking Areas (HIDTAs) to counter drug trafficking.

Objective 3: Help law enforcement to disrupt money laundering and seize and forfeit criminal assets.

Objective 4: Break the cycle of drug abuse and crime.

Objective 5: Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

Goal 3: Reduce health and social costs to the public of illegal drug use.

Objective 1: Support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse.

Objective 2: Reduce drug-related health problems, with an emphasis on infectious diseases.

Objective 3: Promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes: drug testing, education, prevention, and intervention.

Objective 4: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Objective 5: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Objective 6: Support and highlight research and technology, including the acquisition and analysis of scientific data, to reduce the health and social costs of illegal drug use.

Objective 7: Support and disseminate scientific research and data on the consequences of legalizing drugs.

Goal 4: Shield America's air, land, and sea frontiers from the drug threat.

Objective 1: Conduct flexible operations to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Objective 2: Improve the coordination and effectiveness of U.S. drug law enforcement programs with particular emphasis on the Southwest Border, Puerto Rico, and the U.S. Virgin Islands.

Objective 3: Improve bilateral and regional cooperation with Mexico as well as other cocaine and heroin transit zone countries in order to reduce the flow of illegal drugs into the United States.

Objective 4: Support and highlight research and technology – including the development of scientific information and data – to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Goal 5: Break foreign and domestic drug sources of supply.

Objective 1: Produce a net reduction in the worldwide cultivation of coca, opium, and marijuana and in the production of other illegal drugs, especially methamphetamine.

Objective 2: Disrupt and dismantle major international drug trafficking organizations and arrest, prosecute, and incarcerate their leaders.

Objective 3: Support and complement source country drug control efforts and strengthen source country political will and drug control capabilities.

Objective 4: Develop and support bilateral, regional, and multilateral initiatives and mobilize international organizational efforts against all aspects of illegal drug production, trafficking, and abuse.

Objective 5: Promote international policies and laws that deter money laundering and facilitate anti-money laundering investigations as well as seizure and forfeiture of associated assets.

Objective 6: Support and highlight research and technology, including the development of scientific data, to reduce the worldwide supply of illegal drugs.

Administration of the policy

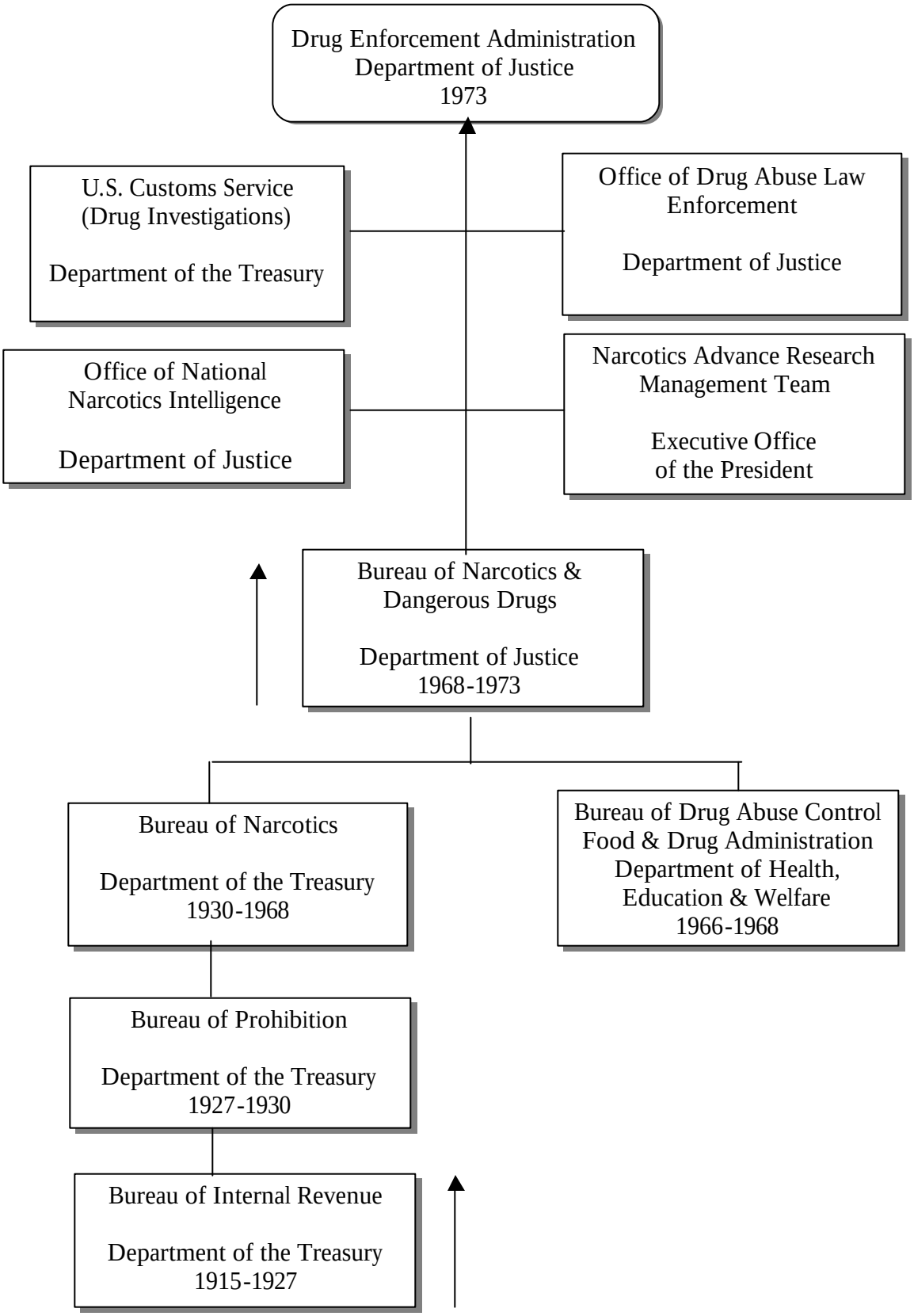
As previously stated, the national drug control budget is enormous. Over $18 billion has been budgeted for the year 2001 for the purpose of supporting the goals and objectives of the National Drug Control Strategy. Numerous federal departments, including Defense, Education, Justice, State and the Treasury, are involved and often must coordinate with state and local government agencies and a wide assortment of community and professional groups. This is all overseen by the ONDCP.

A key government department is the Department of Justice which is responsible for many of the agencies involved in this area and receives a significant portion of the drug control budget; over 8 billion dollars in 2001.[235] Various agencies receive funding through Justice, including the Bureau of Prisons, the F.B.I., INTERPOL, the U.S. Marshals Service, the Immigration and Naturalization Service and the Drug

[235] Source: Executive Office of the President of the United States, *Summary: FY 2002 National Drug Control Budget*, April 2001, page 11.

Enforcement Agency (DEA). The DEA[236] merits special mention in the Justice Department's administration of drug control policy. Its mission is to enforce the controlled substances laws and regulations and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. Established in 1973, it is the successor of Anslinger's FBN and other enforcement arms of the federal government as illustrated in the following graphic.[237]

[236] The DEA's Web page is at http://www.usdoj.gov/dea/.
[237] Source: DEA Web site, at http://www.usdoj.gov/dea/agency/genealogy.htm.


Drug Enforcement Administration
Department of Justice
1973
U.S. Customs Service
(Drug Investigations)
Department of the Treasury
Office of Drug Abuse Law Enforcement
Department of Justice
Office of National Narcotics Intelligence
Department of Justice
Narcotics Advance Research Management Team
Executive Office of the President
Bureau of Narcotics & Dangerous Drugs
Department of Justice
1968-1973
Bureau of Narcotics
Department of the Treasury
1930-1968
Bureau of Drug Abuse Control
Food & Drug Administration
Department of Health, Education & Welfare
1966-1968
Bureau of Prohibition
Department of the Treasury
1927-1930
Bureau of Internal Revenue
Department of the Treasury
1915-1927

Apart from its law enforcement duties, the DEA manages national drug intelligence and is responsible, under the policy guidance of the Secretary of State and U.S. Ambassadors, for all programs associated with drug law enforcement counterparts in foreign countries. In this capacity, the organization liases with the United Nations, Interpol, and other organizations on matters relating to international drug control programs. American actions outside of U.S. territory include "Plan Columbia," a program targeted at reducing cocaine productivity in that country to which over a billion dollars has been committed, as well as well joint enforcement activities undertaken with other governments such as Mexico. As well, under the *Foreign Assistance Act*, the U.S. is required to impose substantial restrictions on bilateral assistance to those countries listed by the White House as being major drug producing or transit countries. Similarly, the *Foreign Narcotics Kingpin Designation Act* permits the President to designate foreign individuals as "drug kingpins," thereby denying them access to the U.S. financial system and making illegal any transactions between the "kingpin" and U.S. companies or individuals.

Current issues and debates

The costs of incarceration, the unequal impact of drug laws on racial minorities and police corruption resulting from the war on drugs are issues that have garnered increased attention in this ongoing debate. For example, the Republican Governor of New Mexico has called for the decriminalization of all drugs – "*Control it, regulate it, tax it*" he has been quoted as saying[238] – citing the mounting cost of addressing drug abuse problems with prison rather than treatment. At our hearings, the Governor told us:

> *I happen to believe that the war on drugs is an absolute miserable failure. (…) When I witness that half of what we spend on law enforcement, half of what we spend on the courts and half of what we spend on the prisons is drug related, I know that there is no bigger issue facing us today. In the United States we are spending $50 billion each year on drug-related crime. (…) Two-thirds of all prisoners in the United States are incarcerated on drug charges. Nearly 500,000 incarcerations, one-quarter of the prison population, are directly related to drugs. It costs over $8.6 billion each year just to keep drug offenders locked up in the United States. Even with all of those expenditures, illegal drugs are now cheaper, more available and more potent than they were 20 years ago.*
>
> *(…) In the United States, which one of these substances gets people arrested? We are arresting 1.6 million people every year. New Mexico has a population of 1.8 million. I live and I drive in New Mexico, a giant state, and I cannot help but think the equivalent of the population of New Mexico is getting arrested in the United States every single year. It's absolutely shocking. Out of those 1.6 million arrests, there are 800,000 for marijuana, and half of those arrests involve Hispanics. Are half the users of marijuana in the United States Hispanic? No, yet half the arrest disproportionally fall on the Hispanic communities.*

[238] "New Mexico Governor Calls for Legalizing Drugs", CNN.com, October 6, 1999, available online at www5.cnn.com/US/9910/06/legalizing.drugs.01/.

Given that situation, what do we need to do? First, we need to legalize marijuana. Second, we need to adopt harm reduction strategies with regard to all the other drugs. Third, we need to move away from a criminal model to a medical model. [239]

Others criticize current policy on the basis that black Americans are disproportionately targeted in drug law enforcement. The group Human Rights Watch notes in a 2000 study that Blacks comprise 62.7% and whites 36.7% of all drug offenders admitted to state prisons, even though data confirms that this racial disparity "bears scant relation to racial differences in drug offending."[240] Various experts also pointed out the harmful effect of drugs on law enforcement, in particular Mr. Joseph McNamara, former chief of police of San Jose, California, now retired, who noted that the corruption of civil servants will be a serious problem as long as the current anti-drug policy remains in effect.[241]

Statistics

In Chapter 6, we presented an overview of data on cannabis use. We round out th description of the situation in the United States with a number of tables on certain selected indicators.

Estimated Domestic U.S. Drug Consumption (in Metric Tons)[242]

Year	Cocaine	Heroin	Marijuana	Methamphetamine
1996	288	12.4	874	14.3
1997	312	13.1	960	11.9
1998	291	12.5	952	15.9
1999	276	12.9	982	15.5
2000	269	12.9	1,009	15.5

[239] Testimony of Mr. Gary E. Johnson, Governor of New Mexico, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, November 5, 2001, Issue 9, page 36 to 38.

[240] Jamie Fellner, Human Rights Watch Associate Counsel, "United States: Punishment and Prejudice: Racial Disparities in the War on Drugs", Human Rights Watch, May 2000, paragraph 2 of "Summary and Recommendations", available online at www.hrw.org/reports/2000/usa.

[241] Joseph D. McNamara, "When Cops Become the Gangsters", *Los Angeles Times*, September 21, 1999, available online at www.nakedgov.com/mcnamara.htm.

[242] Source: Office of National Drug Control Policy, 2000. *What America's Users Spend on Illegal Drugs, 1988-1998*.

