

**Illegal Drugs in Canada: Refocusing
Canada's Drug Strategy**

Major Research Paper

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Introduction

“Billions of dollars have gone into the anti-drug war and it has brought only huge criminal organizations. When you have poured in money for a century surely it is time for you to decide it is not working.”

Dr E.K. Rodrigo, former Drug Tsar of Sri Lanka 2005

In the last decade international attitudes towards the prohibition of illegal drugs have undergone rapid change. For over half a century governments around the world have been fighting a declared “war on drugs.” Within the last two decades, however, most have conceded that this crusade has been an unmitigated failure. Even though most of the international community has acknowledged this failure, it has been slow to re-conceptualize how it views illegal drugs and explore alternative policies. Part I of this paper demonstrates that the rapid globalization of the past three decades has had a significant impact on the scope, speed and scale of deviant globalization, where illicit industries operate in the shadows of the legitimate global economy. It was also around this time that the American-led “war on drugs” was launched, which essentially shaped the international drug control regime. Part II addresses the failures of the current prohibition regime and outlines alternative policy approaches that could instead be taken to address the problem of illicit drugs. In addition, case studies on countries that have been at the forefront of innovative drug policies, namely the Netherlands, Portugal and Australia, will also be examined.

Part III specifically looks at Canada, focusing on its experience with illicit drugs and its past and current drug strategies. It will be demonstrated that Canada’s current drug strategy is flawed for a number of reasons, and that it needs to be refocused and reformed. It will be argued that Canada’s drug strategy is in need of a paradigm shift. Instead of the prohibition approach, which has been the

focal point of Canadian drug policy for the last three decades, Canada's drug strategy should reorient itself towards a public health model. At a conceptual level this means abandoning the long held belief that drug users are criminals, and realizing, instead, those with a drug problem are victims and patients. At the policy level this translates into focusing on harm reduction, treatment and prevention programs, instead of continuing to direct the majority of resources to law enforcement and correctional facilities.

PART I

"In order to fight and defeat this enemy, it is necessary to wage a new, all-out offensive.... this Administration has declared all-out, global war on the drug menace."

President Richard Nixon, 1971

"The War on Drugs has been an utter failure. We need to rethink how we're operating the drug war."

Barack Obama, Northwestern University, 2004

Deviant Globalization & Black Markets

Within the last few decades the infrastructure of the global economy has become increasingly efficient, interconnected and indispensable. This has led to not just the growth of the formal global economy, but also its conjoined deviant twin (Gilman, Goldhammer & Webber, 2011, pg. 3). *Deviant globalization* may describe the cross-border economic networks that produce, transport and consume things, such as; narcotics, rare wildlife, counterfeited goods, looted antiquities, toxic waste, dirty money, unorthodox sexual activities, and humans in search of undocumented work (Gilman et al., pg. 1). This diverse and thriving range of illicit activities and industries takes place in the shadows of the formal, licit global economy. Both are market-driven economies that are enabled by the same globally integrated financial, communication, and transportation system (Gilman et al., p.2). Further, through a dynamic process of creative destruction, both break down boundaries, be it economic, political, social and environmental (Gilman et al., p.2). Therefore, deviant globalization is inextricably linked to and bound with mainstream globalization. While globalization has always had a deviant component, the scope, scale, and speed of deviant globalization has dramatically increased in the past thirty years. These illicit industries, or black markets, span the globe and affect all societies,

representing some of the direst problems jeopardizing international safety and security (Jenner, 2011, pg.902).

Moreover, deviant globalization has profound geopolitical implications. Whereas globalization reinforces the power structures that enable it, deviant globalization works against these sources of power. It degrades state power, erodes state capacity, corrodes state legitimacy, and ultimately undermines the foundations of mainstream globalization in creating a new type of political actor whose geopolitical importance will only grow in the coming decades (Gilman et al., pg. 275).

Participating on the production side of deviant globalization, from entrepreneur to worker, is a survival strategy for those without easy access to legitimate, sustainable market opportunities. Thus, the poor, the uneducated, and those in locations with ineffective or corrupt institutional support for mainstream business dominate deviant industries (Gilman et al., pg. 272). Deviant globalization exposes failures in development and usually some type of collapsing of the state. Deviant entrepreneurs have developed market niches in which extractable returns are more profitable and easier than anything they could get by “owning” enough of some state functions and extracting rents from those instead (Gilman et al., pg 276). Deviant globalization does not thrive in truly “failed states,” that is, places where the state has completely collapsed. Rather, it thrives in weak but well-connected states, where deviant entrepreneurs establish zones of autonomy while continuing to rely on the state to provide some of the remaining services (Gilman et al., pg.277).

Ethics and moral judgment created a space for deviant globalization and has allowed for its sustainability. Every time a community or nation, acting on the basis of its good faith and clear moral values, decides to “just say no” it creates opportunities for arbitrage (Gilman et al., pg.3). Wherever there is a fundamental

disagreement about what is right as well as a connection to the global market, deviant entrepreneurs are there to meet this unfulfilled demand (Gilman et al., p.4). To be sure, deviant globalization includes abhorrent activities, but when people allow moral repulsion to come first in their thinking, it clouds their ability to understand the complexity and implications of deviant globalization. It is only when moral judgment is suspended that one can understand the way in which moral outrage enables deviant globalization; that is, through creating opportunities for entrepreneurs to profit at the margins of the market where the “normal” norms don’t apply. Gilman et al. provide an alternative perspective on deviant globalization, called the *psychodynamic interpretation of demand*, which is captured by the phrase “the return of the repressed” (pg.15). The theory states that Western Europe, then the U.S., followed by parts of Asia became rich while the rest of the world remained more or less poor. The underprivileged and under-resourced became innovative as a function of necessity and recognized that the rich actually had a range of demands that were not being met. These demands were generated by the repressed desires for things the rich communities either marginalized or forbade. As a result, the goods and services the rich tried to expel from their communities have returned. In short, deviant globalization is all too human and is not going away.

The demand for illicit drugs has been around for thousands of years, but the industry did not really take flight until the 1960s. The previous social stigmatization of drugs began to recede in the late 1960s in the U.S. as the use of the recreational drugs became more fashionable and representative of social rebellion reflecting the countercultural movements of the time (Jenner, pg.902). Over the next forty years, the illicit drug market embraced economic globalization in the same way legitimate business did. One of the largest and most profitable deviant

industries is the market for illicit drugs, estimated to be over \$500 billion a year (Count the Costs, 2013, pg.5). The process of getting illegal drugs into the global market is comprised of several stages, including cultivation, production, transportation, trafficking and consumption (Jenner, pg. 902). According to estimates made by the United Nations Office on Drug Crime, in 2005 the global drug trade was worth \$13 billion at the production level, \$94billion at the wholesale level, and \$332 billion at retail level (Count the Costs, pg. 5). Far from prohibition's goal of eliminating drug use, there are approximately 300 million people who use drugs worldwide (Count the Costs, 2012, pg.2).

Virtually every country in the world criminalizes the consumption, production, and distribution of drugs like marijuana, ecstasy, heroin, and cocaine; it is the prohibition of drugs that causes an underground black market to form. The inherent risk of incarceration from producing drugs effectively increases production cost because producers must take steps to avoid detection (Jenner, pg. 904). This creates a monopolistic industry because there are fewer suppliers than a normal free market would dictate (Jenner, pg. 904). These monopolistic conditions, combined with the risk of illicit drugs, allow producers to substantially mark-up the market price of drugs (profit margins are estimated at 300%) and create a lucrative industry (Jenner, pg. 905). In fact, it is one of the top five largest industries in the world and accounts for at least one percent of the global economy. However the illegality of the drug industry is strongly linked to one important externality: violence. In the underground black market, sellers and distributors do not have legal recourse because a court will not enforce contracts for illegal goods. As a result, violence related to the drug industry has spiraled out of control over the past forty years.

Furthermore changes in economic and political life in the latter half of the 20th century, along with revolutionary technologies in the hands of civilians, have dissolved the sealants that governments traditionally relied on to secure their national borders. For instance, governments began to lose their hold on border control. Criminal networks thrive on international mobility through their ability to take advantage of the opportunities that flow from the separation of marketplaces from sovereign states with borders (Naim, 2006, pg.5). For government officials chasing criminals, borders are often insurmountable obstacles. But for criminals, frontiers create convenient shields and business opportunities. (Naim, pg. 15). In this regard the privileges of national sovereignty are turning into burdens and constraints on governments. Due to this asymmetry in the global clash between governments and criminals, governments are systematically losing everywhere. As will be explored in greater detail below, America's "war on drugs" is the poster child of the more extreme sort of failure. The United States has been fighting this (declared) war for over four decades, at an estimated cost of 42.5 trillion dollars (Gilman et al., pg. 279). American's prohibitionist policies have led it to rewrite criminal laws, fill jails with convicts, deploy vast military capabilities abroad, and revise the rules of city policing, even though both experience and scholarship have exposed the failure of the international narcotics regime in theory and practice.

Illicit Drug & International Drug Control

The use of narcotic drugs to heal, soothe, and induce transcendental experiences or seek alleged hidden knowledge has been documented back to ancient Egypt. Early on, opium, in various forms and dosages, was consumed for palliative purposes. The discovery in the early nineteenth century of the technologies for the extraction of morphine from opium and the invention of heroin in the late

nineteenth century, made intravenous administration possible, and its almost immediate effect reinforced its palliative use and subsequent dependence. In addition, the twentieth century also saw the extraction of cocaine from the coca plant (Madsen, 2012, pg. 126). During the American civil war the so-called “army disease” developed when opium was used by soldiers in the North and South to alleviate their sufferings. However, it was not the drug addiction of veterans, which was instead accepted quietly, but racist distain towards Chinese immigrants addicted to opium that led to the first American anti-opium law: the 1875 San Francisco municipal ordinance that outlawed opium dens. At first the Chinese were welcomed foreign labor during the California gold rush, but when open-plot gold exploitation became less lucrative the gold diggers congregated in the cities. Although localized, the 1875 legislation presents two tenets that are important to understanding the genesis of narcotic drug regime: First, social problems are created by someone at a precise moment; they do not exist in a vacuum. Second, politics, whether local, national or international, is instrumental in determining what is and is not considered a social problem (Madsen, pg.126).

After taking control of the Philippines in 1898 the U.S. was forced to decide how to deal with a number of non-Filipino Chinese opium smokers in that country as well (Gray, 2000, pg. 42). At the time the U.S. wanted to strengthen its relationship with China in hopes of opening its market, so it decided to do this by helping it with its notorious opium problem to demonstrate its moral concern. The U.S. State Department set up an international conference in January 1909 in Shanghai that drew in other great powers as well. The *Shanghai Opium Commission* was a great success for U.S. diplomacy as the Chinese were impressed with the American effort. However, the impact on the drug trade was negligible as the delegates were only

allowed to exchange information and make recommendations; no one was obligated to follow through (Gray, pg.44). Particularly, England, France and the Netherlands did not share the Americans delegation's horror of opium.

