Drugs and Crime

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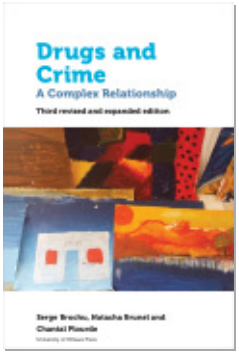

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Chapter 3

The Legal and Political Landscape

In this chapter, we describe how psychoactive substance use fits into the Canadian legal and political landscape. We analyze how our relationship with drugs changed to the point that some were criminalized. We try to understand how legislation and policy affect the relationship between drugs and crime. We also discuss recent policy developments that offer realistic alternatives to repression.

The Road to Repression

As surprising as it may seem, there was a time when some of the drugs that are illicit today appeared not in law books but in ledger books. Some drugs went from being an important legal commodity to the target of a "war on drugs," a vicious battle that has claimed many lives around the world. In a matter of years, certain drugs fell dramatically into disrepute. How did such a sudden shift come about?

Globalization of Trade

In the eighteenth and nineteenth centuries, following the Seven Years' War (1756–63), the British controlled opium production in India through the East India Company.[1] For a long time, much of the output was exported to China, which was considered a stable, secure market. By 1729, China was importing 200 chests of opium annually, and by

the end of the eighteenth century, over 4,000.[2] In 1838, it imported more than 40,000 chests.

Despite a 1729 Chinese imperial edict prohibiting the sale of opium, China began to produce it in addition to importing it. Production levels were high because it was ten times more profitable than growing rice. In addition to its use as a recreational drug, opium was also used "as an antispasmodic, as an analgesic, as a cough [and] fever . . . suppressant" (Lovell 2011, 34).

> During the time between the first [Chinese] prohibition edict of 1729 and the imperial authorities' stricter enforcement around 1800–10, a distinction was made between opium for smoking and medicinal opium. Producing, trading, and selling the former were prohibited; the latter was a legal substance. (Rapin 2013, 57)[3]

Government-ordered eradication campaigns were doomed to fail because of official corruption. A common strategy was to cut off the head of the plant but spare its roots.

After turning a blind eye to the corruption of many of their officials and the disastrous public health effects of feeble enforcement of the 1729 law for many years, Chinese authorities eventually saw things differently. In 1796, as China's economy was collapsing due to the flow of capital to European countries, it published an imperial edict prohibiting opium importation on pain of death.[4] Yet even this extreme measure failed to put an end to the lucrative business, and it is estimated that there were 2 million opium smokers in China in 1835 ((Lovell 2011). Despite constant problems enforcing the policy and the fact that opium abuse was no longer the province of the lowest classes but was ensnaring young people from good families (Lovell 2011), Chinese authorities ordered all foreign merchants to hand over their opium stocks. The English protested vociferously, but over 1,400 tonnes of their merchandise was thrown into the river at Guangzhou (Canton) (Bell 1991).

In England, some 300 trading companies demanded that their government intervene and force Chinese authorities to compensate them for the destroyed merchandise. A press campaign was launched. News from China told of skirmishes between British ships and Chinese junks (Wikipedia 2017). These actions were interpreted as direct attacks on the British Crown, and the reaction was merciless:

> In June 1840, an Indo-British fleet reached the Chinese coast. The attackers' superior firepower brought Canton down quickly. Her majesty's troops sailed up the Yangtze and took control of the movement of goods on the river, thereby depriving the imperial treasury of trade-generated tax revenues. Two years later, the Qing gave in. (*La Tribune* 2013)[5]

In August 1842, intending to secure additional trade advantages for the Crown, "a British squadron sailed up the Yangtze River to Nanking and forced the Daoguang Emperor to capitulate and sign the Treaty of Nanking on August 29, 1842" (Wikipedia 2017).[6]

The treaty opened the Chinese market to British imports. Opium imports reached 12,000 tonnes in 1886. At that point, the British themselves imposed restrictions (De Choiseul-Praslin 1991).[7]

England triumphed in what may have been the first true drug war. Merchants defeated the Chinese empire, and trading nations, such as France and Portugal, applauded the victory (ibid.).

Meanwhile, at the end of the eighteenth century, and in the nineteenth, opiates were regularly prescribed in Western countries to treat certain medical problems (Montigny 2011). In 1789, at the venerable age of eighty-three, Benjamin Franklin wrote to a confidant that he had been using opium to combat "grievous pain" (Benavie 2009, 22).