1997 National Household Survey on Drug Abuse: Past Illicit Drug Use[243]

Respondent Age	Ever Used	Past Year	Past Month
12 – 17	23.7 %	18.8 %	11.4 %
18 – 25	45.4 %	25.3 %	14.7 %
26 – 34	50.8 %	14.3 %	7.4 %
35 and over	31.5 %	6.1 %	3.6 %

1998 Drug Use Amount High School Seniors[244]

Drug	Ever Use	Past Year	Past Month
Marijuana	49.1 %	37.5 %	22.8 %
Cocaine	9.3 %	5.7 %	2.4 %
Crack	4.4 %	2.5 %	1 %
Stimulants	16.4 %	10.1 %	4.6 %
LSD	12.6 %	7.6 %	3.2 %
PCP	3.9 %	2.1 %	1 %
Heroin	2 %	1 %	0.5 %

Drug Prices and Purity Levels: Selected Years 1981-1998[245]

Purchase Amount	1981 Price/Purity (per pure gram)	1988 Price/Purity **(per pure gram)**	1996 Price/Purity (per pure gram)	1997 Price/Purity (per pure gram)	1998 Price/Purity (per pure gram)
Cocaine					
1 g or less	$378.70/40.02%	$218.33/75.99%	159.05/72.5 %	$178.97/64.72%	$169.25/71.23%
10-100 g	191.5/59.59%	78.84/ 83.53%	49.45/ 68.44p. cent	45.58/67.05	44.30/65.92
Heroin					
0.1 g or less	3,114.80/4.69	2,874.19/19.22	2,175.88/23.95	2,114.97/25.24	1,798.80/24.29
1-10 g	1,194.05/19.1	947.32/39.48	373.30/45.21	327.88/45.38	317.97/51.33
Marijuana					
10 g or less	$6.41	$12.50	$10.42	$10	$10.41
100-999 g	2.75	3.41	2.95	2.63	2.59

[243] Source: Office of National Drug Control Policy, Drug Policy Information Clearinghouse. *Drug Data Summary*, April 1999.
[244] *Ibid.*
[245] *Ibid.*

National Drug Control Budget[246]

Year	Amount (in $US billions)
1999	17.1
2000	17.9
2001	18.1
2002	19.2

Total Estimated Arrests and Drug Arrests, 1989-1999[247]

Year	Total Arrests	Arrests for all drug violations		Distribution of arrests for drug violations					
				Heroin/Cocaine		Marijuana		Other Drugs	
		Number	Per-cent	Sale	Possession	Sale	Possession	Sale	Possession
1989	14 340 900	1,351,700	.4	19.1	34.7	6.2	23.1	7.0	9.8
1990	14 195 100	1,089,500	.6	21.0	33.3	6.1	23.9	4.5	11.2
1991	14 211 900	1,010,000	.1	22.5	32.8	6.1	22.4	4.8	11.5
1992	14 075 100	1,066,400	.5	20.6	32.4	6.6	25.5	4.6	10.4
1993	14 036 300	1,126,300	.0	19.2	31.1	6.2	27.6	4.3	11.6
1994	14 648 700	1,351,400	.2	16.8	30.3	5.8	29.8	4.1	13.2
1995	15 119 800	1,476,100	.7	14.7	27.8	5.8	34.1	4.4	13.3
1996	15 168 100	1,506,200	.9	14.2	25.6	6.3	36.6	4.3	13.3
1997	15 284 300	1,583,600	0.3	10.3	25.4	5.6	38.3	4.7	15.8
1998	14 528 300	1,559,100	0.7	11	25.6	5.4	38.4	4.8	14.8
1999	14 031 070	1,532,200	0.9	10	24.5	5.5	40.5	4.1	15.4

[246] These figures represent funds specified for the purpose of supporting the goals and objectives of the National Drug Control Strategy and include funds budgeted for various departments, including Defence, Education, Justice, State, and Treasury,. Source: *National Drug Control Budget Executive Summary, Fiscal Year 2002*, Office of National Drug Control Policy, April 9, 2001.

[247] Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-2000).

Adults in Custody of State or Federal Prisons or Local Jails, 1989-1999[248]

Year	State Prisons	Federal Prisons	Total State & Federal Prisons	**Percent of prisoners who are drug offenders**		Local Jails
				Federal	State	
1989	629,995	53,387	683,382	49.9	19.1	395,553
1990	684,544	58,838	743,382	53.5	21.7	405,320
1991	728,605	63,930	792,545	55.9	21.3	426,479
1992	778,495	72,071	850,566	58.9	22.1	444,584
1993	828,566	80,815	909,381	59.2	22.1	459,804
1994	904,647	85,500	990,147	60.5	22.4	486,474
1995	989,004	89,538	1,078,542	59.9	22.7	507,044
1996	1,032,440	95,088	1,127,528	60.0	22.7	518,492
1997	1,059,588	99,175	1,176,922	62.6	20.7	567,079
1998	1,178,978	123,041	1,232,900	58.7	20.7	592,462
1999	1,209,123	135,246	1,366,369	57.8	Unavailable	605,943

Correctional population in the United States: selected statistics for 1997[249]

In 1997, an estimated 5.7 million adult residents of the U.S. (or approximately 2.8% of all U.S. adult residents) were under some form of correctional supervision. Approximately 70% were supervised in the community, through probation or parole. About 9.0% of black adults were under correctional supervision; for white adults, the figure was 2.0% and for other races it totalled 1.3%.

Federal drug prosecutions: selected statistics for 1999[250]

During 1999 U.S. attorneys initiated investigations involving 117,994 suspects. Of these suspects, 32% were investigated for drug offences. Suspects in criminal matters involving drug offences were more likely to be prosecuted in a U.S. district court (77%) as opposed to suspects involved in violent offences (59%), public order offences (53%) or property offences (50%). Of those convicted of felony drug offences in federal court in 1999, 93% received prison sentences. The average sentence of all offenders sentenced in federal court in 1999 was 57.8 months; for drug offenders, the average was 75.4 months.

[248] Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 1999* (Aug. 2000), *Prisoners in 1998* (Aug. 1999), *Prisoners in 1997* (Aug. 1998), *Correctional Populations in the United States*, 1995, 1994, 1993, 1992, 1991, 1990, 1989. *Jails and Jail Inmates*, 1993-94. *Jail Inmates*, 1992; 1990. Data for 1997 percentages of drug offenders are estimated from Bureau of Justice Statistics, *Substance Abuse and Treatment, State and Federal Prisoners, 1997* (January 1999) and unpublished Bureau of Prisons Data.

[249] Source: *Correctional Populations in the United States, 1997*, Bureau of Justice Statistics, U.S. Department of Justice, (November 2000).

[250] Source: *U.S. Compendium of Federal Judicial Statistics, 1999*, (April 2001).

DEA seizures of non-drug property – 1997[251]

In fiscal year 1997, the Drug Enforcement Agency made 15,860 seizures of non-drug property pursuant to drug forfeiture laws. The total value of this property is estimated at $552 million.

Property Type	Number of Seizures	Value (in dollars)
Cash	8,123	284,680,029
Other financial instruments	507	73,602,092
Real property	748	108,833,498
Vehicles	3,695	47,379,874
Boats	111	5,884,754
Aircraft	24	8,945,000
Other means of transportation	172	1,734,731
Other	2,480	1,734,731

[251] Source: Official of National Drug Control Policy, Drug Policy Information Clearinghouse, *Drug Data Summary*, April 1999.

CHAPTER 21

PUBLIC POLICY OPTIONS

Public policy is not just a matter of enabling legislation, in this case criminal legislation. Nonetheless, when it comes to illegal drugs, criminal legislation occupies a symbolic and determinative place in public policy. It is as if this legislation is the backbone of our public policy. Public discussions of cannabis do not deal so much with such matters as public health, user health, prevention of at-risk or excessive use, but with such questions as the pros and cons of decriminalization, establishing a civil offence or maintaining a criminal offence, or possible legalization and the extent thereof. As we complete our report, the Minister of Justice is releasing trial balloons in relation to decriminalization. Apart from the merits of this approach–to be discussed at length in this chapter – it is clear that tinkering with the criminal legislation is not indicative of an authentic public policy. In this Committee's view, **a public policy on cannabis must be, first and foremost and essentially, a public health policy based on encouraging government and users to assume more responsibility.**

On a general level, the tendency to reduce drug issues to the legal framework fits neatly into the increasing juridicization of social relations, a situation in which legislation is the central, sometimes the only, tool of government policy. However, in the matter of illegal drugs, other factors are also at work.

On the one hand, this attitude has been at the very heart of the approaches to drugs throughout the twentieth century, approaches in which criminal prohibition guides - and restricts - public policy. It is only because of the AIDS crisis that the merits of harm-reduction approaches have been "discovered." Even then, decision-makers were often preoccupied more with protecting non-user members of society than with improving the health of drug users. When governments decided to tackle the criminal behaviour of drug users deriving from the criminalization of drugs (we do not mean organized crime and drug traffickers), the aim was not so much to improve drug users' living conditions but to protect non-users from drug-related "mischief."

On the other hand, criminal prohibition is often thought of as the "ultimate stronghold" against uncontrolled proliferation of drug use. Without criminal prohibition, we were told, cannabis consumption might well explode out of control. The underlying hypothesis, rarely stated explicitly, that criminalizing drugs contributes effectively to reducing their use, has never been demonstrated, however. Quite the

contrary, as this chapter will show, available data tend to demonstrate that prohibitionist policies have little impact on levels of use or availability of drugs.

Public policy cannot be reduced to adopting legislation, the more so since laws rarely contain clearly stated guiding principles setting out aims and objectives. In respect of illegal drugs, where the key issues are, first and foremost, matters of public health and culture (including education and research), and where criminal law should be used only as a last resort, public policy must be based primarily on clear principles and objectives. For this to come about, public policy must be equipped with a set of tools designed to deal with the various issues that drugs represent to societies. Legislation is only one such tool.

The social and economic costs of illegal drugs affect many aspects of society through lower productivity and business loss, hours of hospitalization and medical treatment of all kinds, police time and prison time, and broken or lost lives. Even if no one can pinpoint the exact figures, a portion of these costs arise, not from the substances themselves, but from the fact that they are criminalized. The drug most frequently associated with violence and criminal offences, including impaired driving, is in fact legal, alcohol.[1] Cannabis, the criminal organizations that control part of the production and distribution chain aside, neither leads to crime nor compromises safety. Even its social and health costs are relatively small compared to those of alcohol and tobacco. In fact, more than for any other illegal drug, we can safely state that **its criminalization is the principal source of social and economic costs**.

However, in spite of the fact that the principal social costs of drugs affect business, health and family, the emphasis on the legal debate tips the scales of public action in favour of law enforcement agencies. No one can deny that their work is necessary to ensure public order and peace and to fight organized crime. At the same time, over 90% of resources are spent on enforcing the law, the most visible actions with respect to drugs in the public sphere are police operations and court decisions and, at least in the case of cannabis, the law lags behind individual attitudes and opinions, thus creating a huge gap between needs and practice.

Most national strategies display a similar imbalance. The national strategies that appear to have the greatest chance of success, however, are those that strive to correct the imbalance. These strategies have introduced knowledge and observation tools, identified indicators of success with respect to their objectives, and established a veritable nerve centre for implementing and monitoring public policy. The law, criminal law especially, is put in its proper place, that of one method among many of reaching the defined objectives, not an aim in itself.

This chapter is divided into three sections. The first examines the effectiveness of legal measures for fighting drugs and shows that legal systems have little effect on consumption or supply. The second section describes the various components of a

[1] Please refer to the recent CCSA study: Permanen, K., et. al., *op. cit.*

public policy. The third considers the direction of criminal policy, and defines the main terms used: decriminalization, depenalization, diversion, legalization, and regulation.

INEFFECTIVENESS OF CRIMINAL POLICIES

Two key indicators are usually applied to measure the effectiveness of drug-related criminal policy: reduced demand and reduced supply. Some authors attempt to measure the economic efficiency of various control options[2]; we do not address this aspect as the data are incomplete.

The methods of measuring the impact of public policy on supply and demand are faced with a series of methodological pitfalls. Firstly, the two indicators are relatively artificial and not easily distinguished from one another. In other words, a given measure impacts both indicators simultaneously and are often accomplished by the same institution For example, a police officer conducting drug "education" in schools, theoretically for the purpose of affecting demand, also works to reduce supply. Secondly, the capacity of agencies responsible for affecting one or the other depends on a series of factors relating to their means and resources, their practices and skills, and their competence. For the police, the number of officers per capita and the general thrust of law enforcement services (community police, traditional more reactive police) as well as the priority given to drug-related offences, can influence the volume of reported incidents as well as the decision to lay a charge. Generally speaking, the total resources allocated by a government to its drug policy may affect one or both of these indicators. In short, effectiveness cannot be measured directly.

It is even more difficult to assess, even indirectly, the impact of action taken, when clear objectives, ideally associated with indicators, are not defined, as is the case in Canada at this time, as was seen in Chapter 11. This being the case, and because we are in no position to make a rigorous assessment of public policy on drugs, we will examine the question on the basis of a series of indirect indicators.

Impact on consumption

General policy direction

At the most general level, national governments (see preceding chapter) define a general direction for their policies on drugs. Some are more tolerant or permissive (e.g., the Netherlands, Belgium, Spain, and Germany); others stress prohibition and abstention (e.g., the United States, Sweden, France). Admittedly, these are crude

[2] See Jackson, A.Y. (2002) *op. cit.*, and our discussion in Chapter 18.

categories, ignoring the complexity of each country's policy. Even in the U.S.A. with its "war on drugs", individual cities and states may implement widely different measures. Furthermore, there is often a huge gap between public policy statement and concrete action. For example, in France, a tough stance on use is accompanied by limited user-related police activity. In Canada, as a number of witnesses told us, enforcement by police is often at odds with "lenient" court decisions. In other words, there is no direct relationship between political statements and concrete action.

Some comparative studies have attempted to determine whether or not public policy influences use levels. A study by Reuband compares "tolerant" European countries (the Netherlands, Spain, Denmark, and Italy) and restrictive countries (Germany, France, Norway, United Kingdom, and Sweden). The study found no significant differences between consumption levels, regardless of public policy direction.[3]

The "Message" of the *Conseil fédéral suisse sur la révision de la loi sur les stupéfiants* reports the results of a comparative study on seven European countries by Cesoni, which reached the conclusion that the legal regime had no influence on the frequency of consumption.[4]

Another study carried out for the *Office fédéral suisse de la Santé publique* classifies the policies of European countries on a line from "very liberal" to "very restrictive", relating them to the lifetime prevalence of cannabis consumption. The study shows no relation between severity of legislation and level of use.[5]

We have drawn up two similar charts, classifying the policies of the various countries and adding Canada, Australia, and the United States. We used the Chapter 6 data on lifetime prevalence of consumption in the general population (Chart 1) and in the past month among 15-16 year olds (Chart 2).