Nonetheless, the Commission represents one of the first steps towards an international drug prohibition and eventually led to the 1912 *International Opium Convention* that also established the Permanent Central Opium Board. The Convention, the first international drug control treaty, was signed at The Hague by the U.S., Germany, China, France, the United Kingdom, Italy, Japan, the Netherlands, Persia, Portugal, Russia and Siam. It went into force globally when it was incorporated into the Treaty of Versailles (Wikipedia, 2011). It called for each country to exercise complete control of the cultivation, manufacture and distribution of cocaine, opium and its derivatives (Gray, pg.50). Finally, the transformation of drug policy from a health issue into a law enforcement issue resulted from American policymakers largely opposing the view of drug abuse as a medical problem, and instead forcefully promoting the criminalization of production, trafficking, and possession (Madsen, pg.127). Interestingly, in 1926 the Opium Board of the League of Nations studied some of the unintended consequences of the prohibition recommendations to the Philippines. The report found that not only was opium cheap and readily available on the islands, but that enforcement was corrupt (Madsen, pg.127). Unfortunately, this early example of the causal relationship between narcotics prohibitions, increasing drug availability, failing drug policies and corruption was ignored.

Today there are three main treaties that govern the international drug control system and require government to control drug production, distribution and use; the 1961 *Single Convention on Narcotic Drugs*, the 1972 *Convention on*

Psychotropic Substances, and the 1988 *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Madsen, pg.129).

Interestingly, one of the unintended consequences of these conventions is that they contributed to placing much of the illicit drug trade into the hands of organized crime. Alongside establishing a global prohibition of certain drugs the 1961 convention also strictly regulates many of the same drugs for scientific and medical uses (Count the Costs, pg. 2) Thus creating two parallel markets (ie. the global market and deviant global market): one for medical drugs controlled and regulated by the state or UN institutions; the other for non-medical, unregulated and instead controlled by organized criminals.

The dramatic expansion of world trade during the 1990s also created ample room for illicit trade. During the 1990s the number of reported drug seizures worldwide, which had been stagnant at around 300,000 per year, more than quadrupled to 1.4 million in 2001 (Naim pg. 77). It must be noted that prohibition policies are not completely ineffectual. For example, in 1997 the United States seized over 100,000 pounds of cocaine and 300,000 pounds of marijuana through the interception of drug shipments by sea (Naim, pg.81). A week does not go by without news of an impressive drug seizure in North America. The problem is that even with all these efforts and momentary successes the flow of drugs into the U.S. and other major markets continues (Naim, pg. 81). This is because drugs are harder to control at the source since the sources themselves are multiplying and the drugs then enter into high-value consumer markets, often combined with other illicit and licit products. Both “source control” and the emphasis on repression in the war on drugs simply add value to the drugs that make it onto the market (Naim, pg.81).

Unfortunately the methods to fight the evolving illicit drug trade have changed very

little. The U.S. remains at the heart of global illicit demand even though it is the biggest spender in terms of enforcement resources. By an overwhelming margin those resources go into efforts to stop the supply of drugs rather than to reduce or manage demand. For over half a century this strategic choice has become stubbornly entrenched by successive American administrations, as well as international drug policy. Even when the U.S. attempts to reconsider its drug policy in the end it simply redoubles its investment (Naim, pg.80). Therefore, the narcotic bureaucratic machine keeps humming as clearly “source control” has an addictive quality in itself.

PART II

“I don’t object to discussing any alternatives. But if we are going to discuss alternatives, let’s discuss every alternative ... let’s discuss what alternatives do we have – what is the cost, what is the benefit of each?”

Juan Manuel Santos, President of Colombia

At a time of global economic crisis it is pertinent to evaluate the cost-effectiveness of all major public expenditures against an agreed set of measures. It is startling to note that the enforcement policies that essentially created this criminal market largely went on for decades without being subject to meaningful economic analysis and scrutiny. Rational policy development demands that where failings are identified, reforms or alternative policy approaches that could deliver better outcomes should be fully explored. There is a growing demand for a more balanced and comprehensive evaluation of the wider impacts of current drug law enforcement strategies, and also for the evidence-based exploration of possible alternative approaches. Part II identifies the various alternative policies that could be implemented to address the problem of illicit drugs, as well as provide a brief analysis of a few countries at the forefront of more innovative drug policies.

Prohibition

The war against traffickers pits the force of governments against the force of the market. History and common sense say that in the long run, market forces tend to prevail over those of governments. In this sense, modern trafficking resembles the age-old smuggling that appeared shortly after governments first imposed trade barriers (Naim, pg.223). Lev Timofeev, an analyst of Russia’s shadow economy, has written one of the most comprehensive economic studies of the drug market. His conclusions are stark:

“Prohibiting a market does not mean destroying it. Prohibiting a market means placing a prohibited but dynamically developing market under the control of criminal corporations. Moreover, prohibiting the market means enriching the criminal world with hundreds of billions of dollars by giving criminals wide access to public goods, which will be routed by addicts into the drug traders’ pockets. Prohibiting a market means giving the criminal corporations opportunities and resources for exerting a guiding and controlling influence over whole societies and nations. This is the worst of the negative external effects of the drug market. International opinion has yet to grasp the challenge to the world civilization posed by it.” (Glenny, pg.225)

There are three main arguments that are traditionally used to defend the criminalization of drugs. First, the paternalist argument is that the nature of the harms that drug users risk is a function of the drugs they use, so criminalization of use uses the law to deter persons from taking drugs (Sher, 2003, pg. 30). Second, is the protective argument that just as drug use can harm the user, so too can it harm others (Sher, pg.30). Third, the perfectionist argument believes that drug laws deter a person from using drugs, which prevents them from wasting their lives (Sher, pg. 31). Others have suggested that law enforcement bureaucrats have been a major source of the demand for the initial criminalization of illicit drugs (Bensen et al., 1995, pg. 24). These are some of the key arguments as to why many believe there is a good reason to attach criminal penalties to the use of narcotics.

From an economic point of view, a person’s decision to enter into the drug trade as a producer, distributor, or retailer is entirely rational because the profit margins are so high. In fact, governments do not argue that drug prohibition benefits the economy; rather, they base their arguments on perceived social damage

and morality (Glenny, pg.225). On the contrary, prohibition distorts the economy because it denies the state revenues it would get from taxation of a legal commodity, not to mention the immense cost of policing the trade and the incarceration of criminals (Glenny, pg.225). A report by Harvard economist Jeffrey Miron suggests that legalizing and regulating drugs in the U.S. would yield tens of billions of dollars annually in taxation and enforcement savings (Miron, J & Waldock, K, 2010). Despite the growing evidence of the failings of prohibition and the need to explore alternative approaches, the gap between perception and action is not shrinking. According to the United Nations drugs account for 70 percent of organized criminal activity; therefore, it would seem that the legalization of drugs would deliver the deadliest blow possible against transnational organized criminal networks (Glenny, pg.227). Therefore, it is clearly important to evaluate alternative policy options.

Economists have been at the forefront of this debate, criticizing the effectiveness of the war on drugs and proposing alternative policies from full drug legalization and selective decriminalization. Nobel Prize recipients in economics Milton Friedman and Gary Becker have long advocated the legalization of drugs; further, noteworthy economists George Shultz, Thomas Sowell and William Niskanen have all endorsed liberalizing drug policies (Thornton, 2007, pg. 417). In 1995, Mark Thornton randomly selected 117 economists from the American Economic Association to take part in a survey on drug-policy. The results from that survey found that 58 percent favored a change of policy in the direction towards decriminalization (Thornton, pg.418). Support for liberalization has increased significantly over the past decade. An expert in public policy, Randall Holcombe, has examined reforms such as decriminalization and argues drastic changes must take place. Economist John Humphreys states that drug prohibition is one of the

most obvious examples of the government taking away freedom in an attempt to improve life (2007, pg. 40). Humphreys' states for governments to justify strong intervention they must show that (1) people will make the wrong decision (2) the government will make the situation better, and (3) that this benefit (if any) overrides considerations of freedom (pg. 39). In the case of drug prohibition, it is safe to say governments have failed to prove any of these; in many ways prohibition polices have made things worse.

Legalization

On the opposite end of the policy spectrum from drug prohibition is drug legalization. Advocates of legalization argue that a more radical approach is needed, and that the strict prohibition drug laws have been grossly inadequate in reducing the drug problem (Levinson, 2003, pg.125). However, Dr. Levinson notes that abolishing decades-old policy of drug prohibitions without a more intense scrutiny and analysis is irresponsible (pg. 126). James B. Jacobs in his 1990 article *Imagining Drug Legalization* demonstrates the serious implementation problems of this policy approach by focusing the legalization debate on the costs of legalization in practice, rather than discussing the issue in principle (pg.29). For instance the simplest scenario, yet also the boldest, is to lift criminal prohibitions on manufacture, distribution, sale, possession, and use of all mood- and mind-altering drugs, thereby treating them like alcohol and cigarettes. Drug legalization would substitute legitimate business people and corporations for organized crime importers, wholesalers and retailers (Jacobs, pg.29). These new entrepreneurs would be in a position to reap much greater profits than their underworld predecessors, who had to cope with the risks of imprisonment, forfeiture, exploitation, and violence.

Jacobs discusses four main concerns with legalizing drugs the way alcohol and tobacco are marketed. The first concerns the possible relationship between a policy of legalized psychoactive drugs and the regulation of all other drugs, medicine and food (Jacobs, pg.31). That is, would heroin, cocaine and speed be sold over the counter, while Valium, sleeping and diet pills, and some medicines and antibiotics remain available only on a doctor's prescription? This would allow people unable to obtain sleeping pills without seeing a doctor to purchase heroin and hypodermic needles instead (Jacobs, pg.31). One must ask how long such a situation would last, and if this could lead to the complete dismantling of the regulatory system for food and drugs.

Similarly, another question is whether the current food and drug laws would cover these drugs at all. Before any prescription or over-the-counter drug can be sold to the public it has to be proven "safe and effected for a specific use" by passing a stringent testing criteria that often takes years and many millions of dollars (Jacobs, pg.31). Would these drugs have to meet this requirement or would they be exempted so they only had to list ingredients and possible damages to a persons health? The problem is if some illegal drugs did not obtain approval they would continue to be purchased through the black market and undermine one of legalization's primary goals.

The third issue is that of cost and taxation. The majority of drug legalization advocates view heavy taxation of drugs as a major problem, as they argue that this forces people to carry out other illegal activities to pay for drugs (Jacobs, pg.32). Therefore, for legalization to be successful drugs must be cheap and accessible; otherwise the black market will remain. Some legalization proponents, however, favor high taxes to prevent drugs from being too attractive in the way alcoholic

beverages are heavily taxed. Equally important is that it is mere speculation that making psychoactive drugs legal and inexpensive will reduce drug-related crime. Also, one would assume that as consumption of these drugs would likely increase, so too would the number of crimes committed under the influence of drugs. For instance, drug legalization would likely cause a major increase in the rate of driving under the influence, which is already one of the most serious social problems in North America (Jacobs, pg.33).

The fourth issue is that of legal liability of manufacturers and sellers of psychoactive drugs. If manufacturers and retailer fear liability for overdoses, accidents, addictions, suicides, and intentional or negligent injuries to others, they might be inhibited from entering the market in the first place (Jacobs, pg.33). Some possible solutions to the liability problem would be granting statutory immunity to producers and retailers of recognized drug products, allowing warning labels on drug packages to put burden of risk on consumers, or having government insure all manufacturers against drug causalities. Clearly, each of these solutions carries significant costs and raises major problems.