It was against this political backdrop that the first international conventions on controlling the opium trade—and later, several other psychoactive substances—were signed.

The nineteenth century was a turning point for the history of drugs in many other ways too. The method for extracting morphine and heroin was discovered, hypodermic needles were perfected, the chief alkaloid of coca was isolated, and Vin Mariani and Coca-Cola, which contained relatively small amounts of cocaine, hit the market.

All of these developments, combined with extravagant marketing on the part of pharmaceutical companies and a growing number of opiate prescriptions, led to a surge in the number of users and a gradual change in society's attitude toward drugs and drug users. Nobody in America was particularly concerned about drugs at the beginning of the nineteenth century, but by the turn of the twentieth century, that had changed dramatically. The rapid spread of drug use was antithetical to the aims of certain religious groups[8] and professional associations[9] that backed vigorous anti-drug crusades.

Prohibition

With the late nineteenth and early twentieth centuries came a new outlook on drugs and drug users. There was a growing sense that people who consumed opium derivatives could become pharmacodependent (Benavie 2009). Chinese-American minorities, some of whom used opium regularly, drew the ire of moral entrepreneurs. Anglo-Saxon America, including Canada, made up its mind to do something about this "devilish" substance, as it was described by certain commentators more concerned with sensationalism than with truth (Montigny 2011). Did this mindset find fertile ground in the widespread racism whose target was a minority that was "stealing" jobs from whites? Some are quite certain that it did.

> Around that time, when "Chinese" was synonymous with "opium fiend" and "yellow peril," the United States bowed to union pressure and enacted "exclusion laws" designed to protect American workers. (Béroud 1991, 69)[10]

> However, at the end of the nineteenth century, in Western Canada, puritanical groups were calling for major restrictions on this front. Methodist evangelicals in particular were very vocal in their conviction that atheism and belief systems other than Protestant must not be tolerated because it would lead to the downfall of Anglo-Saxon power. Alcohol, sex, and opium were considered three wellsprings of vice and sin that posed a threat to white Anglo-Saxon Protestant families and their way of life. (Beauchesne 1991, 127)[11]

> The first antiopium laws, beginning with city ordinances in San Francisco in 1875 and Virginia City, Nevada, in 1876, were directed at the smoking of opium, which was associated with Chinese immigrants and deviant whites. Their use of the drug was perceived as symbolic of the immigrants' decadence and as a potential weapon that could be used to undermine American society. In the South, the white majority feared that cocaine use among blacks might cause them to forget their assigned status in the social order. (Nadelmann 1990, 506)

> Beginning in an era of morally tainted racism and colonial trade wars, prohibition-based drug control grew to international proportions at the insistence of the United States. (Sinha 2001, i)

From that point on, the crusade gained momentum; it was only a matter of time until non-medical use of these drugs would be prohibited. The early twentieth century witnessed the creation of new laws prohibiting opium in Canada and the United States. In February 1909, the United States convened a thirteen-member meeting of the International Opium Commission in Shanghai.[12]

> The Commission approved nine resolutions that, while they may look like so much wishful thinking, actually represented phenomenal progress at the time. In the resolutions, the Commission recognized China's right to eradicate the production and abuse of opium (resolution 1). It recommended the immediate closure of opium divans (resolution 7) and the adoption of drastic measures to control the manufacture, sale, and distribution of opium and its derivatives at the national level (resolution 5). It also recognized the duty of all countries to adopt reasonable measures to prevent the shipment of opium to any country which prohibited its entry (resolution 4). (Bell 1991, 4)[13]

These were non-binding resolutions intended to restrict the opium trade. Three years after that, on January 23, 1912, an international convention was ratified in The Hague calling on signatory nations to enact national legislation restricting the production, importation, possession, and use of opiates (UNODC 2013a).

A little over a century later, the current state of global co-operation on drug matters is now laid out in the following three United Nations conventions:

- The Single Convention on Narcotic Drugs, 1961 (amended by the 1972 Protocol), signed by 186 states.
- The Convention on Psychotropic Substances, 1971, signed by 183 states.
- The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

These twentieth-century conventions criminalized the cultivation, manufacturing, trafficking, and distribution of certain drugs except for medical or research purposes. At the instigation of the United States and the United Nations, they endorsed a "war on drugs" strategy.