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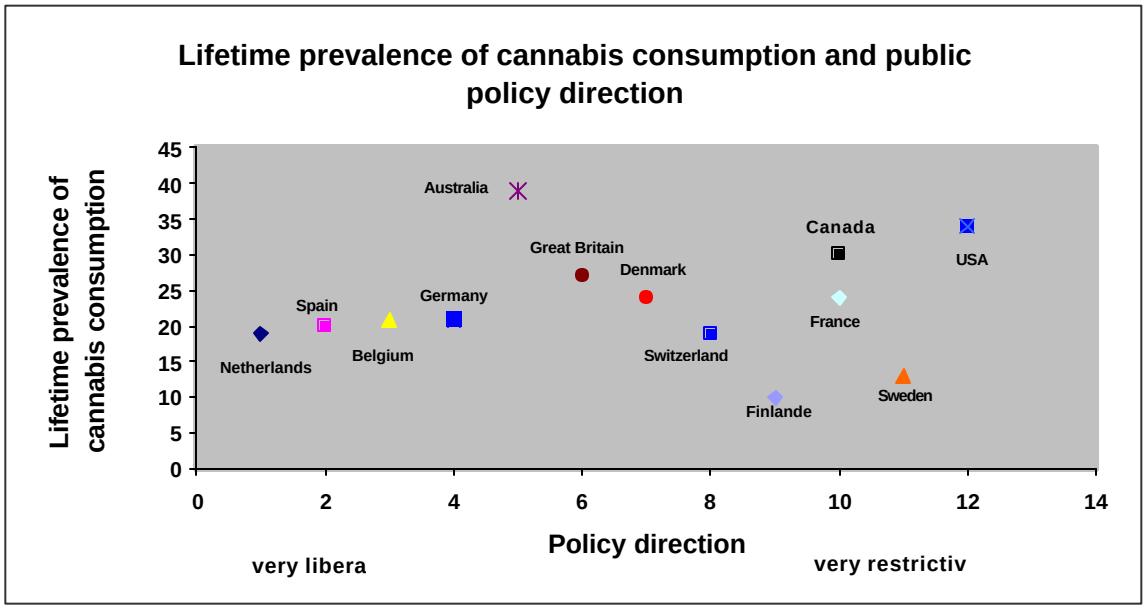
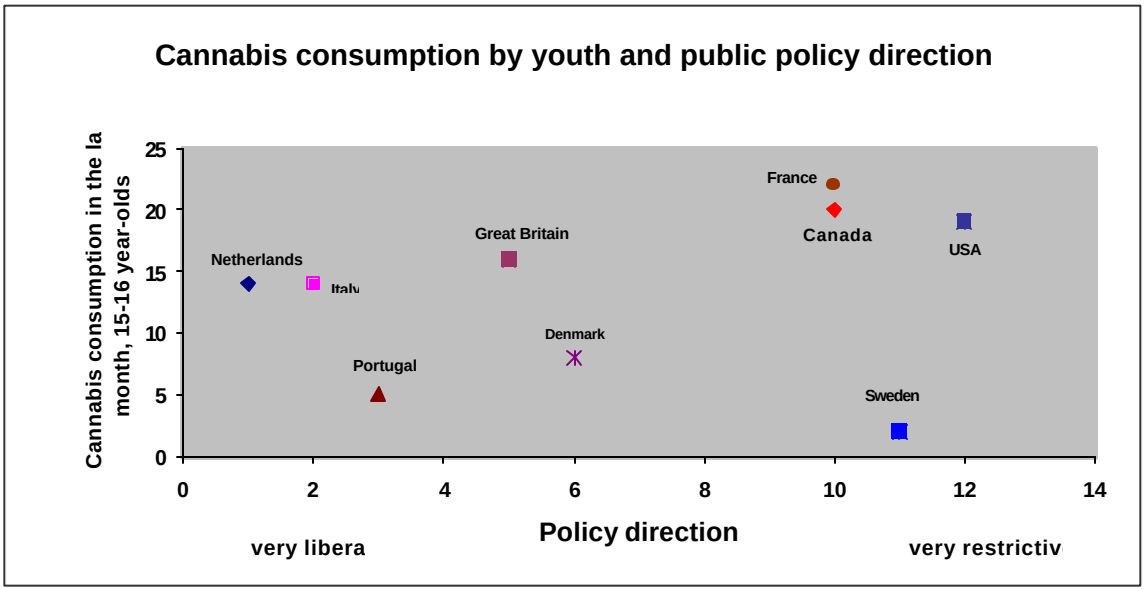
[3] Reuband, K., (1995) "Drug use and drug policy in Western Europe." *European Addiction Research*, vol. 1, 32-41.

[4] Cesoni, L.L. (1999) *Usage et actes préparatoires de l'usage des drogues illicites : les choix en matière d'ncrimination. Analyse comparative de l'usage de drogues illicites de sept législations européennes. In Conseil fédéral suisse*, op.cit., page 3560.

[5] *Conseil fédéral Suisse* (2001) *Message concernant la révision de la loi sur les stupéfiants*, page 3560.

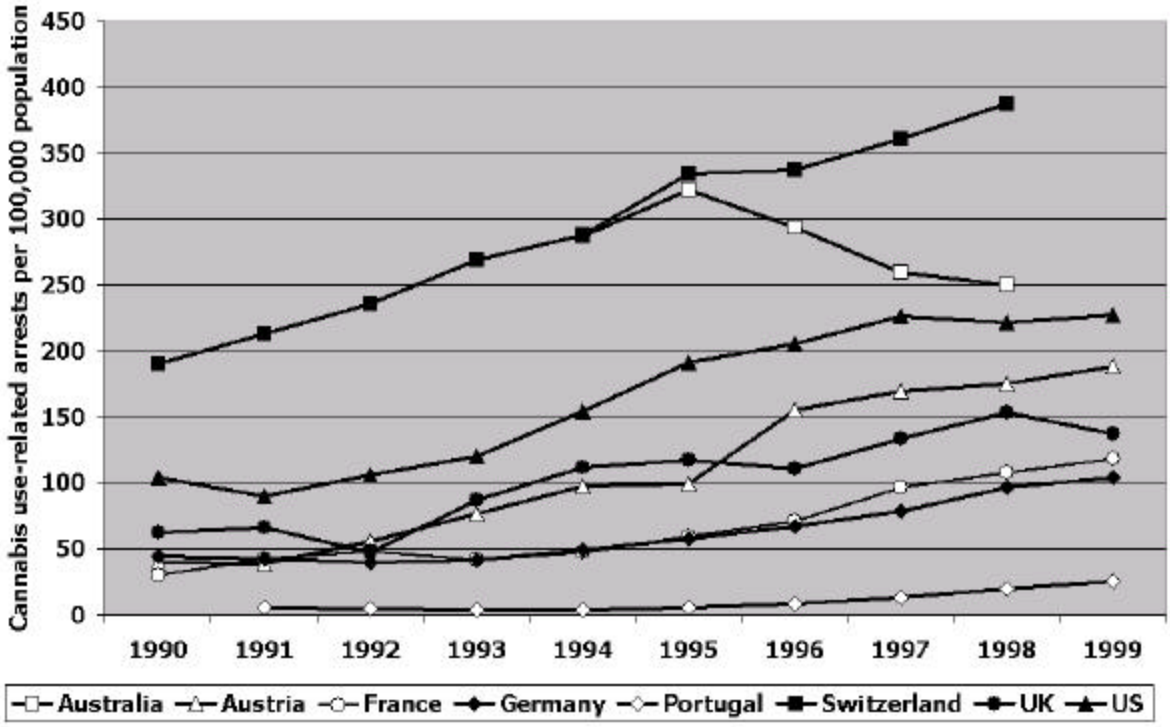




The charts show no direct relationship between consumption levels and public policy direction. Very liberal countries show low rates (Spain, the Netherlands, Portugal), whereas countries that have very restrictive policies show high rates (USA, Canada, France). Of course this may be explained by the fact that these are static statistical data not a time series, and are thus little influenced by variations from year to year. Another possible explanation is that, as few users are arrested, there is a strong inconsistency between words and action. The following section looks at this issue.

Cannabis consumption and arrests

A number of authors have looked at the relationship between arrest levels and delinquent behaviour in general, and in drug consumption in particular. One recent study was conducted by Kilmer[6] within the context of the International Scientific Conference on Cannabis. The following graph is from that study.



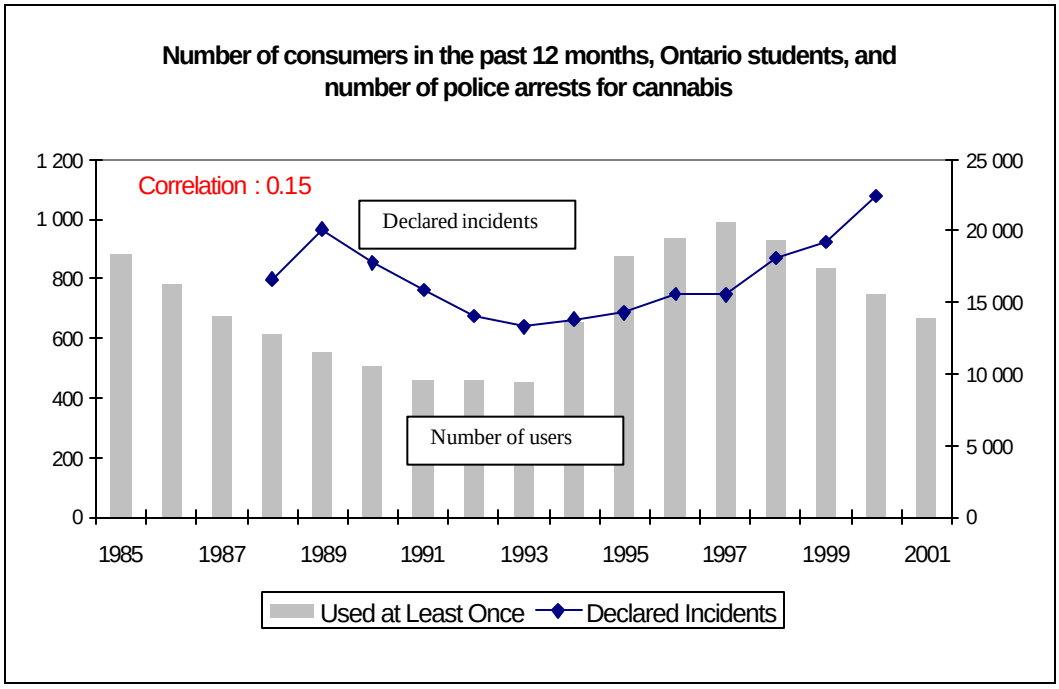
The graph shows that, in all countries, the number of arrests per inhabitant for simple possession of cannabis increased during the 1990s, with Australia the only exception. Switzerland, currently considered relatively moderate, has the highest level of arrests per inhabitant, followed by the USA, Austria, the United Kingdom, France, and Germany.

Here again there appears to be no direct relationship between direction of public policy and arrests. Switzerland and Australia, both of which have far more moderate policies than the USA, arrest proportionally larger numbers of people than that country, although Switzerland's consumption rate is far lower than that of the USA, and Australia's is virtually the same.

6 Kilmer, B., (2002) "Do cannabis possession laws influence cannabis use?" in Pelc, I. (dir.) International Scientific Conference on Cannabis. Brussels.

The variation in rates of arrest cannot be explained by the number of police officers per inhabitant. France has far more officers than does the USA or England, but arrests far fewer people than the USA and fewer than the UK for simple possession.

We created a graph charting the relationship between the number of users among high school youth in Ontario in the past twelve months and incidents declared by the police of cannabis-related offences in the same year in Ontario. We chose Ontario because it is the only province that produces continuous time series on consumption levels, and the Ontario figures are almost identical to the Canadian mean (Chapter 14). The results are shown below.



The graph shows a very weak statistical relationship (0.15) between police activity and cannabis use. In other words, police activity has no dissuasive effect on cannabis experimentation by young students.

Criminology teaches that probability of arrest carries far more dissuasive weight than severity of sentence. As the following table shows, the probability of arrest is very low for cannabis possession offences.

Probability of being arrested for cannabis possession[7]

	1995	1996	1997	1998	1999
Germany			2.7%		
Australia	3.7%			2.1%	
Austria	1.7%		1.7%		2.0%
Canada	1.8%				
United States	2.8%	3.0%	3.1%	3.2%	3.2%
France					2.0%
United Kingdom		2.1%			
Sweden			2.4%	2.9%	

Public spending

While none of the preceding factors appears related to consumption levels, can a case be made for public spending?

There is danger in trying to estimate the overall cost of public policy on drugs. Even for a budget item as seemingly well-defined as law enforcement, estimates are unreliable. As we saw in Chapter 14, the cost of law enforcement ranges from $700 million to $1 billion. Figures on public expenditure related to treatment and prevention, even if we know that they are much smaller than those for law enforcement, are equally unreliable.[8]

Making international comparisons is even riskier. Services are organized differently, costs are not accounted for in the same way, and service orientation and overall government direction vary widely.

With these reservations, we will attempt the exercise based on data from a number of sources. To make the results a little more comparable, we restrict the comparison to law enforcement expenditures which, in any case, account for between 70% and 90% of public spending relating to illegal drugs. The following table summarizes the data. (Note that, for Canada, we have used the data from the CCSA study rather than our own estimates from Chapter 14. Our data show a cost estimate of law enforcement (police, courts, prisons) of approximately $1.5 billion or $50 per capita).