Finally, in many ways drug legalization would be more like a cultural revolution than a change in policy. For better or for worse Western culture is an alcohol culture; in hundreds of ways, alcohol serves as a symbol of good times, friendship, rites of passage, celebration, hospitality, romance and success. It is consumed when people are happy, sad, depressed, bored, tense or just thirsty; society consumes more alcohol than milk (Jacobs, pg.40). Drug legalization will probably lead to a substantial fall in drug prices as the current relatively high price levels reflect dealers' compensation for risk taking (Brettville-Jensen, 2006, pg.558). Thus cheaper drugs may induce some nonusers to take up "the habit," or if drugs

became cheaper than alcohol, heavy drinkers may replacing alcohol with them (Bretteville-Jensen, pg.560). Drug legalization would result in society engaging in a massive experiment, where society would transform from an alcohol culture to a poly-drug culture (Jacobs, pg.41). Moreover, if the legalization hypothesis proves wrong it will be too late to go back to the status *quo ante*, especially once tens of thousands, if not millions, of people developed a taste for new drugs. Therefore complete legalization is not feasible and it would likely not be desirable either. It is such a drastic policy change that there are too many unknowns to predict the outcome. Most economists and policy makers are instead advocating for liberalization in the form of decriminalization and regulation.

Government Regulated System

Taxing and regulating the production, trade, and consumption of addictive and mind altering substances (and other basic needs) proved to be one of the most effective fiscal strategies of states in the 19th century and well into the 20th century. Trades in alcohol, tobacco, and coca provided an indispensable contribution to the revenue of European states, and constituted an important part of the income from their dependencies overseas (Van Der Veen, pg.370). As long as states controlled the territories where these cash crops were cultivated, processed and marketed, they could establish a multitude of regulative mechanisms to capture the returns from the drug trade (Van Der Veen, pg.371). A favored strategy has been legally monopolizing crucial stages in the drug trajectory and licensing them out to the private sector to assure tax collection and the extraction of government revenue from these trades (Van Der Veen, pg.371). Consumer taxes developed with the growth of institutional capacities to administer such taxes.

The fiscal purpose of drug taxation in the late 19th century flowed from public health considerations in the construction and legitimization of fiscally oriented state drug policies. Indirectly, price increases could also be imposed through limiting the access to raw materials which were necessary in the production of alcohol and tobacco (Van Der Veen, pg. 372) Invariably, legally imposed taxation and state imposed scarcity would lead to home growth production and smuggling. Therefore, prohibitive policies, either through price increases (taxing it out of existence) or criminalization, had to be abandoned. This of course was not the case for certain addictive or mind-bending substance such as opium, marijuana, and coca (Van Der Veen, pg. 372). It is on these substances that the existing prohibition regime is developing some of the most conflictive and problematic issues in domestic and international politics.

A call for state regulation and control of drug production and supply has a simple core argument: that if prohibition is both ineffective and counterproductive, only retaking control of the market from criminals and bringing it within the realm of the state will reduce many of the key costs associated with the illegal trade (Count the Costs, 2012, pg.104). This strategy is premised on the idea of market control rather than market eradication, and it is actually in contrast to some of the popular misconceptions that such reform involves “relaxing” control or “liberalizing” markets. Rather it involves rolling out state control into a market sphere where currently there is none.

Either because they do not believe the free-market legalization policy option is desirable or because they do not find it politically acceptable or feasible, some advocate a “government-regulated system.” Immediately a number of questions come to mind. To begin, it would need to be determined which level of government

(local, provincial or federal) would be assigned the task of building a system for drug production and distribution. Jacobs' argues that most states would likely favor federal government control, otherwise the battle for legalization would have to be fought out province by province and allows for a harmonized policy across the country (pg.34). Another important question is which parts of the drug-distribution system the government would take over and control. It seems unlikely that the government would go into the business of growing marijuana, poppies, and coca or that it would establish laboratories for the production of amphetamines, barbiturates, LSD and other designer drugs (Jacobs, pg.35). The political and administrative reality would likely be that government goes no further than retail distribution; however it would still need to be determined whether government would control operations or have a purely a regulating role. Given the approach the government took on alcohol, which is the establishment of the LCBO, it is likely that it would decide to control operations.

However, government run drug stores could operate very differently from liquor stores and lotteries. For instance, they might try to ration the type or amount of drugs that consumers could purchase; but again, attempts to ration drug purchases would perpetuate the black market (Jacobs, pg.35). This is where some legalization proponents seem to unrealistically argue that in order to defeat all the problems attributed to the black market it would be necessary to make all drugs easily and cheaply available to whoever wanted them. As mentioned in Part I, this is an unrealistic goal as it will never be possible to completely eliminate the illicit drug market. Rather, the aim is to fix some of the unintended consequences of prohibition policies, such as reducing drug use and decrease unnecessary public expenditures and illegal activities.

Certain problems could still occur if a “government-controlled system” means extensive government regulation of privately run production and distribution system. If extensive government regulation means that the government would prohibit certain dangerous drugs all together or would peg the strength of some drugs below what was available on the streets then there would be a system of partial prohibition (Jacobs, pg.36). Partial prohibition could bring what some might view as the worst of both worlds, as it would make some psychoactive drugs available while others would remain illegal and could be provided on the black market. That being said, both the LCBO and Canada’s medical marijuana program appear on balance well regulated and supported by Canadian society. Even though this process has been fraught with practical and political challenges, an increasing number of countries are finding ways to begin to legally regulate some illegal drug markets, for example; by expanding the medical supply model, implementing *de facto* legal regulation, or withdrawing from one or more of the conventions then seeking to re-accede with a reservation regarding a particular drug.

Policy making around drug trafficking is inept for a number of other reasons. To begin policy makers represent constituents and, like them, they moralize. Strike, punish and kill policies fail because they focus on moral repulsion and sins, rather than the complex dynamics of the system in which actors participate (Gilman et al., pg.279). Furthermore, politicians are time bound pragmatists who feel the need to show “progress.” Nonetheless there are real policy opportunities to curb the most destructive of the deviant industries and to direct some of the deviant energy into less harmful channels (Gilman, pg. 281). First, state policy cannot eliminate deviant globalization, so it should regulate it instead. For regulation to work it must learn from the vast experiences in regulatory policy and see what can and cannot be done.

In practice, the effectiveness of regulation depends of course on regulatory capacity of governments and the international community. For example, could the “make the polluter pay” principle be applied to other illicit drugs (Gilman et al., pg.281)? This would lead to an overall efficiency gain because under prohibition deviant entrepreneurs and industries are not yet bearing the full cost of the negative externalities they produce. As will be discussed below, the Dutch system attempts to do this through taxation. Second, no state can impose uniform standards or prices on ‘moral offensiveness.’ People and cultures, especially globally, are too diverse to make a single set of moral standards feasible. In practice this means giving up the myth of universal moral opprobrium and acknowledging that world is full of different views on these issues. Third, efficient and fair bargaining requires transparency about costs, benefits and preferences. Most importantly, the regulation of deviant globalization should err on the side of permissiveness (Gilman, pg.283). As already stated black markets cannot be eliminated so there is no sense in trying to regulate them into the ground. Regulation that is tolerant and flexible does provide space for deviant entrepreneurs to operate but it forces them to restrain excesses and limits negative externalities.

Decriminalization

Decriminalization is not a strictly defined legal term, but in drug policy its common usage refers to the removal of criminal sanctions for possessions of small quantities of currently of currently illegal drugs for personal use, with civil and administrative sanctions optional (Count the Costs, 2012, pg.102). Here, possession of drugs would remain an unlawful and punishable offence, although it would not attract a criminal record (Count the Costs, 2012, pg.102). The term is often mistakenly believed to mean the complete removal of possession offences, but

decriminalization as defined above, is actually permitted within the UN drug conventions.

Further assessing the success of decriminalization and regulation policies is difficult given the considerable variation in approaches; approximately 25-30 countries, mainly concentrated in Europe, Latin American and Eurasia, have adopted some forms of non-criminal disposals for possession of small quantities of some or all drugs. While few definitive conclusions can be made, the observation has been made that decriminalization does not lead to the explosion in use that many feared (Count the Costs, 2012, pg.102). Decriminalization can only aspire to reduce the harms created, and costs incurred, by the criminalization of people who use drugs; it cannot reduce harms associated with the criminal trade or supply side-drug enforcement.

Public Health Model

The public health model has never fully been played out, perhaps with the exception of the British system in the early 20th century, although many countries are experimenting with elements of it (ie. needle exchange programs, drug treatment courts, medical marijuana) because of the scientific-based evidence of successes. The medical model, now practically extinct in Britain, provided heroin to addicts in their course of their treatment (Jacobs, pg.39). The system started to break down when it tried to handle pleasure-seeking addicts in the 1960s. In addition the model does not makes sense for most illicit drugs such as crack, LSD, PCP, marijuana or for causal/recreational users, as they cannot be “stabilized” as heroin users sometimes can (Jacobs, pg.39). However, in the 1980s the harm reduction model emerged, focusing on reducing overall drug-related harms. This resulted in a internal policy conflict, with harm reduction approaches evolving and

gaining traction across the globe, but operating within the politically driven drug-war framework (Count the Costs, 2012, pg.64). There is an increasing call for evidence-based policies that supports community-based drug treatment and are consistent with the goals of effective knowledge translation, health equity and ethical practice (Wallace, 2012, pg. 894). Advocates of the public health model argue that urban health workers and other professionals should be trained in the strategies that promote taking action for social justice in order to end the policies of the war on drugs. The view of treating the drug problem as a public health concern rather than through a criminal lens is gaining recognition internationally and is most likely the most promising approach for governments to take.

The Netherlands

In Europe advocates for alternative strategies and policies from the traditional prohibition model have enjoyed a better reception. Most European countries have addressed the problem by decriminalizing small-scale marijuana possession, either in law or de facto in police practice (Naim, pg.82). Europe has also been more aggressive in mandating (and funding) treatment for addicts. In the Netherlands, the Dutch Treasury taxes drug earnings as if they were legal income, because in its view income is income and turnover is turnover, irrespective of its source (Van Der Veen, pg. 354). The Dutch legal tradition is based on the reasoning that law-abiding citizens should not be hit harder than criminals. When caught and brought to court, big-time traffickers face retrospective income tax collection based on meticulous calculations of the costs and benefits incurred from the drug trade; such retrospective tax collection can be quite substantial (Van Der Veen, pg.354). Growers of cannabis do not fear that the tax collector will notify the police since revenue agents have a secrecy obligation towards their clients, which is only waived

if there is a direct damage to state interests (Van Der Veen, pg.354). Thus, growers of a substantial amount of cannabis are advised by the tax department to declare their illicit income. In fact, tax payment can actually benefit growers as they face a much higher retrospective tax collection, including fines, if the criminal justice system cracks down on them.

The Dutch illicit drug taxation may seem unparalleled, yet most, if not all, countries have made provisions to tax incomes from fiscal activities related to the drug trade, be it declared legal or illegal (Van Der Veen, pg.355). The Netherlands differs from other countries in that they have a soft-drugs market that is halfway regulated and partially taxed. The movement of a number of states' efforts to fiscalize illicit trade through their treasuries, regardless of their official goal or justification, indicates that considerations about the obligation of criminals to society or the state's obligation to extract the benefits of crime for use, have started to play a role in shaping the state's relations with the drug trade (Van Der Veen, pg.358). What matters here is that the drug trade does not necessarily escape the taxman.