An array of false impressions combined with major gaps in scientific knowledge about the potentially "criminogenic" effects of certain psychoactive substances misguided many decision-makers and

legislators and played a decisive role in the evolution of repressive measures prohibiting the consumption of certain substances in industrialized countries. This brief glimpse into the history of our relationship with drugs helps us better understand the backdrop to the United States' merciless twentieth-century war on drugs and drug users.

The War on Drugs

For the past century, American and Canadian governments have opted for repressive strategies aimed at eliminating the supply of and demand for drugs. Such strategies have consumed the better part of U.S. funding for action on drugs. To eliminate supply, governments have taken two main approaches to crippling supply chains: waging war against drug producers and hunting down importers and distributors. To eliminate demand, governments criminalized users.

Action Against Drug Producers

Except in the case of cannabis and synthetic drugs, producer countries are generally distinct from the most voracious consumer countries. Southeast and Southwest Asia are known for opium poppy production,[14] and Colombia, Peru, and Bolivia for coca cultivation. Without oversimplifying, we can say that, by and large, southern nations produce drugs for northern markets.

In North America, cocaine was clearly the first target of the cross-border battle. According to the United Nations Office on Drugs and Crime, or UNODC, in 2007 and 2008, Americans and Canadians consumed about 470 tonnes of the white powder, which "is generally transported from Colombia to Mexico or Central American countries . . . and then onwards . . . to the United States and Canada" (UNDOC 2017). Although Mexico is not a major producer, it is deeply involved in drug trafficking. Its many well-organized cartels compete to control the transportation of drugs to the American giant, leaving countless "collateral" victims in their wake.

Cracking down on drug producers located outside consumer countries calls for a foreign policy that relies heavily on military action, such as the Mérida Initiative, a $1.6-billion United States–Mexico partnership launched in 2008 to combat organized crime. Its objective is to take down Mexican organized crime groups by capturing their leaders and disrupting their drug-related revenue streams (production,

distribution, money laundering). The program also aims to enhance Mexican law enforcement capacity and border controls to stop drugs entering the United States from Mexico. Lastly, the program strives to promote an anti-drug culture among Mexicans (U.S. Embassy, Mexico 2015).

The Mérida Initiative escalated the war on drugs in Mexico, resulting in a monumental death toll[15] and the glorification of a *narco cultura*.

> Alongside the violence emerged new cultural identities that embraced the values espoused by criminal gangs. *Narco cultura* celebrates the drug trafficker lifestyle through popular music and telenovelas. *Narcocorridos* ("sick songs") portray criminals as heroes who have achieved wealth and success in a country where poverty prevails. (Légaré-Tremblay 2014)[16]

In producer countries such as Peru, Bolivia, and Colombia, and others farther afield, such as Afghanistan and Myanmar, drug crops are not only part of the local flora, they also bring in more revenue than any other crop. Drug lords step in where an ineffectual state cannot provide segments of the population with a decent income. Cultivating plants that supply the raw material for drugs is part tradition and part response to economic factors because so few other national products enjoy such stable—and in some cases, growing—demand. Persuading small farmers to cultivate cereal crops, fruit, or coffee instead of coca or poppies is no easy task.

Feeble political and territorial control is largely responsible for the tens of thousands of hectares of illegal crops cultivated in many drug-producing countries. Chouvy (2014) concluded that efforts to reduce supply have failed. Basically, some small farmers deny the legitimacy of such legislation and do not hesitate to engage in activities that they feel are within their rights, particularly in lawless regions where the authorities are impotent or quite simply corrupt (ibid.; Polet 2013a, 2013b).

Action Against Drug Importers and Distributors

Even as it targets producers in foreign countries, the war on drugs is also being fought on the home front, taking aim at importers and distributors in the consumer country. The objective is to seize all drugs

being manufactured or cultivated and intercept drugs being smuggled into and distributed around the consumer country.

At the turn of the last century (1908), when opiates were widespread, Canada enacted the *Act to prohibit the importation, manufacture and sale of opium for other than the medicinal purpose*, otherwise known as the *Opium Act*. Unemployment, racism, and the rise of temperance movements converged to create ideal conditions for the enactment of this first Canadian drug law (Brochu and Magrinelli Orsi 2008). In 1911, cocaine and morphine were added under the *Opium and Drug Act*. Codeine, heroin, and cannabis joined the ranks of proscribed substances in Canada in 1923 following a series of articles by Judge Emily Murphy—the first female magistrate in Canada and in the British Empire—that interwove statistics, medical information, and racist and moralistic anecdotes that were later assembled in a book entitled *The Black Candle* (Brochu and Magrinelli Orsi 2008). Canada's current legislation on narcotics, the *Controlled Drugs and Substances Act* (CDSA), was adopted in 1996 (Government of Canada 1996).