[7] Table reproduced from Kilmer, B., *op.cit*, page 108.

[8] See Kopp, P. and Fenoglio (2000) *Le coûts social des drogues licites (alcool et tabac) et illicites en France.* Paris: OFDT.

Costs of enforcing legislation in various countries

	Cost of enforcing legislation	Per capita costs
Germany, 1992 [9]	DM 6.3 billion	
Australia, 1992 [10]	A$450 million	
Canada, 1992 [11]	US$300 million	US$10
United States [12]	US$12.3 billion	US$40
France, 1998 [13]	US$500 million	US$8
The Netherlands [14]	US$230 million	US$15

We note that countries in which consumption levels are average (Germany, the Netherlands) spend less than the USA, which has a high consumption rate; in addition, these countries, specifically, show law enforcement expenditures above those of two far more restrictive countries (France and Canada).

In short, here again cannabis consumption levels appear unaffected by public policy that aims to reduce demand by cracking down on use.

Impact on supply

Does public policy affect drug availability or price? The available data suggest not.

In spite of sustained efforts to exert national and international control, battle drug trafficking (macro and micro, local and international), the availability of drugs, and cannabis in particular, has not fallen. Price has fallen significantly (e.g., heroin, cocaine) or remained relatively stable (e.g., cannabis and derivatives).[15] The relative price increase for some grades of cannabis is at least as closely linked to attempts to improve

[9] Source: Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Brief presented to the Special Senate Committee on Illegal Drugs, page 13.

[10] Source: Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Brief presented to the Special Senate Committee on Illegal Drugs, page 13.

[11] Single, E., et. al., *op. cit.*

[12] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[13] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[14] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[15] See above, in the United States, one of the most complete studies on the question: Abt Associates (2001) *The price of illicit drugs: 1981 through the second quarter of 2000.* Washington, DC: Office of National Drug Control Policy.

"quality" (e.g., THC content, organic cultivation) and the large profit margin earned by producers and traffickers, as it is to the efforts of law enforcement agencies.

Conclusion

The title of this section includes our conclusion: **if the aim of public policy is to diminish consumption and supply of drugs, specifically cannabis, all signs indicate complete failure. We agree with the conclusions from the Swiss studies that prohibiting cannabis use through the application of criminal law appears to have little, if any, influence on levels of use.**

One may think the situation would be worse if not for current anti-drug action. This may be so. Conversely, one may also think that the negative impact of anti-drug programs that are currently centre stage are greater than the positive effect, specifically non-compliance with laws inconsistent with majority attitudes and behaviour.

One of the reasons for this failure is the excessive emphasis placed on criminal law in a context where prohibition of use and a drug-free society appear to remain the omnipresent and determining direction of current public policies.

Does this mean nothing can be done? We do not believe so. Does it mean market forces should be allowed to rule as if drugs were goods like any other commodity, a solution suggested by some free-market advocates?[16] Certainly not. Psychoactive substances, including cannabis, alcohol, and medications, are not ordinary commodities. Although cannabis (see Chapter 7) does not have the deleterious effects that some people claim and is in some respects a less harmful substance than tobacco, it must be the subject of regulation and government intervention.

The question raised by the patent and costly failure in human, social, and economic terms of Canada's public policy direction to date, is what should be the direction and components of public policy on cannabis and, as a corollary, the role and direction of legislation. This is what is discussed in the following sections.

GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS

We are fully aware of the somewhat artificial distinction imposed by our mandate between cannabis and its derivatives and other psychoactive substances. Different substances lead to different types of uses. This is as true of cannabis as it is of alcohol, medications, cocaine, or ecstasy. The uses differ with the substance - cannabis consumption differs from consumption of medications or even alcohol. There is nonetheless a common basis to the non-medical uses of psychoactive substances, which are primarily seen as a source of pleasure, even a method of enhancing awareness and the senses. There are of course other forms of use: abuse, for example, is not based

[16] For example, economist Milton Friedman.

on pleasure but rather a physiological and psychological mechanism symptomatic of loss of control, even distress. Nevertheless, throughout history human beings have consumed psychoactive substances for reasons relating to self-liberation.

Uses also differ for a given substance. Cannabis use, originally associated with self-medication and religious rites, in twentieth century western societies became an expression of a counter culture and the hippie movement, before becoming a recreational drug. Although most cannabis use is self-regulated, in some cases, when associated with at-risk behaviour, use can lead to abuse.

For public policy on psychoactive substances to adequately encompass the common dimensions of substance use, it must be **integrated**, yet flexible enough to allow for **approaches that are adapted** to different substances.

An integrated public policy on drugs would be administered by a decision-making body capable of making links between the substances and their uses so as to propose a meaning to different drug uses. A public policy on drugs revolves around the varying uses made of drugs and not on the substances themselves. In other words, an approach more like that taken by France's *Mission interministérielle* instead of an approach by multiple decision-making bodies, each one operating in a functional silo, in competition with the others as in the States, or for that matter in Canada, where illegal drugs, tobacco and alcohol are handled by different agencies.

An adaptable policy would be able to propose, define and develop tools suited to the various substances. Abuse of cigarettes causes lung cancer, not death due to impaired driving. Some medications, however, do lead to fatal accidents. Cannabis may be associated with both problems: cancer related to combustion, and highway accidents related to psychomotor effects. We must be in the position to understand what is specific to a given substance and what is common to a variety of substances.

A public policy, both integrated and adaptable must aim for knowledge of the relationship between substances and methods and contexts of use, in order to define the determining factors that separate non-problematic self-regulated consumption, from at-risk behaviour, and excessive use and related problems. There are two broad types of problems: the first affect user health, the second the health and safety of others; they must be dealt with in different ways. Certain measures must be preventive - inform users of risks and, specifically, help individuals recognize the signs of at-risk behaviour that can lead to problems. Those who consistently smoke between three and five cigarettes a day, something very few tobacco consumers may be able to do, are probably at no greater risk of lung cancer than non-smokers. Learning to manage consumption, recognizing the dangers, and having the means and the tools to do so are key. Other methods are dissuasive in nature: where drinking and driving are involved for example. Finally, some measures are curative: whatever the substance, from simple aspirin to heroin, for all kinds of reasons that pre-date consumption of the substance itself, some individuals consume abusively in a way that leads to health problems. The tools for treatment and cure must be available.

Thus, and this is the third criterion, a public policy on psychoactive substances must primarily be a **public health policy**: prevention, abuse deterrence, and treatment are the three prongs of public health intervention. A public health policy does not attempt to oblige people to live healthy lives or to have the community decide individual behaviour for some elusive public good. What we envision is a public health policy that contributes to **reducing the risks relating** to the different uses of different substances. A public health policy on psychoactive substances is thus a risk reduction policy.

Harm reduction approaches have been associated with needle exchange or the prescription of methadone or heroin. Some think that harm reduction policies rely too heavily on a medical model, simply softening the negative effects of an otherwise prohibitionist regime.[17] Harm reduction has been described as a "*transition doctrine, contradictory and ambiguous, with the ambiguity enabling unlimited adaption*." [Translation][18] Even worse, according to American psychiatrist Thomas Szasz, it is a morally repugnant position reflecting government therapeutic paternalism.[19]

We believe that what is essential is recognition that (1) use of psychoactive substances cannot be eliminated, it is part of the human experience and not all use is abuse - whatever the substance - and (2) all substances can have negative consequences for both the user and society, making it advisable to contribute to individual and community well-being by providing information, abuse prevention tools and a treatment infrastructure. Recognition that an individual is no less a citizen, indeed no less a good citizen, because he chooses to smoke cannabis rather than drink alcohol, or chooses to use rather than abstain, but that individuals and societies, according to the circumstances and method of consumption, will have different needs is the key .

A public policy on drugs does not target users: its implementation embraces them. For too long, in any discussion of illegal drugs, including cannabis, the focus has been on understanding the characteristics specific to consumers, as if they had some feature distinguishing them fundamentally from users of tobacco, alcohol, or psychotropic medications for non-medical use. Although problem users may indeed have common characteristics, it is neither the substance nor being a user that is the question: other factors underlying development of at-risk behaviour should be given more attention.

Some people told us that harm and risk reduction policies, or for that matter decriminalizing cannabis, would "trivialize" its use. On the contrary, this is normalization, not trivialization. Excessive use of any substance is harmful: all substances may endanger user health, even coffee. Normalizing the use and the user does not mean trivializing them. A public policy on drugs aims to **normalize uses of psychoactive substances:** that implies not marginalizing users, while at the same time

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17 For example, critical assessment in Caballero and Bisiou, pages 114-115.

18 *Ibid.*, page *116.*

19 *Ibid*., page 120

not trivializing use and shrugging our shoulders, ignoring the dangers specific to various substances.

To summarize: a **public policy on psychoactive substances must be both integrated and adaptable, target at-risk uses and behaviours and abuses taking a public health approach that neither trivializes nor marginalizes users**. Implementation of such a policy must be multifaceted, as we will see now.

COMPONENTS OF A PUBLIC POLICY

The public policies described in the preceding chapter, as well as the policies of Denmark, Portugal, and Mexico, have a number of elements in common: they rely on a strong decision-making body, promote interconnection and multiple viewpoints, aim at national consensus on clear and measurable objectives, and rely on independent knowledge and assessment tools.

Strong decision-making body

One may disagree with the political orientation of the American Office of National Drug Control Policy (ONDCP); but no one can deny the office gives strong direction to American national policy on drugs. Although one may be critical of the structural rigidity of the French *Mission interministérielle* (MILDT), or its timidity with respect to legislative debate, however, one cannot help but agree that the MILDT has strongly influenced French policy and practice in the past five years. Each country covered in the preceding chapter has a highly visible, well-known decision-making body that has undeniable legitimacy and methods of action that meet expectations.

In our opinion, the question of drugs, inasmuch as it is broader than the jurisdiction of a single government department or level of government, inasmuch as it refers to our collective ways of relating to society and others, and especially inasmuch as it demands both integration and differentiation, must be governed by an agency that is not accountable to a particular department and can define direction for (not enforce diktats on) all players.

Interconnection

The policies on psychoactive substances are the concern of educators and therapists, police officers and anthropologists, diplomats and local associations and, of course, users. The ability to tie things together for knowledge and comprehension purposes supposes an ability to link specialties, administrations, individuals. This is the meaning of interconnection that a public policy must be capable of making.

A shared definition of shared objectives

In Chapters 11 and 18, we saw that federal policy on drugs, in addition to lacking rigour and clarity, means and infrastructures, is not a national policy. This does not mean there is no place for specific approaches by the provinces and territories that make up the Canadian mosaic. However, if a common culture on drugs is to emerge, if we are to better understand behaviours of use through geographic comparison, if players are to benefit from the experience of others, tools must be developed for the joint definition of shared objectives.

Moreover, the ability - and the will - to define objectives is the foundation of any future evaluation to determine whether or not the action taken is in sync with the objectives and is effective; in short, defining objectives is necessary because we must be able to assess the impact of what we do.

Information tools

A public policy must also rest on knowledge. Many witnesses, from all over, told us this. European Union member countries, the United States and Australia have developed powerful knowledge tools, specifically agencies that monitor drugs and drug addictions. These monitoring agencies, most of them independent of the government and political influence, are capable of measuring changing trends and forms of use of various substances, understanding emerging trends and new products, even assessing public policies. We are unable to see how Canada can fail to develop a national knowledge tool on psychoactive substance use.

LEGISLATIVE OPTIONS

So what do we do with the legislation? Legislation stems from public policy direction, which it supports and completes; it is a means, not an end.

Cannabis debates are highly contaminated by discussions on decriminalization, depenalization, legalization. The terms are frequently poorly understood, especially as they are not necessarily clear. This section defines each key term in the debate and suggests indicators that can be used to assess each option.

Clarification of terminology

Decriminalization or depenalization

The United Nations Drug Control Programme (UNDCP) glossary of terms on drugs gives the following definitions of the two terms.

> ***Decriminalization or depenalization***
> *Removal of penal controls and criminal sanctions in relation to an activity, which however remains prohibited and subject to non-penal regulations and sanctions (e.g., administrative sanctions such as the removal of driving licence).*
> *Under the "prohibition with civil penalties" option, the penalties for the possession of amounts of drugs deemed in law as being for personal use are still illegal but are dealt with by civil sanctions such as infringement notices which attract a monetary penalty, rather than by criminal sanctions such as a criminal record or imprisonment. Typically, the harsher criminal penalties still apply to the more serious offences of possession, supply, manufacture or cultivation of amounts of the drug deemed in law to be for trafficking or commercial purposes.* [20]

For Caballero and Bisiou, depenalization means essentially removing drugs from the field of criminal law. They distinguish between total depenalization and depenalization of use.[21] The first removes all control except free-market forces. This is a far cry from the UNDCP definition. Depenalization of use corresponds more closely to decriminalization as defined by UNDCP. It is also the definition given by the European Monitoring Centre for Drugs and Drug Addiction.

Possessing or holding cannabis for personal use has been decriminalized in Germany, Australia, Spain, Italy, Portugal, the Netherlands, and some American states. The resemblance ends there because each country has slightly different way of reaching the goal. In Australia and the American states where possession of cannabis has been decriminalized, possession remains illegal and subject to a fine. In Germany, the constitutional court has ruled that prosecution for possession of small quantities of cannabis contravenes basic rights and is unjustified. In Spain and Italy, possession of small amounts of cannabis is not an offence and consumption is authorized except in public places. However, as in Portugal, individual possession of cannabis is subject to an administrative penalty (fine in Spain and Portugal; suspended licence in Italy).[22] In the Netherlands, the possession offence has never been repealed, although use and certain types of sale (coffee shops) are tolerated.