In 1976, the Netherlands passed a formal policy to allow the possession and sale of up to about ninety cannabis cigarettes or 30 grams (UNODC, 2012, pg.23). In the 1980s, guidelines were approved to allow more local control and discretion in commercial cannabis practices and quickly "coffee-shops" selling cannabis appeared around the country. Coffee shops increased in prevalence and the number of them grew eleven-fold in eight-years with nine in 1980, 102 in 1988, and a lower end estimate of 1,200 in 2001 (UNODC, 2012, pg.23). Nonetheless, the Netherlands maintains that it is not in favor of legalizing marijuana. Coffee shop owners are held to pay taxes on their turnover, although the tax officer does not expect them to

keep double entry bookkeeping. This is mainly because the supply of drugs at the “backdoor” is still criminalized and, at times, prosecuted (Van Der Veen, pg.355). While the sale to customers is equally criminal according to the law it is not enforced. The Dutch coffee shops reportedly pay over €300 million in tax annually, and turn over approximately €1.6 billion (Boesler, 2012). MacCoun and Reuter note that the early effects of this policy change appear to be minimal as between 1976 and 1984 cannabis use remained about the same for adults and youth. However, perhaps due to the commercialization and glamorization of cannabis use, from the mid-1980s to mid-1990s they found that lifetime prevalence of cannabis in Holland increased consistently. Others also suggest that the increase could be a result of anti-drug attitudes eroding due to normalization of use (UNODC, 2012, pg.24).

Within the past few years there has been a shift in Dutch policy. The government has been reducing the number of coffee shops, with the number standing at approximately 700, which translates into one coffee shop for every 29,000 citizens (UNODC, 2012, pg.24). Furthermore, new restrictions by the Dutch government have been implemented which include: allowing only Dutch citizens to buy cannabis from coffee shops and in the future forbidding coffee shop within a distance of 350 meters from schools (UNODC, 2012, pg.24). The main driver of this is “drug tourism” arriving from other European countries, which was to be expected given the centrality of the Netherlands in Western Europe and the elimination of border controls between countries within the European Union. If Canada were to experiment with this program it would likely not experience the same level of drug tourism as the Dutch. This is primarily because Canada only shares a border with the U.S. and the level of border security between the two countries is very high.

Given the easy availability of cannabis in the U.S. it would not be worth it for Americans to cross the border to use a Canadian “coffee shop.”

As of 2010 the proportion of police investigations in the Netherlands into cases of soft drugs, which includes cannabis, is increasing; however, hard drugs still form the majority of cases (EMCDDA, 2012, pg.11). Nonetheless, there has been a general decreasing trend in criminal justice cases in the Netherlands. The number of suspects classified by the police as drug users decreased in this period from 10,823 suspects in 2003 to 5,960 suspects in 2010 (EMCDDA, pg. 11). Furthermore, the number of arrestees registered by the police as a drug users is decreasing, as well as the proportion of addicts amongst very active prolific offenders (EMCDDA, pg.11). However, combating the professional cultivation of cannabis remains a subject of intensified coordination efforts of taxes, housing corporations, police and electricity companies. While the number of coffee shops has decreased, this does not appear to have affected the availability of cannabis. With the new measures implemented (ie. license for residents, distance criterion for schools, and ban of cannabis from coffee shops with more than 15 percent THC) it remains to be seen whether cannabis availability will change and if there will be a shift from legal selling points to illegal sources.

A major concern of decriminalization or legalization is the social effects this will have on society; that is, whether liberalization in drug policy would lead to the development of a drug-user culture. Reinerman and Cohen did an interesting experiment on experienced cannabis users in Amsterdam and San Francisco to see if there were significant differences in the common-sense rules by which cannabis users regulate their use. The comparative study took representative samples of experienced cannabis users in two cities with many similarities (cosmopolitan,

politically liberal and culturally tolerant) but with different drug control regimes- Amsterdam (decriminalization) and San Francisco (criminalization).

Interestingly, in both cities users reported selectivity in the times, locations, and situations they found suitable for cannabis use. Similar to other leisure activities and forms of consumption, cannabis use occurs within a normative fashion that functions to maximize pleasure while minimizing disruption of daily routines (Reinarman & Cohen, pg. 394). For instance, contrary to what might be expected, Amsterdam respondents more often reported using at home, while San Francisco respondents reported using more outdoors and in the cinema; both samples mentioned social situations like “with friends,” “at parties,” or “going out” the most (Reinarman & Cohen, pg.397). The situations most often mentioned as not suitable for cannabis use were work and study; again, unexpectedly, more frequently in Amsterdam (Reinarman & Cohen, pg.397). Further, respondents in both cities reported that positive emotional states were more suitable for cannabis use, whereas negative emotional states are unsuitable. Cannabis was most frequently consumed with friends, followed by a spouse/partner, then alone (Reinarman & Cohen, pg.402). In terms of people with whom they would definitely not use cannabis, parents topped the list followed by coworkers, relatives, children, strangers and people who do not use and/or oppose the use of cannabis (Reinarman & Cohen, pg.402). Finally the most common bit of advice all centered upon the virtues of moderation, 76% Amsterdam users but only 12% in San Francisco (Reinarman & Cohen, pg.406). One reason for this might be due to the wide availability of cannabis in Amsterdam requires such cautionary advice, or perhaps because cannabis has long been decriminalized its user culture is more highly developed and has rendered moderation normative.

Another interesting study worth noting was a cross-national comparison on adolescent drinking and cannabis use in the United States, Canada and the Netherlands. The study is interesting because the three countries have quite different laws and policies regarding minimum age to purchase, jurisdiction, criminal sanctions for possession and consumption, enforcement, and adjudication policies (Simons-Morton et al., pg.65). U.S. laws and policies remain the strictest out of the three countries; enforcement is a priority and strict penalties apply to both users and sellers. In contrast, the Netherlands employs unique, harm-reduction policy approach that does not impose criminal sanctions for possession and use of small amounts and employs lax enforcement of possession laws (Simons-Morton et al., pg.65). Canada is somewhere in between, with federal laws that are similar to those in the U.S., but with enforcement and judicial practices that are more consistent with harm reduction (Simons-Morton et al., pg.65). The Netherlands has allowed regulated sales of small amounts of cannabis to those 18 and older; however, the purchase and possession of cannabis are nominally criminal offences in the U.S. and Canada (Simons-Morton et al., pg.65). In the United States cannabis laws are primary and enforcement is a priority, leading to hundreds of thousands of arrests a year. Yet in Canada and the Netherlands cannabis police generally tolerate possession and use, with considerable local variability in enforcement (Simons-Morton et al., pg.65). The study found no evidence that strict cannabis laws in the U.S. deterred use compared to the similarly restrictive but less vigorously enforced laws in place in Canada, and the regulated access approach in the Netherlands (Simons-Morton et al., pg.68). The consensus appears to be that Dutch policies have been a pragmatic response to a social problem, and were adjusted as benefits and disadvantages were recognized.

Portugal

Portugal's policy of depenalization came into effect in 2001 (named 30/2000), allowing people to possess up to an average of "ten days" supply for consumption of any illicit drug (Redmond, 2012, pg. 2). When a person is found with three to ten days worth of supply the case is referred to an administrative panel, which makes recommendations for treatment and/or monetary sanctions (Redmond, pg.3). Trafficking and cultivation of illicit substances as well as possession of quantities exceeding a ten-day supply remain criminal offenses (UNODC, 2009, pg.24). Over a decade later the reform continues to attract considerable attention with some calling it a 'resounding success' and others viewing it as a 'disastrous failure' (Hughes & Stevens, 2012, pg. 101). In terms of drug use none of the nightmare scenarios touted by predecriminalization opponents materialized; there was only a moderate increase in reported lifetime cannabis use around or immediately post reform, followed by a subsequent, slight decline (Hughes et al., pg.103). The most comprehensive data gives grounds for arguing that while there was some growth in the scale of drug use in post-reform Portugal, there was an overall positive net benefit for the country. Hughes and Stevens examined Portugal relative to Spain and Italy (chosen for their similarity in geography and drug situation) and concluded that post-reform Portugal is performing better for most indicators (p.109). The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) supported these conclusions as well, stating that the model best describes a public health policy founded on values such as humanism, pragmatism, and participation (Count the Costs, 2012, pg.103).

Dr. João Goulã, President of the Portuguese Drug Institute and Chairman of the EMCDDA, highlights that the changes in Portugal's drug policy came from the

bottom up with extensive discussion in the community (Douglas et al, 2012, pg. 23). Support for the current drug policy remains positive with 70 percent of the population supporting the national approach. He also stresses the importance of linking the adoption of decriminalization to a changed environment involving improved treatment and rehabilitation (Douglas et al., pg.23) What is of great concern in the case of Portugal's reform is the way in which extremely diverging accounts have been disseminated to the public when it is clear that the reform warrants neither praise nor condemnation of being a complete success or failure (Hugh et al., pg.11). Given its potential use in promoting or blocking drug law reform in Portugal and elsewhere, the selective use of data and divergent conclusions are somewhat expected. Nonetheless, it is critical that both academics and advocates be careful in communicating their claims so that evidence-informed accounts are more than mere ammunition for the policy battlefield.

Australia

In the 1960s Australia was confronted with a strong increase in the use of illegal drugs and its initial response, similar to other countries, focused primarily on law enforcement, and similar to other countries, they did not prove very successful. In the 1980s Australia realized it needed to re-direct its drug control policy to increase the emphasis placed on prevention and treatment. This resulted in the 1985 *National Campaign Against Drug Abuse* that stressed that drug abuse should be treated primarily as a *health issue* (UNODC, 2008, pg.24). The approach emphasized that drug use was a complex problem that could never be entirely eliminated. There were indications that the shift was misunderstood, or, perhaps purposely, misinterpreted to mean that authorities had become defeatists and soft on drugs. Even if a harm reduction model is the focus of a nation's drug policy, drug

use can still remain illegal and supply control is usually not abolished. Rather, making drug policy a health issue means that law enforcement is not given top priority. The introduction of harm-reduction interventions, notably the Needle and Syringe Programs (NSPs), was effective in decreasing some of the associated health and social welfare costs associated with drug abuse (UNODC, 2008, pg.26). The differential feature of the Australian approach is its focus on a policy of *harm minimization* which also includes supply and demand reduction strategies (UNODC, 2008, pg. 26). This differs from the classical “harm reduction” strategies, pursued in other countries. Thus Australia addressed the problem with a unique mix of drug control interventions. Australia’s 1993-1997 *National Drug Strategy* (NDS) continued its ongoing focus on harm minimization, with its main strategic goals being:

- 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 behavior 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;
- Prevent the spread of hepatitis, HIV/AIDS and other infectious diseases associated with the unsafe injection of illicit drugs.

Under this plan six strategic concepts were used to underpin the development and implementation of drug policy, which were; harm minimization, social justice, maintenance of controls over the supply of drugs, inter-sectorial approach,

international cooperation, and evaluation (UNODC, 2008, pg.27). What is interesting to note about this strategy is the balanced way drug control is approached as a health, law enforcement, and criminal justice problem, and the inclusion of evaluation as one of the six pillars of the policy. This was innovative at the time, and helped Australia avoid the HIV epidemic. However, despite an overall positive evaluation of the NDS for its innovative approach, little progress was made in reducing drug use levels in Australia (UNODC, 2008, pg.27). This was largely because, while the burden of drug control was placed increasingly on the shoulders of prevention and treatment, these programs were given insufficient financial resources (UNODC, 2008, pg. 24).