In all cases, decriminalization is partial. It is sometimes *de jure* (Spain, Italy, Portugal) and sometimes *de facto* (the Netherlands, Denmark).

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[20] UN Office for Drug Control and Crime Prevention (2000) *Demand Reduction. A Glossary of Terms.* Vienna: author, page 18.

[21] Caballero and Bisiou, *op.cit*, page 117.

[22] See EMCDDA (2001) *Decriminalisation in Europe? Recent Developments in Legal Approaches to Drug Use.* Lisbon: author, available on line at www.emcdda.org

In Canada, some authors have written in favour of decriminalizing cannabis. One of the best known papers on this option may be that published by the policy committee of the Canadian Centre on Substance Abuse.[23] The authors identify four options for decriminalization:

- Fines under the *Controlled Drugs and Substances Act* (CDSA) excluding incarceration as a possible sanction. The option retains the illegality of cannabis possession and related criminal record consequences.
- Civil offence: here again the sanction is a fine, although the option differs from the first in that cannabis possession is no longer sanctioned under the CDSA, but subject to a sanction under the *Contraventions Act.*
- Alternative measures (or diversion): under this option, possession remains a punishable criminal offence, but sanctions are suspended if the offender agrees to another form of "treatment" or community service. Drug treatment courts are a form of alternative measure.
- Transfer to the provinces: under this approach, the provinces would be free to adopt the control measures they deem necessary (with the exception of criminal measures which are exclusively federal). However, it is difficult to understand the reasoning of the authors on this approach as it is more a form of legalization than decriminalization.

In Quebec, the *Comité permanent de lutte à la toxicomanie (*CPLT*)* has made a recommendation proposing diversion measures when deemed appropriate by the authorities.[24] The CPLT defines diversion as the "*exercise, by the Crown prosecutor, of a discretionary power enabling him to desist from prosecuting the offender and instead apply alternate measures*" [Translation].[25] However, diversion may be given a broader definition, in which the discretionary power is exercised by the police prior to a charge, giving a consumer a simple warning. The CPLT opinion notes the following.

- Cannabis related offences account for at least 60% of offences under the CDSA, with possession the most frequent.
- The number of offences for possession of cannabis is rising, whereas the proportion that lead to prosecution is falling, even though such prosecution remains in a majority (approximately 60% of 1997 cases).
- The practice of laying charges and applying alternative measures varies among regions of Canada and within Quebec.
- Most sentences handed down by the courts are fines.

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[23] Fischer et al., (1998) "Cannabis Use in Canada: Policy Options For Control.' *Policy Options.* October.

[24] *Comité permanent de lutte à la toxicomanie* (1999) *Avis sur la déjudiciarisation de la possession simple de cannabis.* Montreal: CPLT.

[25] *Ibid.,* page 2.

This timid recommendation refuses to take a systematic approach and even links cannabis consumption to delinquent or criminal activities, relating risk to consumption of products with a high THC concentration, as if consuming spirits should be subject to stronger measures than drinking wine.

The term "decriminalization" is obviously loaded with contradictions. Even though the term purports to remove it from the ambit of criminal law, cannabis consumption remains illegal. The sanction may be less severe, but a sanction still applies, one that, in some cases, can have the same impact as a criminal sanction and entail even greater discrimination: a young or disadvantaged person unable to pay the fine faces a far greater risk of ending up in prison than an adult or socially secure individual. As explained to the Committee by Dr. Kendall:

> *However, a cautionary note should be sounded. If Canada did adopt this recommendation, we should be concerned and thus take steps to avoid the situation in Australia, or to repeat that situation, where the imposition of a cannabis expiation program actually led to a net widening effect, because the police now ticketed individuals that they had previously ignored. Many of those so ticketed failed to appear to pay their fines, and subsequent numbers entered the criminal justice system for non-payment of fines and subsequently received criminal convictions. There was an unintended result in that the number of persons criminalized is as large, or perhaps larger, than before the measure was implemented.* [26]

In spite of its merits and success, the Dutch system of controlled cannabis sale, a form of *de facto* decriminalization, has no way of regulating production and distribution, which is still controlled at least in part by organized crime, or exercising quality control, specifically the concentration of THC.

In the opinion of some authors, decriminalization is in fact simply less severe prohibition.[27] In other words, in the guise of a socially responsible and rational measure, decriminalization in fact furthers a prohibitionist logic. Same grounds, different form. This model has no greater capacity for prevention or education than a strict prohibition model. Even worse, the prohibition model is based on clear and consistent theory, whereas the same cannot be said of decriminalization as an approach.

Some will say that decriminalization is a step in the right direction, one that gives society time to become accustomed to cannabis, to convince opponents that chaos will not result, to adopt effective preventive measures. We believe however that **this approach is in fact the worst-case scenario, depriving the State of a regulatory tool needed in dealing with the entire production, distribution, and consumption network, and delivering a rather hypocritical message at the same time.**

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[26] Dr. Perry Kendall, Medical Health Officer for the Government of British Columbia, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First session, Thirty-seventh Parliament, September 17, 2001, Issue 6, page: 40.

[27] MacCoun, R., Reuter, P. and T. Schelling (1996) "Assessing alternative drug control regimes." *Journal of Policy Analysis and Management.* Vol 15, no 3, page 332.

Legalization

The United Nations glossary of terms defines this term as follows.

Legalization

Removal of the prohibition over a previously illicit activity, e.g., non-medical trade or consumption of psychoactive substances. It does not necessarily imply the removal of all controls over such activity (e.g. restriction on sale to minors). [28]

The term "legalization" is equivalent to Caballero and Bisiou's concept of depenalization, although it does not rely solely on market forces but includes a form of regulation entailing some restrictions. To quote:

Controlled legalization is a system that aims to replace existing prohibition of drugs by regulation of their production, trade, and use with a view to restricting abuse that can damage society (…) unlike depenalization, penal law retains its role in preventing damage to third parties by users (drunkenness) or producers (contraband). [Translation] [29]

No system for controlled legalization of cannabis currently exists. Switzerland comes close with its bill to amend the *Loi sur les stupéfiants*. This type of regulation is nothing new: colonial opium and kif regulatory bodies operated well into the first half of the twentieth century.

Conversely, legalized systems exist for the manufacture, distribution, sale and production of such products as alcohol, tobacco, and psychotropic medications. These could be used as a model for regulating the cannabis production chain.

Regulation

The United Nations glossary of terms defines regulation as follows:

Regulation

The rules governing all aspects of drug control promulgated pursuant to legislation. Violation of these rules may attract criminal or non-criminal penalties, such as fines and license suspension, depending on the seriousness and the intentional nature of the violation. [30]

Although one may play with words, regulation is in fact a necessary application of any form of control, whether within a system of prohibition or a system of legalisation. All consumer products, from the automobiles we drive to the food we eat, are subject to some form of regulation. Quality control, environmental standards, compliance with industrial standards, regulations on accessibility—all are forms of regulation essential

[28] UNDCP (2000) *op.cit*, page 41.
[29] Caballero and Bisiou, *op.cit*, page 132.
[30] UNDCP (2000) *op.cit*, page 63

for ensuring no one is poisoned by the food they eat, drives a defective vehicle, or plugs in a dangerous appliance.

Regulation is the most current form of government control; criminal law usually intervenes when the controls fail or mandatory standards are not met.

The same is true of the current international system for controlling narcotics. Canadian legislation deals with "controlled" substances. The control system may range from prohibition of all non-medical and non-scientific use (e.g., opium, cocaine, cannabis), to less severe control measures that allow accessibility to products deemed dangerous, under specific conditions.

Classification of legal policy systems

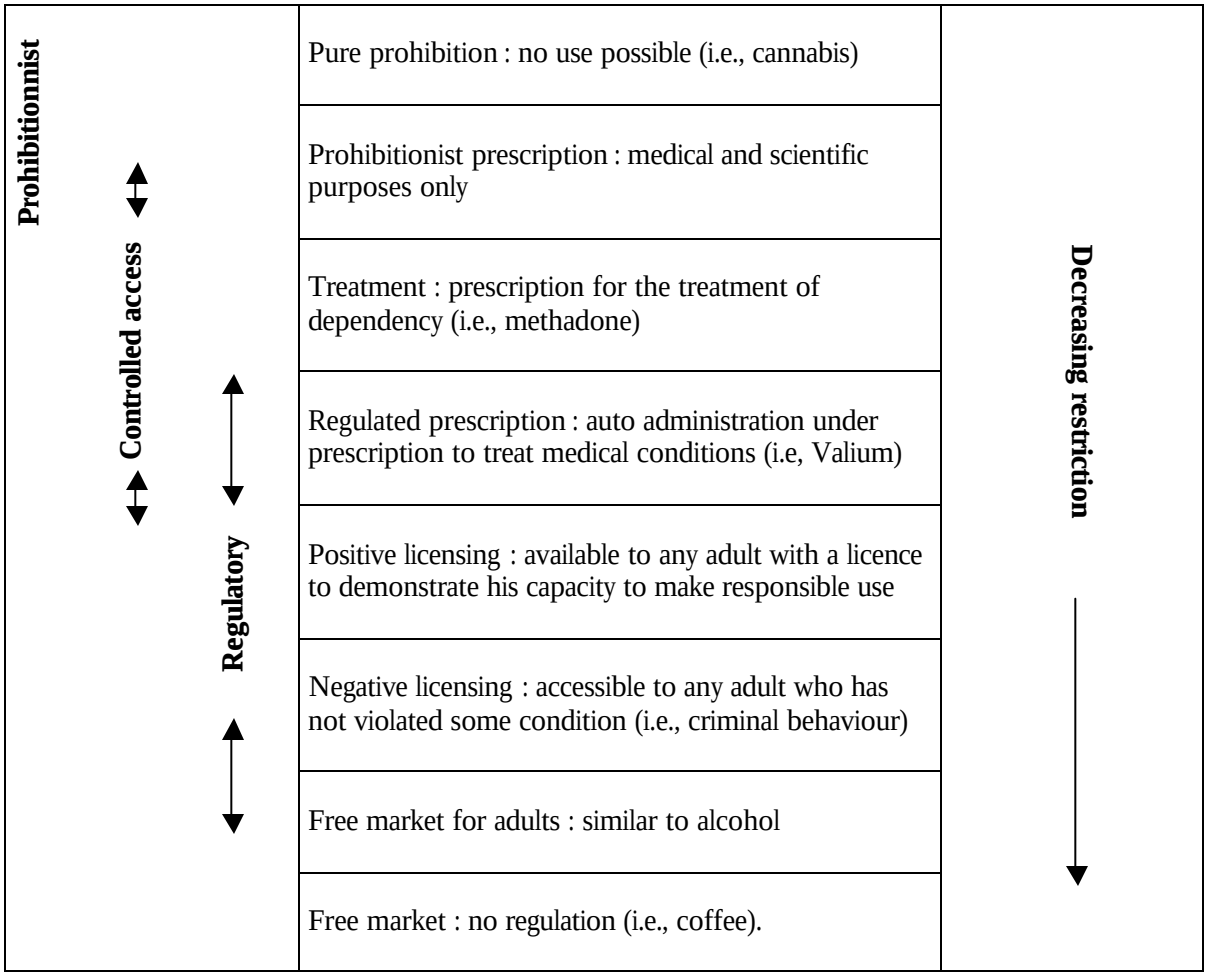
MacCoun, Reuter and Schilling examine various systems of legal policy, which they divide into three main types: prohibitionist, controlled access, and regulated access, each of which can be broken down further. Their classification system is reproduced below.[31]

Prohibitionist systems vary along a number of lines: based on the nature of prohibited activity (e.g., possession, use, use in public); based on the severity of sanctions (civil penalty, criminal penalty, imprisonment); based on the severity of enforcement (resources, priorities); and based on the capacity to exercise discretionary power (diversion, alternative measures). This makes it clearer why decriminalization remains in essence a prohibitionist approach, albeit a less severe one.

Controlled access systems are in a grey area somewhere between prohibition and regulation. In some ways, they are more like prohibition models, particularly by giving powers of decision to a physician or pharmacist rather than promoting individual user responsibility. This is the medical model criticized by Szasz, Caballero and, closer to home, Malherbe, in his discussion paper on the role of ethics and public health. One can see why harm reduction approaches belong in this grey area, somewhere between prohibition and regulation, with the prescription of methadone or heroine for treating addiction the perfect example of medical power.

The third type is the regulatory model that exercises various types of control on who (who may purchase, restrictions on minors), what (different accessibility levels for different substances), how (point of sale, location, requirement for producers and vendors) and when (time of day, days of the week).

[31] MacCoun and coll., *op. cit,* page 333. [1996 issue vol.15 not available]



In our opinion, **there are basically only two systems:** a prohibition system and a legalization system. Both rest on regulation, and the nature and direction of this regulation determines their specific features.

Prohibitionist systems may be subdivided into criminal and medical prohibition. In the first case, sometimes referred to as outright prohibition, the justice system (police and the courts) is central. In the second, the physician is the key player. In both cases, the user is considered a "minor", a person in danger who must be protected from himself. Some call this legal paternalism. Both variations can be more or less strict, more or less severe, but rest on the concept that all use that poses a danger to the user and society and must be strictly controlled. In this scenario, **decriminalization of use is a weak variation of prohibition**, in the long run entailing more disadvantages than advantages. In addition to failing to affect the production chain and retaining the illegal aspect, it leaves no room for dispensing information to and promoting responsible behaviour by users, or for strong preventive measures. Conversely, **the harm**

reduction approach is a strong variation of a prohibition system. While this approach recognizes the impossibility of eliminating the damage done by market criminalization, it seeks nonetheless to reduce the negative effects of prohibition on users, who are the focus of its main thrust, by introducing education on drug content (for example, analysis of ecstasy consumed at raves).

Prohibition System

	Main player	Degree of prohibition	Severity
Criminal	Police / Justice	Prohibition of fabrication, cultivation, production, sale, trafficking, use and consumption Decriminalization of use with criminal process / diversion Civil offences	↓
Medical	Physician	Recognized therapeutic uses only Treatment for dependency General prescription by a physician	

A prohibition system, whether criminal or medical, calls for regulation derived from criminal law: any interaction with drugs that is not authorized under the medical model is punished by a criminal or quasi-criminal penalty.

The other type of system rests on legalization of cannabis. It can also take various forms.

Legalization System

	Main player	Accessibility level	Degree of control
State	Community	User licences Licence for production / distribution / sale	+ ↓
Market	User	Free market	-

Legalization systems range from issuing a user licence under certain conditions (e.g., no criminal record, no dependency problems), to permitting a completely uncontrolled free market.

Criteria for a legal policy on cannabis

Some studies have explored the question of the comparative effectiveness of public policy systems in cost/benefit terms, others in terms of social costs. The first type of analysis is impossible simply because no two strategies are different enough for purposes of comparison: there is no cannabis regulation model that can be compared to a prohibition model. The other approach is to consider the social costs incurred by drugs based on a "cost of illness" model in a "counter-factual" scenario: what would happen if there were no consumption of this drug? However, as we saw in Chapter 18, it is difficult to establish the real costs related to cannabis and the response of public policy to it, and impossible to determine real social costs.

> *The question is whether or not society would be better off if the use of one or more currently illegal drugs was authorized. The answer is only if public well-being is enhanced (or the social cost of drugs is reduced). No one knows the impact on social costs of legalization of illicit drugs. It is impossible to predict the impact of increased consumption, substitution of tobacco and alcohol for currently illegal drugs, the lower current negative impact attributable to drug illegality and, moreover, the combined impact of all these factors. The superiority of neither prohibition nor legalization is provable. [Translation]* [32]

The counter-factual scenario used in studies of the social costs of drugs is itself a formidable challenge, as it rests on the unproven concept of eradicating consumption of a drug. The model is drawn from the field of health, in which a counter-factual model may be legitimate because, in some cases, a disease can be completely or almost completely eradicated (e.g., childhood diseases). It does not apply to drugs, as the process is necessarily so hypothetical that one wonders if it is worth the effort. It is one thing to try and identify as accurately as possible the diversity of social and economic costs incurred by drugs and then reflect on public policy options; it is another to claim they can actually be measured.

MacCoun, Reuter, and Schelling propose two series of criteria, the first considering different applications to different substances, the second based on acceptable costs and consequences. Using a four-axis matrix, they distinguish:

- scope of consequences: community and user health; community and individual performance; public order and security;
- potential damage to each of the above;
- those affected by the damage (users, traffickers, family members, employers, neighbours, society); and

[32] Kopp, P., and P. Fenoglio (2000) *op.cit*, page 12.

- primary source of the damage (substance, legal status, legal intervention).

How do we make a choice? At the outset, it must be understood that, at the end of the line, the **decision is necessarily a political one**. Epidemiological data on levels of use and empirical data on effects and consequences are clear: cannabis is not as dangerous a substance as interdiction policies would like us to believe. Comparative data on public policies, although more limited, also make it clear that measures undertaken under prohibitionist regimes have not been effective. This much said, no one can predict what will happen under an alternative regime, such as the regulated access model we are proposing. This is why we insist that any comprehensive strategy on cannabis must be based on a public health model and involve tools to evaluate its implementation and effects.

Application to cannabis

We do not have all the empirical data required to make a decision with respect to all the potential consequences of different control systems. To produce such data, one would have to have experienced the different regimes of cannabis control. Since the early twentieth century, various degrees of prohibition are all there has been, however.

Be that as it may, we would hazard a guess that, even if we did have empirical data, in the final analysis the decisions would still be political in nature because they are basically public policy decisions which, as discussed in our chapter on guiding principles, are not defined on the basis of scientific knowledge alone.

Nonetheless, if we attempt to apply these criteria to cannabis, we believe that a **system of regulated access** is most likely to reduce the negative consequences for both users and society.

	Prohibition	Regulation
Consequences on:		
Health	- Use denied therefore no possible distinction between forms of use (use, at-risk use, abuse) - Difficulties adapting prevention to reality due to predominance of abstinence - Health costs due to lack of knowledge of forms of use - Absence of quality control may bring about problems - Difficult for users to recognize at-risk use and acknowledge possible dependency	- Possible increase in number of users - Enhanced recognition of use and ability to distinguish between forms of use - Ability to promote prevention not based on abstinence - Possible increase in health care for abusive users resulting from increase in number of users - Opportunity to control quality and THC content - Monitoring of at-risk behaviour and forms of non-penal treatment

Conduct of individuals and society	- Enhanced individual performance (e.g., school, professional) if prohibition totally successful and no substitute exists - Users potentially dealing with criminal networks - Human rights infringements - Theoretical decrease in availability of substance - Theoretical increase in price of substance	- Possibility of increased negative impact on users and their families if consumption increases - Legal access leading to normalizing and demystifying - Control over price and availability - Elimination of the negative consequences of criminalization and marginalization of users - Need to control impaired driving - Need to maintain restrictions regarding sale to minors
Public order and safety	- Increased organized crime - Significant illegal trafficking - Decreased respect for the law - Violence in criminal organizations	- Decrease in —not elimination of—organized crime - Increased control over illegal trafficking - Possible increase in the insecurity of people residing near points of sale

We are fully aware that our statements with respect to a regulatory system are wholly theoretical. We do think, however, that all the data we have collected on cannabis and its derivatives provide sufficient ground for our general conclusion that the **regulation of the production, distribution and consumption of cannabis, as part of an integrated and adaptable public policy, best responds to the principles of autonomy and governance that foster human responsibility and of the limitation of penal law to situations where there is demonstrable harm to others. A regulatory system for cannabis should permit, in particular, :**

- **more effective targeting of illegal traffic and a reduction in the role played by organized crime;**
- **prevention programs better adapted to the real world and better able to prevent and detect at-risk behaviour;**
- **enhanced monitoring of products, quality and properties;**
- **better user information and education;**
- **respect for individual and collective freedoms, and legislation more in tune with the behaviour of Canadians.**

In our opinion, Canadian society is ready for a responsible policy of cannabis regulation that honours these basic principles.

CONCLUSIONS AND RECOMMENDATIONS

The Senate Special Committee on Illegal Drugs' mandate was to examine Canada's public policy approach in relation to cannabis and assess its effectiveness and impact in light of the knowledge of the social and health-related effects of cannabis and the international context. Over the past two years, the Committee has heard from Canadian and foreign experts and reviewed an enormous amount of scientific research. The Committee has endeavoured to take the pulse of Canadian public opinion and attitudes and to consider the guiding principles that are likely to shape public policy on illegal drugs, particularly cannabis. Our report attempted to provide an update of the state of knowledge and of the key issues, and sets out a number of conclusions in each chapter.

This final section sets out the main conclusions that emerge from all this information and presents the resulting recommendations that derive from the thesis we have developed namely: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy insofar as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equivalence of others.***

LE DAIN – ALREADY THIRTY YEARS AGO

Thirty years ago, the Le Dain Commission released its report on cannabis. This Commission had far greater resources than did we. However, we had the benefit of a much more highly developed knowledge base and of thirty years' historical perspective.

The Commission concluded that the criminalization of cannabis had no scientific basis. Thirty years later, we can confirm this conclusion and add that continued criminalization of cannabis remains unjustified based on scientific data on the danger it poses.

The Commission heard and considered the same arguments on the dangers of using cannabis: apathy, loss of interest and concentration, learning difficulties. A majority of the Commissioners concluded that these concerns, while unsubstantiated, warranted a restrictive policy. Thirty years later, we can assert that the studies done in the meantime have not confirmed the existence of the so-called amotivational syndrome and add that most studies rule out this syndrome as a consequence of the use of cannabis.

The Commission concluded that not enough was known about the long-term and excessive use of cannabis. We can assert that these types of use exist and may present some health risks; excessive use, however, is limited to a minority of users. Public policy, we would add, must provide ways to prevent and screen for at-risk behaviour, something our policies have yet to do.

The Commission concluded that the effects of long-term use of cannabis on brain function, while largely exaggerated, could affect adolescent development. We concur, but point out that the long-term effects of cannabis use appear reversible in most cases. We not also that adolescents who are excessive users or become long-term users are a tiny minority of all users of cannabis. Once again, we would add that a public policy must prevent use at an early age and at-risk behaviour.

The Commission was concerned that the use of cannabis would lead to the use of other drugs. Thirty years' experience in the Netherlands disproves this very clearly, as do the liberal policies of Spain, Italy and Portugal. And here in Canada, despite the growing increase in cannabis users, we have not had a proportionate increase in users of hard drugs.

The Commission was also concerned that legalization would mean increased use, among the young, in particular. We have not legalized cannabis, and we have one of the highest rates in the world. Countries adopting a more liberal policy have, for the most part, rates of usage lower than ours, which stabilized after a short period of growth.

Thirty years later, we note that:

- **Billions of dollars have been sunk into enforcement without any greater effect: there are more consumers, more regular users and more regular adolescent users;**
- **Billions of dollars have been poured into enforcement in an effort to reduce supply, without any greater effect: cannabis is more available than ever, it is cultivated on a large scale, even exported, swelling coffers and making organized crime more powerful; and**
- **There have been tens of thousands of arrests and convictions for the possession of cannabis and thousands of people have been incarcerated; however, use trends remain totally unaffected and the gap the Commission noted between the law and public compliance continues to widen.**

It is time to recognize what is patently obvious: our policies have been ineffective, because they are poor policies.

INEFFECTIVENESS OF THE CURRENT APPROACH

No clearly defined federal or national strategy exists. Some provinces have developed strategies while others have not. There has been a lot of talk but little significant action. In the absence of clear indicators accepted by all stakeholders to assess the effectiveness of Canadian public policy, it is difficult to determine whether action that has been taken is effective. Given that policy is geared to reducing demand (i.e. drug-use rates) and supply (by reducing the availability of drugs and pushing up drug prices), both these indicators may be used.

A look at trends in cannabis use, both among adults and young people, **forces us to admit that current policies are ineffective**. In chapter 6, we saw that trends in drug-use are on the increase. If our estimates do indeed reflect reality, no fewer that 2 million Canadians aged between 18 and 65 have used cannabis at least once over the past 12 months, while at least 750,000 young people between the ages of 14 and 17 use cannabis at least once per month; one third of them on a daily basis. This proportion appears, at least in the four most highly-populated provinces, to be increasing. Statistics suggest that both use and at-risk use is increasing.

Of course, we must clearly establish whether the ultimate objective is a drug-free society, at least one free of cannabis, or whether the goal is to reduce at-risk behaviour and abuse. This is an area of great confusion, since Canadian public policy continues to use vague terminology and has failed to establish whether it focuses on substance abuse as the English terminology used in several documents seems to suggest or on drug-addiction as indicated by the French terminology.

It is all very well to criticize the "trivialization" of cannabis in Canada to "explain" increases in use but it must also be established why, if this is indeed the case, this trivialization has occurred. It is also important to identify the root cause of this trivialization against a backdrop of mainly anti-drug statements. The courts and their lenient attitude might be blamed for this. Perhaps the judiciary is at the forefront of those responsible for cannabis policies and the enforcement of the law. It must also be determined whether sentences are really as lenient as some maintain. A major issue to be addressed is whether harsher sentences would indeed be an effective deterrent given that the possibility of being caught by the police is known to be a much greater deterrent. Every year, over 20,000 Canadians are arrested for cannabis possession. This figure might be as high as 50,000 depending on how the statistics are interpreted. This is too high a number for this type of conduct. However, it is laughable number when compared to the three million people who have used cannabis over the past 12 months. We should not think that the number of arrests might be significantly increased even if billions of extra dollars were allocated to police enforcement. Indeed, such a move should not even be considered.

A look at the availability and price of drugs, **forces us to admit that supply-reduction policies are ineffective**. Throughout Canada, above all in British Columbia and Québec, the cannabis industry is growing, flooding local markets, irritating the

United States and lining the pockets of criminal society. Drug prices have not fallen but quality has improved, especially in terms of THC content – even if we are sceptical of the reported scale of this improvement. Yet, police organizations already have greater powers and latitude – especially since the September 11, 2001 tragedy – in relation to drugs than in any other criminal matter. In addition, enforcement now accounts for over 90% of all illegal drug-related spending. To what extent do we want to go further down this road?

Clearly, current approaches are ineffective and inefficient – it is throwing taxpayers' money down the drain on a crusade that is not warranted by the danger posed by the substance. It has been maintained that drugs, including cannabis, are not dangerous because they are illegal but rather illegal because they are dangerous. This is perhaps true of other types of drugs, but not cannabis. We should state this clearly once and for all, for public good, stop our crusade.

PUBLIC POLICY BASED ON GUIDING PRINCIPLES

However much we might wish good health and happiness for everyone, we all know how fragile both are. Above all, we realize that health and happiness cannot be forced on a person, especially not by criminal law based on a specific concept of what is morally right. No matter how attractive calls for a drug-free society might be, and even if some people might want others to stop smoking, drinking alcohol, or smoking joints, we all realize that these activities are well and truly part of social reality and the history of humankind.