Therefore in 1997 the Australian Government launched the *National Illicit Drug Strategy "Tough on Drugs."* It attempted to make Australia a much more difficult target for drug traffickers and provide more funds to border control and the Australian Federal Police in order to increase the number of investigative staff, increase the capacity its cargo profiling system, improve communication and IT capabilities, and increase police funding for informant handling and witness protection (UNODC, 2008, pg. 30). Despite being titled "Tough on Drugs" the strategy included proposals to enable the diversion of drug users from prison to treatment through drug treatment courts (DTCs) with a view of breaking the cycle of drug dependency and criminal behavior. The original strategy encompassed a range of supply and demand reduction measures at a total cost of AUD\$516 million, with 41 percent allocated to supply reduction measures and 59 percent allocated for demand reduction initiatives (UNODC, 2008, pg.30).

Australia also developed Cannabis Expiation Notice Schemes (CEN), based on the logic of harm minimization. The main argument for an expiation system was

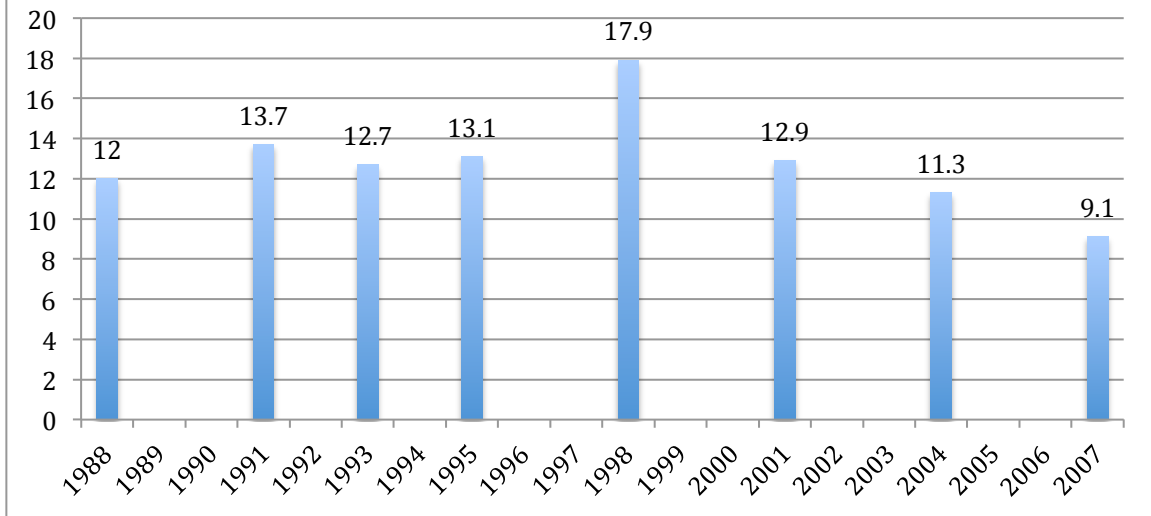
the potential cost savings and the reduction of negative social impacts upon convicted minor marijuana offenders (UNODC, 2008, pg.42). The underlying rationale is that a distinction should be made between private use of marijuana on the one side and producing and dealing marijuana on the other side. People were eligible for the CEN scheme for possession of up to 100 grams of cannabis of herb and cultivation of up to 10 plants of cannabis (UNODC, 2008, pg.42). Offenders avoid prosecution by paying the specified fine (usually between AUD\$50 to AUD\$150) within 60 days. The CEN scheme has been supported by law enforcement and is viewed to be much more cost-effective approach. Furthermore, the CEN scheme did not result in a drastic increase in marijuana users and that the former punitive prohibition model did not provide a better deterrent effect (UNODC, 2008, pg.44). The adverse social consequences of a marijuana conviction were seen to outweigh those of receiving an expiation notice.

Over the next two decades Australia maintained that drug strategy approach, refining it to include a focus on evaluation and evidence based policy formations, more financial resources, and the rediscovery of supply control as a key element in overall harm reduction. Australia's *National Drug Framework* (1998/1999-2002/03) and *National Drug Strategy- Australia's Integrated Framework* (2004-2009) continue to seek a balance between harm reduction, supply reduction and demand reduction strategies. Its harm minimization approach focuses on both licit and illicit drugs and includes preventing anticipated harm as well as reducing actual harm. The main priority areas of the strategy are: prevention, reduction of supply, reduction of drug use and related harms, improved access to quality treatment, development of the

workforce, organizations and systems, strengthened partnerships, and identification and response to emerging trends (UNODC, 2008, pg.37).

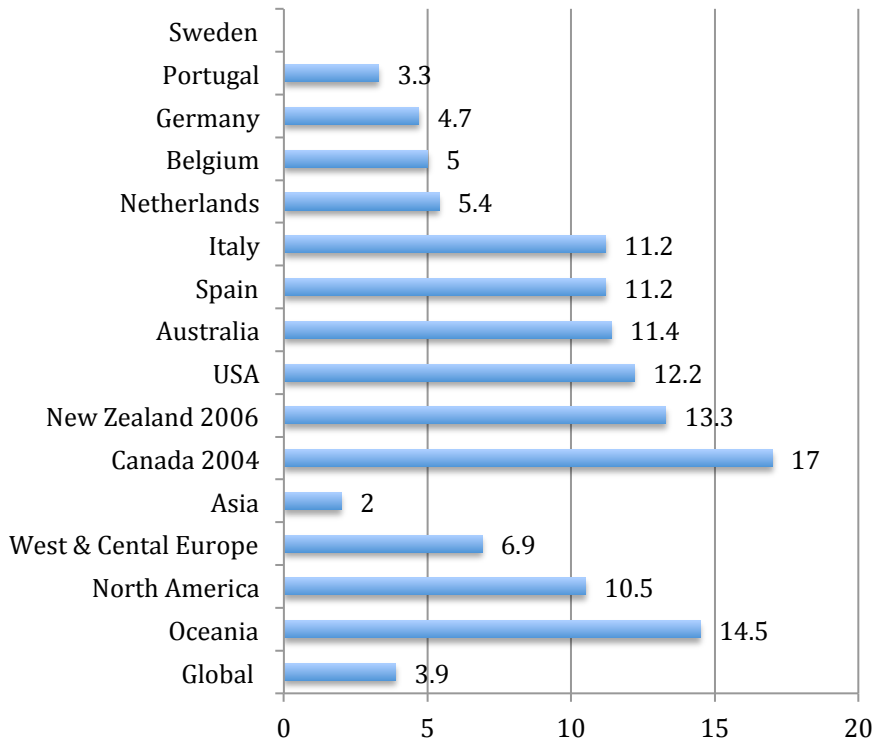
Supply reduction emphasizes that law enforcement activities also (1) increase the likelihood of people seeking treatment, (2) assist in prevention outcomes (3) reduce funds available for illicit drug prevention, and (4) reinforce the message that illicit drug use is not condoned by the community (UNODC, 2008, pg.37). The main emphasis for harm reduction is on public education campaigns and to work with service providers to reduce drug use and drug related harm. Treatment is targeted towards (1) reducing barriers to treatment, (2) supporting new treatment options (3) building strong partnerships between treatment services and mental health services, and (4) increasing the involvement of primary care such as general practitioners, in early intervention, relapse prevention and shared care (UNODC, 2008, pg. 38). After two decades of refining, Australia's harm minimization strategy appears to have been mainstreamed and to be delivering positive results; drug use between 1998 to 2006 has been characterized by major reductions. As can be seen in Figure (1) below, in Australia cannabis use increased by 49 percent between 1988 and 1998 but fell again by 49 percent between 1998 and 2007 (UNODC, 2008, pg. 52). The increase in cannabis is most likely linked to changing perceptions of the risks of cannabis use and its rising availability. Drug use, and changes in drug use, is in general a multidimensional phenomenon, depending on a large set of factors. Therefore, a key question that remains, but is impossible to truly answer, is to what degree drug policy has an impact on the attitudes or the availability of drugs.

Figure (1): Annual prevalence (in %) of cannabis use in Australia among the population, and 14 and above (1988-2007)



Despite the success of reducing cannabis use in Australia after 1998, its use is still high by international standards (see Figure (2) below). Among countries with reliable monitoring systems, Canada, New Zealand and the U.S. show higher levels of cannabis use. However, Canada, which pursues similar drug policies as Australia, shows notably higher prevalence of annual use (17 %).

Figure (2): Annual prevalence (in %) of cannabis use in selected countries in 2006/2007



*UNODC estimates, **Age Adjusted 15-64 years Source: UNODC, 2008 World Drug Report

PART III

“What I think everybody believes is that the current approach is not working. But it is not clear what we should do.”

Prime Minister Stephen Harper, Summit of Americas, 2011

Canada, perhaps unlike any other country in the world, has a number of conditions in place that make it conducive to a vibrant smuggling trade. The country has the longest international border that it shares with the U.S., the largest supplier and consumer of drugs and contraband in the world, and most uniquely, a large proportion of the population lives within a short distance of the border. The fact that organized crime in Canada has long been a branch plant of American organized crime is but one expression of the umbilical economic relationship between the two countries (Schneider, pg.554). By the start of the new millennium, a plethora of powerful crime groups and networks representing a diverse range of nationalities and ethnicities were active. Canada’s close relationship with the U.S. has always been somewhat of a blessing and a curse. As it has been in so many other ways, Canada has been heavily influenced and pressured to follow America’s strict prohibition approach and join its crusade on the war on drugs.

Illicit Drugs in Canada

By the early 1990s, Canadian law enforcement agencies started to intercept imports of a new “designer drug,” commonly referred to as MDMA and better known by its street name “ecstasy”, that had already gained wide spread popularity in Europe (Schneider, pg.355). The profit margin for MDMA is extremely high; during the mid-1990s one ecstasy pill could sell for \$30-40 dollars and cost about fifty-cents to \$2 to produce (Schneider, pg.355). The rebirth of synthetic production in Canada in the late 1990s was due to a number of reasons: the intensified enforcement

actions in the U.S. and the lack of such restrictions in Canada; the ease at which ecstasy and crystal meth can be produced and their high profit potential; proximity to large U.S. market; and the presence of criminal groups already with experience in drug manufacturing. In 2000 Canadian police discovered eight MDMA labs; between November 2002 and July 2005, police dismantled seventeen labs in Midwestern Ontario alone (Schneider, pg. 355). The RCMP noted that B.C. had the highest concentration of illegal drugs in Canada, followed by Ontario. In its 2005 International Narcotics Control Strategy Report, the U.S. State Department declared that the sharp increase in the production of ecstasy north of the border has created conditions “for Canada to become a major U.S. supplier of this dangerous drug.” (Schneider, pg. 335)

Nonetheless, even the recent spike in the production of ecstasy and methamphetamine cannot compare with the country’s largest and most profitable illicit cash crop: marijuana. By the end of the 1990s there were thousands of marijuana “grow operations” in the country and the number only increased in the new millennium (Schneider, pg.357). RCMP figures reveal that from 1994 to 2002, domestically grown marijuana grew by more than 600 percent (Schneider, pg. 357). Technology has also allowed new entrants to participate in this lucrative market. For instance, the most coveted and expensive marijuana is no longer cultivated in the tropical jungles of Colombia or Mexico, but comes from British Columbia, Canada. Known as the “BC bud,” it is grown using advanced hydroponics and cloning techniques in special nurseries that keep temperature and other conditions at optimal levels throughout the year (Naim, 2006, pg.70). The B.C. bud business involves smuggling cannabis into the U.S. and moving cash, but sometimes also cocaine and weapons, back from the United States to Canada. According to

Canadian law enforcement officials, this industry has grown to a gigantic \$7 billion-a-year business in 2005 (Naim, pg.71). This means it is responsible for more than 5 percent of British Columbia's GDP (Glenny, 2008, pg.214). A decade ago it barely existed.