Consequently, what role should the State play? It should neither abdicate responsibility and allow drug markets to run rife, nor should it impose a particular way of life on people. Instead, we have opted for a concept whereby public policy **promotes and supports freedom for individuals and society as a whole**. For some, this would undoubtedly mean avoiding drug use. However, for others, the road to freedom might be via drug use. For society as a whole, this concept means a State that does not dictate what should be consumed and under what form. Support for freedom necessarily means flexibility and adaptability. It is for this reason that public policy on cannabis has to be clear while at the same time tolerant, to serve as a guide while at the same time avoiding imposing a single standard. This concept of the role of the State is based on the **principle of autonomy and individual and societal responsibility.** Indeed, it is much more difficult to allow people to make their own decisions because there is less of an illusion of control. It is just that: an illusion. We are all aware of that. It is perhaps sometimes comforting, but is likely to lead to abuse and unnecessary suffering. An ethic of responsibility teaches social expectations (not to use drugs in public or sell to children), responsible behaviour (recognizing at-risk behaviour and

being able to use moderately) and supports people facing hardship (providing a range of treatment).

From this concept of government action ensues a limited role for criminal law. As far as cannabis is concerned, **only behaviour causing demonstrable harm to others shall be prohibited**: illegal trafficking, selling to minors, impaired driving.

Public policy shall also draw on available knowledge and scientific research but without expecting science to provide the answers to political issues. Indeed, scientific knowledge does have a major role to play as a **support tool in decision-making,** at both an individual and government level. Indeed, science should play no greater role. It is for this reason that the Committee considers that a drug and dependency observatory and a research program should be set up: to help those decision makers that will come after us.

A CLEAR AND COHERENT FEDERAL STRATEGY

Although the Committee has focused on cannabis, we have nevertheless observed inherent shortcomings in the federal drug strategy. Quite obviously, there is no real strategy or focused action. Behind the supposed leadership provided by Health Canada emerges a lack of necessary tools for action, a patchwork of ad hoc approaches from one substance to another and piecemeal action by various departments. Of course, co-ordinating bodies do exist, but without real tools and clear objectives, each focuses its action according to its own particular priorities. This has resulted in a whole series of funded programs developed without any tangible cohesion.

Many stakeholders have expressed their frustration to the Committee at the jig-saw of seemingly evanescent pieces and at the whole gamut of incoherent decisions, which cause major friction on the front lines. Various foreign observers also expressed their surprise that a country as rich as Canada, which is not immune to psychoactive substance-related problems, did not have a "champion", a spokesperson or a figure of authority able to fully grasp the real issues while at the same time obtaining genuine collaboration of all stakeholders.

It is for this reason that we are recommending the creation of the position of National Advisor on Psychoactive Substances and Dependency to be attached to the Privy Council. We do not envisage this as a super body responsible for managing psychoactive substance-related budgets and action. In fact, we favour an approach similar to that of the *Mission interministérielle à la drogue et à la toxicomanie* in France over one modelled on the United States' Office of National Drug Control Policy. The Advisor would have a small dedicated staff, with the majority of staff loaned from the various federal departments and bodies concerned by the drugs issue.

The Advisor would be responsible: for advising the Cabinet and the Prime Minister on national and international psychoactive substance-related issues; for

ensuring co-ordination between federal departments and agencies; for overseeing the development of federal government psychoactive substance-related objectives and ensuring these objectives are satisfied; and to serve as a Canadian Government spokes-person on psychoactive substance-related issues at an international level.

Recommendation 1

The Committee recommends that the position of National Advisor on Psychoactive Substances and Dependency be created within the Privy Council Office; that the Advisor be supported by a small secretariat and that federal departments and agencies concerned by psychoactive substances second, upon request, the necessary staff.

NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESSOURCES AND TOOLS

A federal policy and strategy do not in themselves make a national strategy. Provinces, territories, municipalities, community organizations and even the private sector all have a role to play in accordance with their jurisdiction and priorities. This is necessary and this diversity is worth encouraging. However, some harmonization and meaningful discussion on practices and pitfalls, on progress and setbacks, and on knowledge, are to be encouraged. Apart from the resource-starved piecemeal action of the Canadian Centre on Substance Abuse, there are all too few opportunities and schemes to promote exchanges of this type. **The current and future scale of drug and dependency-related issues warrants the Canadian Government earmarking the resources and developing the tools with which to develop fair, equitable and well-thought out policies**.

Like the majority of Canadian and foreign observers of the drug situation, we were struck by the relative lack of tools and measures for determining and following up on the objectives of public psychoactive substance policy. One might not agree with the numbers-focused goals set out by the Office of National Drug Control Policy for the reduction of drug use or for the number of drug treatment programs set up and evaluated. However, we have to admit that at least these figures serve as guidelines for all stakeholders and as benchmarks against which to measure success.

Similarly, one might not feel totally comfortable with the complex Australian goal-definition process, whereby the whole range of partners from the various levels of government, organizations and associations meet at a conference every five years. However, at least those goals agreed upon by the various stakeholders constitute a clear reference framework and enable better harmonization of action.

The European monitoring system with its focal points in each European Union country under the European Monitoring Centre for Drugs and Drug Addiction umbrella might seem cumbersome; and the American system of conducting various annual epidemiological studies might appear expensive. We might even acknowledge that there are problems with epidemiological studies, which are far from providing a perfect picture of the psychoactive substance-use phenomena. However, at least these tools, referred to and used throughout the Western world, enable the development of a solid information base, with which to analyse historical trends, identify new drug-use phenomena and react rapidly. In addition, it allows for an assessment of the relevance and effectiveness of action taken. No system of this type exists in Canada, which is the only industrialized Western country not to have such a knowledge structure.

It is for these reasons that the Committee recommends that the Government of Canada support various initiatives to develop a genuine national strategy. Firstly, the Government should call a national conference of the whole range of partners with a view to setting out goals and priorities for action over a five-year period. This conference should also identify indicators to be used in measuring progress at the end of the five-year period. Secondly, the Canadian Centre on Substance Abuse needs to be renewed. Not only does this body lack resources but it is also subject to the vagaries of political will of the Minister of Health. The Centre should have a budget in proportion with the scale of the psychoactive substance problem and should have the independence required to address this issue. Lastly, a Canadian Monitoring Agency on Drugs and Dependency should be created within the Centre.

Recommendation 2

The Committee recommends that the Government of Canada mandate the National Advisor on Psychoactive Substances and Dependency to call a high-level conference of key stakeholders from the provinces, territories, municipalities and associations in 2003, to set goals and priorities for action on psychoactive substances over a five-year period.

Recommendation 3

The Committee recommends that the Government of Canada amend the Canadian Centre on Substance Abuse enabling legislation to change the Centre's name to the *Canadian Centre on Psychoactive Substances and Dependency*; make the Centre reportable to Parliament; provide the Centre with an annual basic operating budget of 15 million dollars, to be increased annually; require the Centre to table an annual report on actions taken, the key issues, research and

trends in the federal Parliament and provincial and territorial assemblies and legislatures; mandate the Centre to ensure national co-ordination of research on psychoactive substances and dependency, and to conduct studies into specific issues; and mandate the Centre to undertake an assessment of the national strategy on psychoactive substance and dependency every five years.

Recommendation 4
The Committee recommends that in the legislation creating the Canadian Centre on Psychoactive Substances and Dependency, the Government of Canada specifically include provision for the setting up of a Monitoring Agency on Psychoactive Substances and Dependency within the Centre; provide that the Monitoring Agency be mandated to conduct studies every two years, in co-operation with relevant bodies, on drug-use trends and dependency problems in the adult population; work with the provinces and territories towards increased harmonization of studies of the student population and to ensure they are carried out every two years; conduct ad hoc studies on specific issues; and table a bi-annual report on drug-use trends and emerging problems.

A PUBLIC HEALTH POLICY

When cannabis was listed as a prohibited substance in 1923, no public debate or discussion was held on the known effects of the drug. In fact, opinions expressed were disproportionate to the dangers of the substance. Half a century later, the Le Dain Royal Commission of Inquiry on the Non-Medical Use of Drugs held a slightly more rational debate on cannabis and took stock of what was known about the drug. Commissioners were divided not so much over the nature and effects of the drug but rather over the role to be played by the State and criminal law in addressing public health-related goals. Thirty years after the Le Dain Commission report, we are able to categorically state that, **used in moderation, cannabis in itself poses very little danger to users and to society as a whole, but specific types of use represent risks for users**.

In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed in a discriminatorily fashion to the risk of arrest and to the criminal justice system; society sees organized crime

enhance their power and wealth by benefiting from prohibition; and governments see their ability to conduct prevention of at-risk use diminished.

We would add that, **even if cannabis were to have serious harmful effects, one would have to question the relevance of using the criminal law to limit these effects**. We have demonstrated that criminal law is not an appropriate governance tool for matters relating to personal choice and that prohibition is known to result in harm which often outweighs the desired positive effects. However, current scientific knowledge on cannabis, its effects and consequences are such that this issue is not relevant to our discussion.

Indeed available data indicate that the scale of the cannabis use phenomenon can no longer be ignored. Chapter 6 indicated that no fewer than 30% of Canadians (12 to 64 years old) have experimented with cannabis at least once in their lifetime. In all probability, this is an underestimation. We have seen that approximately 50% of high school students have used cannabis within the past year. Nevertheless, a high percentage of them stop using and the vast majority of those who experiment do not go on to become regular users. Even among regular users, only a small proportion develop problems related to excessive use, which may include some level of psychological dependency. Consumption patterns among cannabis users do not inevitably follow an upward curve but rather a series of peaks and lulls. Regular users also tend to have a high consumption rate in their early twenties, which then either drops off or stabilizes, and in the vast majority of cases, ceases altogether in their thirties.

All of this does not in any way mean, however, that cannabis use should be encouraged or left totally unregulated. Clearly, it is a psychoactive substance with some effects on cognitive and motor functions. When smoked, cannabis can have harmful effects on the respiratory airways and is potentially cancerous. Some vulnerable people should be prevented, as much as possible, from using cannabis. This is the case for young people under 16 years of age and those people with particular conditions that might make them vulnerable (for example those with psychotic predispositions). As with alcohol, adult users should be encouraged to use cannabis in moderation. Given that, as for any substance, at-risk use does exist, preventive measures and detection tools should be established and treatment initiatives must be developed for those who use the drug excessively. Lastly, it goes without saying that education initiatives and severe criminal penalties must be used to deter people from operating vehicles under the influence of cannabis.

As for any other substance, there is at-risk use and excessive use. There is no universally accepted criterion for determining the line between regular use, at-risk use and excessive use. The context in which use occurs, the age at which users were introduced to cannabis, substance quality and quantity are all factors that play a role in the passage from one type of use to another. Chapters 6 and 7 identified various criteria, which we have collated in table form below.

Proposed Criteria for Differentiating Use Types

	Environment	Quantity	Frequency	Period of use and intensity
Experimental / Occasional	Curiosity	Variable	A few times over lifetime	None
Regular	Recreational, social Mainly in evening Mainly in a group	A few joints Less than one gram per month	A few times per month	Spread over several years but rarely intensive
At-risk	Recreational and occupational (to go to school, to go to work, for sport…) Alone, in the morning Under 16 years of age	Between 0.1 and 1 gram per day	A few times per week, evenings, especially weekends	Spread over several years with high intensity periods
Excessive	Occupational and personal problems No self regulation of use	Over one gram per day	More than once per day	Spread over several years with several months at a time of high intensity use

If **cannabis itself poses very little danger to the user and to society as a whole, some types of use involve risks**. It is time for our public policy to recognize this and to **focus on preventing at-risk use and on providing treatment for excessive cannabis users**.

Recommendation 5

The Committee recommends that the Government of Canada adopt an integrated *policy on the risks and harmful effects of psychoactive substances* covering the whole range of substances (medication, alcohol, tobacco and illegal drugs). With respect to cannabis, this policy shall focus on educating users, detecting and preventing at-risk use and treating excessive use.

A REGULATORY APPROACH TO CANNABIS

The **prohibition of cannabis does not bring about the desired reduction in cannabis consumption or problem use**. However, this approach does have a whole series of harmful consequences. Users are marginalized and over 20,000 Canadians are arrested each year for cannabis possession. Young people in schools no longer enjoy the same constitutional and civil protection of their rights as others. Organized crime benefits from prohibition and the criminalization of cannabis enhances their power and wealth. It is a well-known fact that society will never be able to stamp out drug use – particularly cannabis use.

Some might believe that an alternative policy signifies abandoning ship and giving up on promoting well-being for Canadians. Some might maintain that a regulatory approach would fly in the face of the fundamental values of our society. We believe, however, that the continued prohibition of cannabis jeopardizes the health and well-being of Canadians much more than the regulated marketing of the substance. In addition, we believe that the continued criminalization of cannabis undermines the fundamental values set out in the *Canadian Charter of Rights and Freedoms* and borne out by the history of a country based on diversity and tolerance.

We do not want to see cannabis use increase, especially among young people. Of note, the data from other countries that we compared in Chapters 6 and 20 indicate that countries such as the Netherlands, Australia or Switzerland, which have put in place a more liberal approach, have not seen their long-term levels of cannabis use rise. The same data also clearly indicate that countries with a very restrictive approach, such as Sweden and the United States, are poles apart in terms of cannabis use levels, and that countries with similar liberal approaches such as the Netherlands and Portugal are also at opposite ends of the spectrum, falling somewhere between Sweden and the United States. We have concluded that public policy itself has little effect on cannabis use trends and that other more complex and poorly-understood factors play a greater role in explaining the variations.