In Canada nearly all cannabis is supplied domestically. However, there is a significant profit incentive for Canadians to sell cannabis to the U.S. market. In British Columbia fifty pounds of domestic cannabis is worth USD \$55,000 at wholesale prices; yet two and half hours south of the border in Washington, its value almost doubles to \$100,000 (Glenny, 2008, pg. 212). If taken to California this would add another \$50,000 to its value and in Kentucky it could be sold for \$200,000, almost four times its original value (Glenny, 2008, pg. 213). In B.C., for even the most junior participants, the profits from this trade are seductive. According to Stephen Easton of the Simon Fraser Institute in Vancouver a modest marijuana-growing operation of 100-plants can amount to almost \$20,000 per harvest, with four harvests a year, gross revenue is nearly \$80,000 (Glenny, pg.213). A conservatively high estimate for production cost would be around \$25,000; thus the return on invested money remains high (Glenny, pg.213). According to a 2007 UN World Drug Report Canada ranked 5th in world per capita marijuana consumption and first among industrialized nations (Schneider, pg.358). According to the RCMP, between 70 to 95 percent of B.C. marijuana makes it way into the American market. However, both Canada and the U.S. confirmed in their Drug Threat Assessment that this amounts to a mere 2 percent of America's cannabis consumption (Glenny, pg.231). It is evident that by international standards Canada's illegal drug situation as a whole is not critical. However, Canadians are some of the largest consumers of

cannabis and the illegal production, trafficking and consumption of cannabis is significant and should be a top policy priority in Canada.

Canada's Drug Strategy

From the very inception of the international drug regime international politics have played a major part in the decision process, and the transfer of the “war on drugs” to Canada in the 1980s is no exception. There are those that argue, and evidence to support them, that political rather than health or crime concerns were the driving force that brought America’s war on drugs to Canada in the late 1980s. For example, two days after President Ronald Reagan declared a new war on drugs in the United States, Prime Minister Brian Mulroney made an unexpected announcement of his intention to wage war on drugs in Canada (Jensen & Gerber, 1993, pg.453). Political conditions in Canada indicate that prior to Prime Minister Mulroney’s announcement of a drug “epidemic” in Canada, his public popularity was in jeopardy. This was similar to the political conditions Reagan was experiencing in the U.S. (Jensen & Gerber, pg. 454). Triggered by the negotiations around the Free Trade Agreement (FTA) with the U.S., the leader was seen as “cozying up” too close to American politics and interests (Fischer, 1999, pg.200). The contemporaneous spread of images about cocaine and crack in the U.S. to Canadians through the media provided Mulroney with the safe political issue he needed to bolster his administration’s downward spiral in the polls (Jensen et al., pg. 455). However, in Canada the crack/cocaine ‘epidemic’ arrived much later than in the U.S. and in reality its effects were much more limited (Fischer, 1999, pg.200). Nonetheless, around 1985-86 a wave of stories describing a crack/cocaine epidemic emerged in the Canadian media, and between 1985 to 1990 the percentage of cocaine drug abuse stories increased from 22% to 45% (Fischer, 1999, pg.200). Apparently even high-

ranking government officials were unaware of Mulroney's plan to declare a war on drugs. A top-level official from Health & Welfare Canada remarked: "When [the PM] made that statement, then *we* had to make it a *problem*" (Erickson, 1992, pg. 248). Furthermore, it remains unclear what indicators the prime minister was referring to in his claim of a drug epidemic as none of the usual drug use data had shown marked increases over recent years; rather, they showed a steady decline since their peak times in the late 1970s (Fischer, Jensen & Gerber, Erickson).

In 1987, Canada's Drug Strategy (CDS) was officially launched, even though the drug war soon became a minor part of the Tory agenda. Even the rhetoric had changed; instead terms like "epidemic" and "war," more neutral language such as "drug strategy" was now being invoked by sympathetic political leaders (Jensen et al., pg.458). During 1981 to 1991 Gallup Canada did not list concern over illicit drug use as one of the top five common answers to the question "What do you think is the most important problem facing this country today?" (Jensen et al., pg.458). As a result, Prime Minister Mulroney failed to generate public support for his war on drugs. The CDS bore three key messages for policy reform: it proposed to base Canada's traditionally prohibitionist drug policy on a balanced approach between supply and demand reduction; underlined the "reduction of drug-related harm" as the guiding paradigm for its policy efforts; and established a new drug control law to be placed at the core of the measures and approach initiated by the CDS program (Fischer, 1999, pg. 201). It has been suggested that these "demand reduction" components constituted rather small and ineffective initiatives in terms of reshaping the overall direction and profile of Canadian drug policy (Fischer, 1999, pg.201). However, while the policy was presented to the public with a gentler approach in line with Canadian public opinion, most of the financial support has gone to law

enforcement. As will be elaborated below, criminal sanctions and law enforcement responses have become more zealous since the advent of the national drug strategy.

For decades, Canadians of all stripes have argued that the penalties associated with the possession of certain drugs far outweigh the seriousness of the crime. In 1969 Pierre Trudeau's Liberal government ordered the first serious look at changing Canadian laws. In 1970 the Commission of Inquiry into the Non-Medical Use of Drugs suggested going beyond decriminalization, recommending a mere fine of \$100 for possession for any drug, including "hard drugs" like heroin and cocaine. Deemed by some analysts as "one of the politically-explosive documents ever put before the government" the recommendation was immediately rejected (CBC Digital Archives, 2012). Politicians and ruling governments have a decided advantage over all other interest groups in the drug legalization debate. They directly create the policies that relate to the treatment of the drug problem, while also provide funding for research institutions which study drug policy, the effects of drugs, and other related issues of importance.

In the past the Canadian government has not explicitly promoted any specific version of drug policy. In fact, the Canadian government had rarely been put into this position because the huge influx of news reports and stories of the American "war on drugs," with its focus on strict prohibition, had been enough to set the terms for the drug debate in Canada in the past decades, without Canadian government intervention (The Drug Legalization Debate, University of Toronto). However, recently, the issue of illegal drugs, and what policy approach should be taken, has become quite polarizing in Canada. Canadian public support is not unanimous for military style enforcement, as there has been a growing demand for the decriminalization of "soft drug" (Snedden, 2001, pg.5). About 60 percent of

Canadians now favor decriminalization or legalization of marijuana possession, with more than 75 percent of British Columbians wanting a relaxation in laws relating to cannabis possession (Glenny, pg.219). Thus B.C. has entered into a collision course with the U.S. The future course of narcotic policy, particularly the debate between Washington and Ottawa, will have enormous implications for the global shadow economy, for international policing, and for domestic policy across the world.

Within the last decade the costs of illicit drugs to the Canadian economy have grown substantially. In 2002 there were 1,695 deaths and 554,131 criminal offences attributed to illegal drug use (Rehm et al., 2006, pg. 2). In 2002 it is estimated that the cost of substance abuse totaled almost \$40 billion in Canada, with illegal drugs accounting for \$8.2 billion or 20.7 percent (Rehm et al., pg.3). Direct national healthcare costs attributed to illicit drug use were estimated to be over \$1.13 billion for 2002. In terms of law enforcement, 23 percent of all criminal charges processed through Canadian courts in 2002 were attributed to illicit drugs, at an associated cost of \$330 million that year (DeBeck, 2006, pg.4). In addition, in 2002 policing costs associated with illicit drugs were estimated to be \$1.43 billion (DeBeck, pg.4). Furthermore, drug law enforcement has contributed to incarceration rates in Canada that exceed those of many Western European Countries.

In 1992, the National Drug Strategy became “Canada’s Drug Strategy” and its five year budget was increased from \$210 to \$270 million, and of note, a substantial proportion of funds previously directed towards demand reduction were redirected to supply reduction efforts (DeBeck, pg.5). In 2001, the Auditor General reported that the federal government has failed to effectively lead and coordinate a national approach to addressing problematic substance use (DeBeck, pg.6).

Furthermore, it was also discovered that the government did not even know what

the provinces, territories and municipalities were spending on supply/demand reduction activities and lacked basic information pertaining to the progress of their activities (DeBeck, pg.6). In addition, in 2001 the Report of the Senate Special Committee on Illegal Drugs reviewed many of the harmful effects of enforcement-based policies and advised the Canadian government to move towards a regulatory approach for controlling cannabis since the current enforcement of cannabis prohibition has been unsuccessful in reducing consumption.

Canada's Drug Strategy (2003) attempted to address past criticisms (deficient federal leadership and coordination, lack of harmonization across and within levels of government around research, knowledge and evaluation frameworks, under-investment in demand reduction initiatives and outdated legal and policy approaches), stating it would use a balanced approach to reduce both supply and demand through prevention, treatment, enforcement and harm reduction initiatives (DeBeck, pg.7). Nonetheless, as can be seen in Figure (3) Canada's Drug Strategy overwhelmingly directed its funds to enforcement initiatives, at 73 percent or \$213 million (DeBeck, pg.7). This left 27 percent, approximately \$90 million, for demand reduction and harm reduction initiatives such as coordinating and monitoring the strategy, research, prevention, treatment and harm reduction.