An exemption regime making cannabis available to those over the age of 16 would probably lead to an increase in cannabis use for a certain period. Use rates would then level out as interest wanes and as effective prevention programs are set up. This would then be followed by a roller-coaster pattern of highs and lows, as has been the case in most other countries.

This approach is neither one of total abdication nor a sign of giving up but rather a vision of the role of the State and criminal law as **developing and promoting but not controlling human action** and as **stipulating only necessary prohibitions** relating to the fundamental principle of respect for life, others and a harmonious community, and as **supporting and assisting others and not** judging and condemning difference.

We might wish for a drug-free world, fewer tobacco smokers or alcoholics or less prescription drug dependency, but we all know that we shall never be able to eliminate

these problems. More importantly, we should not opt to criminalize them. The Committee believes that the same healthy and respectful approach and attitude should be applied to cannabis.

It is for this reason that the Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme for the production and sale of cannabis under the authority of a licence. Licensing and the production and sale of cannabis would be subject to specific conditions, that the Committee has endeavoured to specify. For clarity's sake, these conditions have been compiled at the end of this section. It should be noted at the outset that the Committee suggests that cigarette manufacturers be prohibited from producing and selling cannabis.

Recommendation 6
The Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme. This legislation should stipulate the conditions for obtaining licences as well as for producing and selling cannabis; criminal penalties for illegal trafficking and export; and the preservation of criminal penalties for all activities falling outside the scope of the exemption scheme.

Recommendation 7
The Committee recommends that the Government of Canada declare an amnesty for any person convicted of possession of cannabis under current or past legislation.

A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE

In Chapter 9, we noted that cannabis has not been approved as a medicinal drug in the pharmacological sense of the word. In addition to the inherent difficulties in conducting studies on the therapeutic applications of cannabis, there are issues arising from the current legal environment and the undoubtedly high cost to governments of conducting such clinical studies.

Nevertheless, we do not doubt that, for some medical conditions and for certain people, cannabis is indeed effective and useful therapy. Is it more effective than other types of medication? Perhaps not. Can physicians currently prescribe cannabis at a known dosage? Undoubtedly not. Should persons suffering from certain physical

conditions diagnosed by qualified practitioners be permitted to use cannabis if they wish to do so? Of this, we are convinced.

Regulations made in 2001 by the Health Canada, even though they are a step in the right direction, are fundamentally unsatisfactory. They do not facilitate access to therapeutic cannabis. They do not consider the experience and expertise available in compassion clubs. These regulations only govern marijuana and do not include cannabis derivatives such as hashish and cannabis oils.

It is for these reasons that the Committee recommends that Health Canada amend the *Marihuana Medical Access Regulations* in order to allow compassionate access to cannabis and its derivatives. As in the previous chapter, proposed rules have been compiled at the end of this chapter.

Recommendation 8

The Committee recommends that the *Marihuana Medical Access Regulations* be amended to provide new rules regarding eligibility, production and distribution of cannabis for therapeutic purposes. In addition, research on cannabis for therapeutic purposes is essential.

PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS

In chapter 8, we discussed the fact that research has not clearly established the effects of cannabis when taken alone on a person's ability to operate a vehicle. Nevertheless, there is enough evidence to suggest that operating a vehicle while under the influence of cannabis alters motor functions and effects a person's ability to remain in his or her lane. We have also established that the combined effects of cannabis and alcohol impair faculties even more than alcohol taken alone. Epidemiological studies have shown that a certain number of cannabis users do drive under the influence of the substance and that a large proportion of these people, mainly the young, appear to believe that cannabis does not impair their ability to drive.

This chapter also indicated that no reliable and non-intrusive road-side detection tools exist. Saliva-based equipment is a promising development but for the time being, provide random results. We have also established that a visual recognition system, which has mainly been developed and assessed in the United States, is a reliable way of detecting drug-induced impaired driving faculties.

Recommendation 9

The Committee recommends that the Criminal Code be amended to lower permitted alcohol levels to 40 milligrams of alcohol per 100 millilitres of blood, in the presence of other drugs, especially, but not exclusively cannabis; and to admit evidence from expert police officers trained in detecting persons operating vehicles under the influence of drugs.

RESEARCH

Research on psychoactive substances, and particularly on cannabis, has undergone a boom over the past 20 years. The Committee was able to fully grasp the actual extent of this increase, since we faced the challenge of summarizing it. Not all research is of the same quality and the current political and legal climate governing cannabis hampers thorough and objective studies. Nevertheless, a solid fact base was available to the Committee, on which to base its foregoing conclusions and recommendations.

However, more research needs to be done in a certain number of specific areas. In Chapter 6, we established that a lack of practical research on cannabis users has resulted in only a limited amount of information on contexts of use being available. It is also currently difficult to establish criteria on the various types of cannabis use in order to guide those responsible for prevention. The Committee suggests that cannabis use of over one gram per day constitutes excessive use and that between 0.1 and one gram per day equates to at-risk use. We also suggest that any use below 16 years of age is at-risk use. This is of course enlightened speculation, but speculation nevertheless, which remains to be explored.

In Chapters 16 and 17, we referred to the fact that we know very little about the most effective prevention practices and treatment. Here also, the current context hindered. As far as prevention is concerned, the more or less implicit "*just say no*" message and the focus on cannabis use prevention are strategies that have been dictated by the prohibition-based environment. In terms of treatment for problem users, abstinence-based models have long been the dominant approach and continue to sit very poorly with harm-reduction-based models. Thorough assessment studies are required.

The Canadian Centre on Psychoactive Substances and Dependency must play a key role in co-ordinating and publishing the results of studies. The Centre does not have to conduct research itself. This can and indeed must sometimes be carried out by academics. The Health Research Institutes are also natural players. However, it is important to clearly identify a single central body to collect research information. This will enable the information to be distributed as widely possible and, we hope, used.

Recommendation 10

The Committee recommends that the Government of Canada create a national fund for research on psychoactive substances and dependency to fund research on key issues - more particularly on various types of use, on the therapeutic applications of cannabis, on tools for detecting persons operating vehicles under the influence of drugs and on effective prevention and treatment programs; that the Government of Canada mandate the Canadian Centre on Psychoactive Substances and Dependency to co-ordinate national research and serve as a resource centre.

CANADA'S INTERNATIONAL POSITION

The Committee is well aware that were Canada to choose the rational approach to regulating cannabis that we have recommended, it would be in contravention of the provisions of the various international conventions and treaties governing drugs. We are also fully aware of the diplomatic implications of this approach, in particular in relation to the United States.

We are keen to avoid replicating, at the Canada-US border, the problems that marked relations between the Netherlands, France, Belgium and Germany over the issue of drugs-tourism between 1985 and 1995. This is one of the reasons that justifies restricting the distribution of cannabis for recreational purposes to Canadian residents.

We are aware of the fact that a significant proportion of the cannabis produced in Canada is exported, mainly to the United States. We are also aware that a considerable proportion of heroin and cocaine comes into Canada via the United States. We are particularly cognisant of the fact that Canadian cannabis does not explain the increase in cannabis use in the United States. It is up to each country to get its own house in order before criticizing its neighbour.

Internationally, Canada will either have to temporarily withdraw from the conventions and treaties or accept that it will be in temporary contravention until the international community accedes to its request to amend them. The Committee opts for the second approach, which seems to us to be more consistent with the tradition and spirit of Canadian foreign policy. In addition, we have seen that international treaties foster the imbalanced relationship between the Northern and Southern hemispheres by prohibiting access to plants, including cannabis, produced in the Southern hemisphere, while at the same time developing a regulatory system for medication manufactured by the pharmaceutical industry in the Northern hemisphere.

Canada could use this imbalanced situation to urge the international community to review existing treaties and conventions on psychoactive substances.

Canada can and indeed should provide leadership on drug policy. Developing a national information and action infrastructure would undoubtedly be key to this. **Canada must also play a leading role in the Americas**. We believe that Canada enjoys a favourable international reputation and that it can promote the development of fairer and more rational drug – in particular cannabis - policies. We also contend that Canada should strive for the creation of a European Observatory-style Drug and Dependency Observatory for the Americas within the Organization of American States.

Recommendation 11

The Committee recommends that the Government of Canada instruct the Minister of Foreign Affairs and International Trade to inform the appropriate United Nations authorities that Canada is requesting that conventions and treaties governing illegal drugs be amended; and that the development of a Drugs and Dependency Observatory for the Americas be supported by the Government of Canada.

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS

FOR THERAPEUTIC AND RECREATIONAL PURPOSES

Amendments to the *Marihuana Medical Access Regulations* (Production and sale of cannabis for therapeutic purposes)

A. Eligible person

A person affected by one of the following: wasting syndrome; chemotherapy treatment; fibromyalgia; epilepsy; multiple sclerosis; accident-induced chronic pain; and some physical condition including migraines and chronic headaches, whose physical state has been certified by a physician or an individual duly authorized by the competent medical association of the province or territory in question, may choose to buy cannabis and its derivatives for therapeutic purposes. The person shall be registered with an accredited distribution centre or with Health Canada.

B. Licence to distribute

A Canadian resident may obtain a licence to distribute cannabis and its derivatives for therapeutic purposes. The resident must undertake to only sell cannabis and its derivatives to eligible persons; to only sell cannabis and its derivatives purchased from producers duly licensed for this purpose; to keep detailed records on the medical conditions and their development, consumption and the noted effects on patients; to take all measures needed to ensure the safety of the cannabis products and to submit to departmental inspections.

C. Licence to produce

A Canada resident may obtain a licence to produce cannabis and its derivatives for therapeutic purposes. The resident must undertake: not to hold a licence to produce cannabis for non therapeutic purposes; to take the measures necessary to ensure the consistency, regularity and quality of crops; to take the measures necessary to ensure the security of production sites; to know and document the properties and concentrations of each harvest with respect to Delta 9 THC; to sell only to accredited distribution centres and to submit to departmental inspections.

D. Other proposals

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

- Establish a program of research into the therapeutic applications of cannabis, by providing sufficient funding; by mandating the ***Canadian Centre on Psychoactive Substances and Dependency*** to co-ordinate the research program; and by providing for the systematic study of clinical cases based on the documentation available in organizations currently distributing cannabis for therapeutic purposes and in future distribution centres; and
- Ensure that the advisory committee on the therapeutic use of cannabis represents all players, including distribution centres and users.

Amendment to the *Controlled Drugs and Substances Act* (CDSA) (Production and sale of cannabis for non therapeutic purposes)

A. General aims of the bill

- To reduce the injurious effects of the criminalization of the use and possession of cannabis and its derivatives;
- To permit persons over the age of 16 to procure cannabis and its derivatives at duly licensed distribution centres; and
- To recognize that cannabis and its derivatives are psychoactive substances that may present risks to physical and mental health and, to this end, to regulate the use and trade of these substances in order to prevent at-risk use and excessive use.

B. Licence to distribute

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA with respect to the distribution of cannabis. A Canadian resident could obtain a licence to distribute cannabis. The resident must undertake **not to distribute to persons under the age of 16; must never have been sentenced for a criminal offence, with the exception of offences related to the possession of cannabis, for which an amnesty will be declared**; and must agree to procure cannabis only from duly licensed producers. In addition, in accordance with the potential limits imposed by the *Canadian Charter of Rights and Freedoms*, licensed distributors shall not display products explicitly and shall not advertise in any manner.

C. Licence to produce

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA with respect to the production of cannabis. A Canadian resident could obtain a licence to produce cannabis. The resident must undertake to only sell to duly licensed distributors; to sell only marihuana and hashish with a

THC content of 13% or less; to limit production to the quantity specified in the licence; to take the measures needed to ensure the security of production sites; to keep detailed records of quantities produced, crops, levels of THC concentration and production conditions; and to submit to departmental inspections. No person charged with and sentenced for criminal offences, with the exception of the possession of cannabis, for which an amnesty will be declared, shall be granted a licence. No person or legal entity, directly or indirectly associated with the production, manufacture, promotion, marketing or other activity connected with tobacco products and derivatives shall be granted a licence. In accordance with the potential limits imposed by the *Canadian Charter of Rights and Freedoms*, cannabis products and their derivatives shall not be advertised in any manner.

D. Production for personal use

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA in order to permit the personal production of cannabis so long as it is not sold for consideration or exchange in kind or other and not advertised or promoted in any other way. In addition, quantities shall be limited to ensure production is truly for personal consumption.

E. Consumption in public

Consumption in public places shall be prohibited.

F. International trade

All forms of international trade, except those explicitly permitted under the Act shall be subject to the penalties provided in the CDSA for illegal trafficking.

G. Other proposals

- Ensure the establishment of a National Cannabis Board with duly mandated representatives of the federal government and the governments of the provinces and territories. The Board would keep a national register on the production and sale of cannabis and its derivatives, set the amount and distribution of taxes taken on the sale of cannabis products and ensure the taxes collected on the production and sale of cannabis and derivatives are directed solely to prevention of at-risk use, treatment of excessive users, research and observation of trends and the fight against illegal trafficking.
- The provinces and territories would continue to develop prevention measures that should be directed at at-risk use, as a priority. The ***Canadian Centre on Psychoactive Substances and Dependency*** should be mandated

to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.

- The provinces and territories would continue to develop support and treatment measures that should be directed at excessive use, as a priority. The ***Canadian Centre on Psychoactive Substances and Dependency*** should be mandated to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.
- Increase resources available to police and customs to fight smuggling, export in all its forms and cross-border trafficking.

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II – WITNESSES QUOTED IN THE REPORT

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