Figure (3): Illicit drug portion of actual federal drug strategy expenditures for 2004-2005 by category

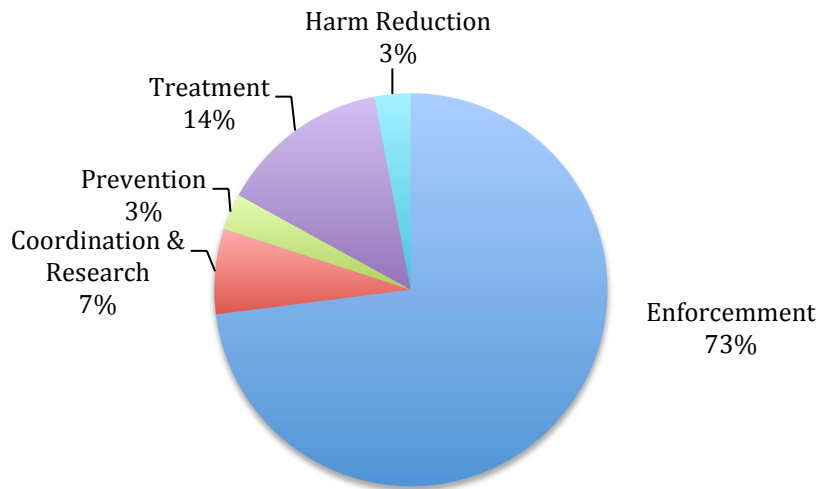
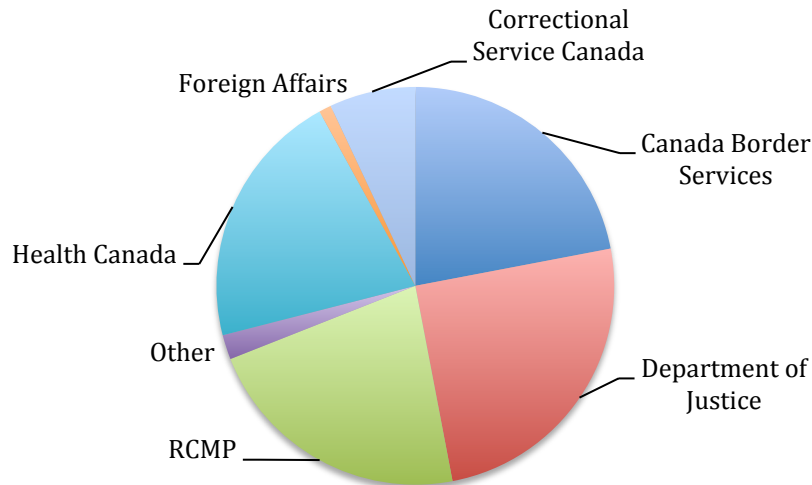


Figure (4) demonstrates that according to the Treasury Board Secretariat in 2004-2005, the distribution of the Drug Strategy funds reveal that enforcement-related departments received a total of 77 percent of the budget. While the allocation of funds to enforcement-based initiatives has decreased from 93 percent in 2001 to 73 percent in 2005 it is clear that Canada has been slow, perhaps even resistant, to the growing body of scientific evidence indicating that many of the harms associated with psychoactive drugs are due to enforcement based policies and practices (Debeck, pg. 8). For example, increased enforcement strategies have been found to destabilize drug markets and disperse drug scenes into surrounding areas, which, in turn, separates the drug users from health and prevention services (ie. needle exchange, treatment programs).

Figure (4): Illicit drug portion of actual federal drug strategy expenditures for 2004-2005 by department



Even though directing most resources towards supply reduction has been shown to be ineffective, since the Conservative Party won a majority in the House of Commons in 2008 it has continued with a prohibition approach and passed even harsher penalties to combat drugs, crime, and terrorism in an effort to align itself more with America. Most notable was the *Safe Streets and Communities Act* introduced on 20 September 2011, which received Royal Assent on 13 March 2012. Referred to as the “omnibus crime bill” it increases or establishes mandatory minimum sentencing for child sexual offences, violent and repeat young offenders, drug crime, and property crime. In terms of drugs, it amends *Controlled Drugs and Substances Act* with the new *Penalties for Organized Drug Crime Act*. The amendments include: (Department of Justice, 2012)

- Mandatory minimum penalties for serious drug offences, including when such offences are carried out for organized crime purposes or if they involve targeting youth. These serious drug offences include production, trafficking,

possession for the purpose of trafficking, importing and exporting, and possession for the purpose of exporting.

- The mandatory minimum penalty would apply where there is an aggravating factor, including where the production of the drug constituted a potential security, health or safety hazard.
- **Aggravated factors** involve; offences committed for the benefit of organized crime, involving threat of violence or use of weapons, someone that has previously committed a serious drug offence, abusing a position of authority, or access to restricted area, in or near a school, involving youth, and in relation to youth.
- The **security, health and safety factors** are: the accused used real property that belong to a third party to commit the offence; the production constituted a potential security, health or safety hazard to children; the production constituted a potential public safety hazard in a residential area; and the accused placed or set a trap.

If an addicted, non-violent offender successfully completes a treatment program, the court would not be required to impose the mandatory minimum and could impose a reduced sentence. Most significantly, the Bill includes mandatory prison terms for drugs listed in Schedule I (heroin, cocaine, and methamphetamine) and Schedule II (marijuana, cannabis). Generally the minimum sentence would apply where there is an aggravating factor. It also increases the maximum penalty for the production of marijuana from seven to 14 years (Department of Justice, 2012). Since it was first introduced the Bill has received considerable criticism. First, many studies have indicated that increasing penalties will not affect crime (Greenspan &

Doob, 2012). Second, imprisonment is very expensive and the government should demonstrate that imprisonment is the most effective way of achieving a reduction in drug use, production and trafficking (Greenspan & Doob, 2012). It will not be able to do this and, unsurprisingly, it has never tried. The evidence clearly shows that increasing imprisonment will have very little, if any, net impact on drug use; if it did, the United States would be the safest place in the world (Greenspan & Doob). Moreover, the U.S. has more people in prison for drug-related crimes than the entire European Union has prisoners; despite the fact that the U.S. population is 40 percent smaller than the EU (Boesler, 2012). In fact, focusing on incarceration to reduce illicit drug use has proved to be an expensive way to fail.

Recently, the idea of drug treatment courts (DTCs) has gained popularity in Canada. These DTCs attempt to divert those who violate controlled drugs regulations from prisons into treatment programs. The Canadian model is based on the American drug court system, which aimed to reduce prison overcrowding after it was found that up to three-quarters of the prison population growth could be attributed to drug offenders. Since the establishment of the first DTC in Florida in 1989, over 1600 DTCs have been instituted in the U.S.; in fact, DTCs represent a key point of contact between people who use drugs and addiction treatment services (Werb, 2008, pg.12). In fiscal year 2004-2005 \$3.28 million was allocated to drug treatment courts in Canada. The introduction of DTCs in Canada was and continues to be a subject of political debate. For instance, when funding for the DTCs was close to running out the Liberal party's justice critic, Dominic LeBlanc, stated that "at their core, they (the Conservatives) don't like these drug treatment courts" and that the Conservative government "want to incarcerate people in jails for longer sentences" (CBC News, 2009). However, some argue that there is

insufficient scientific evidence to support this approach because while these drug treatment courts continue to be promoted, voluntary treatment programs that have established success rates remain chronically under-funded.

Compared to the U.S. and Australia, Canada's experience with DTCs has been limited. Currently there are DTCs in Toronto, Vancouver, Edmonton and Regina, Winnipeg and Ottawa. Yet, the current government's emphasis on extra-judicial diversion programs suggests that DTCs are becoming more attractive to Canadian policy-makers (Werb, pg.13). The popularity and expansion of DTCs is driven by the belief that DTCs have lower-rates of recidivism and drug use and that they are cost effective. Two major DTC evaluations were undertaken in Toronto and Vancouver, however it was found in both evaluations that information concerning post-program drug use was either not collected or did not yield reliable information (Werb, pg. 13-14). In terms of costs and costs-effectiveness, Werb et al. note that currently the Vancouver DTC does not have the ability to graduate a higher proportion of participants, which they say suggests that the ineffectiveness of this delivery model may be the primary reason for the low cost-effectiveness of the program (pg.15). The total cost of the Vancouver DTC during December 2001 to March 2005 was \$4,058,819, which resulted in 42 participants who either graduated or completed (Werb, pg.15). Unfortunately, due to the lack of data on post-program drug use it is hard to conduct a proper cost-benefit analysis and determine the success of the program.

In addition, the federal government announced that it would be changing the way Canadians access marijuana for medical purposes. The Minister of Health, the Honourable Leona Aglukkaq, stated that the current regulations have left the system open to abuse (Health Canada, 16 December 2012). According to Health

Canada 72 percent of applicants who possess a license for medical marijuana suffer from arthritis, spiral cord injury, spinal cord disease, multiple sclerosis, cancer, AIDS/HIV, or epilepsy (Makuch, 2013). Over the last decade the program has grown exponentially from under 500 authorized persons in 2002 to over 26,000 today; the government states this rapid increase has had unintended consequences as a result of allowing individuals to produce marijuana in their homes (Health Canada, 2012). The main program reform will see that the government no longer produces and distributes marijuana for medical purposes, instead opening the market to companies that meet strict security requirements (Health Canada, 2012). The government claims this will enhance public safety as production will no longer take place in homes. Interestingly, documents released in 2007 revealed that Ottawa applies a 1,500 percent premium on the medical marijuana it sells to sick patients. While the federal government pays its licensed suppliers \$328.75 per kilo, those with prescriptions to purchase small amounts from the government end up paying the equivalent of \$5000 per kilogram (Schneider, pg.360). As editorialized by Maclean's magazine, "the government is charging criminal street rates for providing pot to the sick, and yet it continues to argue that legalizing and regulating the pot trade would be a terrible affront to the nation's morality" (Schneider, pg.360).

The government claims these new changes will cut red tape for individuals by ensuring they have access to marijuana for medical purposes, while striking the right balance between patient access and public safety. However, others have their reservations. There are those that claim the new program, which forces patients to rely on pricier government sanctioned growers for their medications rather than growing it themselves or relying on designated growers, may actually force many of the 28,115 Canadians currently authorized to use dried marijuana to then illicitly

grow their own pot (Makuch, 2013). The current \$1.80/gram costs for marijuana will rise to \$8.80/gram with full implementation expected by March 31, 2014 (Makuch, 2013). This price increase will leave many patients without a cheap source of medication. In a 2012 assessment of Health Canada's medical marijuana program, the *Harm Reduction Journal* found that 61 percent of Canadian medical-marijuana users have an income below \$30,000. In order to avoid expensive medical bills from commercial suppliers, some participants may engage in "guerrilla growing," which is essentially growing marijuana on property that doesn't belong to you.

Interestingly, Vancouver has lead the way in Canada with its public health model approach to heroin. Heroin, which is strictly illegal, gained ahold over parts of inner city Vancouver and other urban areas in British Columbia in the late 1980s and 1990s (Glenny, pg.222). Vancouver decided to follow Europe's step and became acquainted with a system called harm reduction which replaced traditional drug programs and sought to assist and rehabilitate drug users (Glenny, pg.222).

Vancouver developed its own program, *Four Pillars*, that essentially assumes the drug users to be victims rather than perpetrators and seeks ways in which social and health services can assist addicts to minimize the risks to them and to wider society (Glenny, pg.222). A critical element to this initiative is the needle exchange program, where the state provides unused needles to prevent the spread of infectious diseases; similar programs have been hugely successful in Europe. In 2003, when the mayor of Vancouver received approval from the federal government to open up an injection site, called Insite, at a B.C. medical facility downtown where addicts could receive professional help administering heroin (Glenny, pg.222).

In 2003 the Government of Canada agreed to exempt the Vancouver Coastal Health Authority from the *Controlled Drugs and Substances Act* in order to allow

Insite to operate. Insite was styled as a pilot project and granted a three-year exemption linked to rigorous evaluation. However, when the Conservative government was elected 18 months later it had the clear intention of taking a hard line on issues of crime and illegal drug use (CBC News, 2011). The new minister of health announced a renewal only until December 2007. Faced with the threat of closure, supporters of Insite launched a legal challenge arguing that closure of the facility would constitute a violation of the rights of users of the facility (Fafard, 2012, pg. 906). In September 2012 the Supreme Court of Canada rejected the argument that provincial jurisdiction over health trumped federal jurisdiction over the criminal law and upheld the right of the Minister to enforce the *Controlled Drugs and Substances Act*. However, in what many view as a watershed moment, the Court also ruled that the Canadian Charter of Rights and Freedoms protects the individual rights of drug users and requires the Minister to exempt the facility from federal drug control legislation (Vancouver Coastal Health, 2011). This court decision represents a victory for proponents of safe injection sites in Canada.

The defenders of Insite shifted their argument from stressing the benefits of safe injection sites to a more expansive one of social justice. It was argued that Insite must continue in order to meet the needs of drug users who suffer from an illness, that being addiction, to which the only fair, just, and effective response must be a health service response (Fafard, pg. 909). This is not surprising since social justice lies at the heart of the public health enterprise and is core to the harm reduction movement. Otherwise, the alternative is to return to portraying drug users as criminals who are less than full citizens and to deny them their fundamental human rights (Fafard, pg. 909). This social justice argument was a key element of the case put before the Court. Furthermore, Justice McLachlin wrote in

the ruling that the Minister should generally grant an exemption to supervised injection sites when there is evidence that it will decrease the risk of death and disease (Wells, 2011). The ruling stated, “Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on public safety and health objectives of Canada during its eight years of operation” (CBC News, 2011).

PART IV

“Begin the transformation of the global drug prohibition regime. Replace drug policies and strategies driven by ideology and political convenience with fiscally responsible policies and strategies grounded in science, health, security and human rights – and adopt appropriate criteria for their evaluation.”

The Global Commission on Drug Policy, 2011

Recommendation

The debate on the future of drug policy often appears highly polarized between punitive “drug warriors” and libertarian “legalizers.” However, this caricature is unhelpful as it is driven by the media’s desire for a more dramatic debate (Count the Costs, pg.98). In March 2009 the Commission on Narcotic Drugs held its fifty-second session in Vienna. There the Heads of State and Ministers issued a public declaration recognizing that they have a shared responsibility in solving the world’s drug problem. They reaffirmed their commitment to international cooperation and a multilateral approach to reduce the supply of and demand for illicit drugs (UNODC, 2009, pg. 45). Crucially, the states recognized that health had to be the foundation for international drug policy and recognized the need to support services to prevent drug use and to treat, care for and rehabilitate drug users (UNODC, pg.45). The re-orientation to a health-based approach and subsequent decriminalization of drug use requires a shift from the primary goal of supply reduction to one of harm reduction. A shift in this direction generally involves some key elements, including: decreasing the intensity of user-level enforcement; legal reforms such as decriminalization (or other sentencing reforms such as abolition of mandatory minimums); and institutional reforms such as moving responsibility of drug policy from departments of criminal justice to health (Count the Costs, 2012, pg.102). This was a clear acknowledgement that the war on drugs has failed and that it is time to explore alternative measures.

Therefore, what Canada, and the wider international community, need is a paradigm shift in the way the drug problem, as a whole, is conceptualized. A paradigm shift, a concept developed by Thomas Kuhn in his influential book *The Structure of Scientific Revolutions*, is a change in the basic assumptions, or paradigms, within the ruling theory of science (1962). In Kuhn's view the paradigm is not simply the current theory but the entire worldview in which it exists and all of the implications come with it. When enough significant anomalies have accrued against a current paradigm the scientific discipline is thrown into a state of crisis (Kuhn, 1962). During this crisis, new ideas, perhaps even ideas previously discarded, are tried and eventually a new paradigm is formed which gains its own new followers. An intellectual battle then takes place between the followers of the new paradigm and the holdouts of the old paradigm. This is essentially what is happening with narcotic drug policies both nationally and internationally. Since the 1980s it has been evident that the prohibition model has not worked. It is costing a preposterous sum of money, which in turn, only fuels the illicit drug industry. Further, this strict model of prohibition policies cannot combat with the pace and interconnectedness of the globalized world. Thus, some scholars, economists and policymakers began to advocate for a paradigm shift and to make solving the drug problem a health issue first. It is only when we truly change the way we conceive the problem that everything else that ebbs and flows from it (ie. beliefs, attitudes, debates, policies, programs) will achieve progress and success.

In Canada, tobacco and alcohol exist towards one end of the spectrum in a legal, for profit economy. Illegal drugs such as marijuana, heroin, and cocaine exist towards the other end of the spectrum in a criminal-prohibition, black-market economy (Health Officers Council, pg.2). It is argued that a more centrist public

health approach to currently illegal drugs is needed; where policies are set to minimize harms. This approach would strike a balance in minimizing the prevalence of harmful use and negative health impacts and also minimize any collateral harms to society from regulatory sanctions (Health Officers Council, pg.2). A more comprehensive public health approach for drug control should be adopted by the federal, provincial and municipal governments of Canada.

A number of countries, such as the Netherlands, Portugal and Australia, have seen immediate scientific-based success in harm reduction initiatives, and decided to make harm reduction or harm minimization the focal point of their drug strategy. As mentioned in the previous section the “war on drugs” mentality that has engulfed the Americans for over three decades has failed to gain traction among Canadians in the 1980s and remains a polarizing and contentious issue in Canada. There are clearly a large number of communities across Canada, as seen in the case of Vancouver, that seem to favor a harm reduction approach. Safe injection sites and the medical marijuana program prevailed because of the scientific evidence of their success, which lends greater credence to making drugs a health issue. In regards to cannabis, the proposed changes to Canada’s medical marijuana program and the implementation of mandatory minimum sentencing will likely produce more negative consequences such as increased drug use and illegal production and distribution. Instead of providing treatment to teach people how to take control of their lives and become a net benefit to society, this method has been shown to produce repeat and more serious offenders, and increase both judicial and correction costs.

One suggestion is that Canada could experiment with the Dutch “coffee shop” approach, and *de facto* decriminalize cannabis. As was done with the needle

exchange program, Insite, Canada could launch a pilot project in Vancouver since 75 percent of the population is already in favor of the decriminalization of cannabis. The large-scale production, dealing, import and export of cannabis would remain prosecuted to the full extent of the law, as in the Dutch system. Given that the cannabis business represents 5 percent of Vancouver's GDP there is a great economic incentive to regulate it. In the Dutch system, how coffee shops get their supplies is rarely investigated, but since Canada already has designated growers for its medical marijuana program it could also monitor the supply side. In the Netherlands, a reliance on non-enforcement has become common. The Dutch courts have long determined that the institutionalized non-enforcement of statutes with well-defined limits constitutes *de facto* decriminalization. Nonetheless, given the current government's extreme "tough on crime" approach over the last few years, it does not seem willing to experiment with the Dutch non-enforcement model on cannabis.

Given this, it is recommended then that Canada study Australia's harm minimization strategy and learn from its successes and failures. Canada could benefit from refocusing its drug policy in a harm minimization direction because Canada and Australia are very similar in many respects; in particular they are very close allies in the area of security. Like Canadians, Australians have shown a much more measured and tolerant attitude to the problem of illegal drug use, and Canadians would likely be much more receptive to a harm minimization strategy than continuing the ineffective and costly American war on drugs approach. It is recommended that Canada should consider following the Australian approach by improving its drug treatment court system and implementing Cannabis Expiation Notice (CEN) schemes. In terms of CEN schemes, clearly the recent passage of the

Safe Streets and Communities Act is going in the opposite direction as it establishes harsher penalties. As has been discussed above, this is the wrong approach to take. As demonstrated in the U.S. it leads to the construction of super-prisons filled with minor offenders who would be better off in a drug treatment program or some other type of harm reduction initiative which focuses on turning these individuals lives around.

In terms of Canada's Drug Treatment Court (DTC) system there is great potential for it to become an effective way of saving the judicial and correctional systems money and providing users with the help they need; but a number of reforms need to be made. One criticism of the DTC program in Canada is that its focus on abstinence causes those individuals characterized by severe drug dependence to often be at the highest risk of "failing" a DTC program (Werb, pg.16). For example, of the 284 drug offenders referred to the Toronto drug court, over two-thirds have been expelled from the program. Therefore the most dependent users often fail the program and are sent back to the judicial system while less dependent individuals are rewarded. Obviously this is significant downside to the current DTC system since those with the most severe addiction are most likely to reoffend and be incarcerated. This could lead to an increase in both the overall cost to the judicial and correctional system, and lead to the prolongation of the individual's placement within these systems even though these systems clearly fail to address drug dependency. Similar to Canada's Drug Strategy at large, the current DTC system in Canada falls short in its disregard of program evaluation. As a result it makes it very difficult to properly assess the efficacy of these programs.

Some criticize the government's decision to expand Canada's DTC system as premature, given the lack of comprehensive evaluation on the program (Werb et al.,

pg.16). Clearly, these programs, much like any government program, should be subject to rigorous analysis. Specifically, DTCs must monitor the long-term measures of drug use and recidivism, the impact of DTCs on society (ie. rates of crime), and measure the cost-effectiveness of the DTCs compared to other interventions aimed at reducing drug-use and drug related crime. It seems apparent that the program continues to view addicts as criminals given the role of judicial coercion and pressure of strict abstinence that the model enforces rather than a public health concern. This is another example of how a paradigm shift is clearly needed because the DTC system can only be as effective as the treatment programs it offers. Given the success of DTCs in U.S. and Australia the DTCs clearly have significant potential in helping addicts and reducing drug use and also reducing judicial and correctional costs. DTCs should provide the necessary support to equally help those with less dependent addictions who have a high chance of managing their drug use, as well as those with severe addictions where the DTC treatment program is their last chance before incarceration.

While Canada's federal system presents a challenge to developing a national drug strategy centered on harm reduction, the challenge is not insurmountable. Developing a nation drug strategy has been complicated because while law enforcement is controlled by they federal government, health has been delegated to the provinces. The case of Insite brought this big constitutional issue to slight as it was a chief concern in the ruling, but it demonstrated that successful harm reduction programs can succeed (Cosh, 2010). Even Justice Huddart, one of the three panel judges in the Insite case, emphasized that B.C. needed flexibility with its drug problem and that "Canadian federalism must remain responsive to the actual needs of the public," and safe injection sights was clearly one of those needs

(Cosh, 2010). It seems that harm reduction programs, such as safe injection sites, have a greater chance of not being blocked by the federal government when there is support from both the provincial government and the local community (Wells, 2011).

Conclusion

A great irony of the war on drugs is that although it was launched with the intention of protecting public health, it has achieved the exact opposite. The crusading rhetoric of the war on drugs describes drugs as an “evil” that must be “combat,” when in reality enforcement institutions and practices overwhelmingly target some of the most vulnerable and marginalized populations (socially deprived communities, young people, people with mental health problems, people who are dependent on drugs). The war on drugs disproportionately punishes those most in need, making it more of a war on drug users or as some argue, a war on people. There is a range of serious negative costs from the current global drug law enforcement policies that cut across policy areas and produce their own unintended consequences. The inevitable result is the development of distorted policy priorities and implementation of ineffective programs. There should be a re-orientation to a health-based approach and decriminalization of personal possession and use (civil or administrative sanctions only). Evidence suggests that if implemented intelligently as part of a wider health re-orientation, decriminalization can deliver criminal justice savings, and positive outcomes on a range of health indicators, without significantly increasing use. What governments seem to finally be realizing, after 40 years of losing the war on drugs, is that drug policy is partly a matter of deciding which negatives it can learn to live with. Canada will find success when the Canadian response to the drug problem is crafted in accord with Canadian experience and culture.

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