In 2012, the Government of Canada adopted Bill C-10, the *Safe Streets and Communities Act*. Among other things, it amended the CDSA by adding minimum prison sentences for the production, importation, exportation, and possession with the intent to export of substances such as cocaine, heroin, and methamphetamine. Minimum sentences were also established for the cultivation of six or more marijuana plants and the production of cannabis oil and resin. It is worth noting that section 720(2) of the *Criminal Code* provides for the provinces to implement a treatment program for drug-dependent individuals under court supervision, which gives judges the option of not imposing the mandatory minimum sentence if the offender successfully completes the treatment program offered.

Under the CDSA, the maximum penalty for importing or trafficking drugs such as opiates, cocaine, PCP, amphetamines, GHB, and large quantities of cannabis is life imprisonment. An individual convicted of dealing drugs for organized crime purposes, of using violence or a weapon, or of a repeat offence is liable to a minimum penalty of one year in prison. The minimum penalty for offences involving minors or for dealing drugs in a prison as defined by the Criminal Code is two years in prison. Trafficking less than 3 kg of cannabis is liable to imprisonment for a maximum term of five years less a day. Trafficking in certain other drugs, such as mescaline, LSD, and magic mushrooms, is liable to ten years in prison.

Harsh penalties may serve as something of a deterrent to the few drug dealers who are aware of them, but the biggest challenge when it comes to catching traffickers is thwarting their schemes to import and distribute drugs, an undertaking further complicated by the sheer size of Canada and the United States combined with the massive quantity of goods of all kinds imported every week. Is it even possible to monitor every potential point of entry closely enough?

Criminal networks are in a constant state of flux. If an entry point is blocked, drug traffickers quickly find another to get their products in (Thoumi 2002). With the dawn of the digital era, some distributors are opting to do business in online marketplaces. An estimated $90 million worth of drugs changed hands on Silk Road, a darknet market or cryptomarket, shut down in 2013 by the FBI (Nancy 2015; The Economist 2014a). Since then, dozens of cryptomarkets that look like legal e-commerce sites but that guarantee the buyer's anonymity have sprung up, enabling resellers and consumers in areas without ready access to traditional dealers to purchase drugs (Aldridge and Décary-Hétu 2016; The Economist 2014b). The recent expansion of cryptomarkets has implications for the people behind them, as well as for legislators. As Aldridge and Décary-Hétu (2016) point out:

> One important question must therefore be asked: given the potential we've discussed here for harm reduction to arise from the online drug trade—for drug dealers, for users and within the markets themselves—should drug cryptomarkets be a high priority for law enforcement? We might consider reframing the problem: instead of deeming cryptomarkets problematic because the criminals operating there are harder for law enforcement to reach, perhaps we should consider the possibility that cryptomarkets reduce the problems associated with this kind of criminality. (p. 28)

According to the most optimistic police estimates, only about 10 percent to 20 percent of drug imports are intercepted, which is a drop in the bucket. Seizures have very little impact on the criminal organizations involved. Even if police agencies managed to completely halt the inbound flow of illicit drugs, clandestine laboratories would step into the breach and quickly bring substitute products to market. It has become relatively easy to synthesize substances with the stimulating effects of cocaine or the natural properties of opiates. These products are already on the market and regularly consumed by users.

Action Against Users

Launched in 2007, the Government of Canada's National Anti-Drug Strategy focused on three main areas: prevention, treatment, and enforcement (Nasr and Phillips 2014).[17] Enforcement is just one of the three pillars of Canada's strategy, but since this chapter is about political and legal aspects of drugs, its repercussions are our primary focus here.

Let us now turn to enforcement provisions that affect users. Under the CDSA, a person found to be in possession of opiates, cocaine, or PCP may be sentenced to up to seven years in prison. For cannabis, the penalty can be up to five years less a day, but if the quantity does not exceed 30 g (or 1 g of resin), it is a summary conviction offence with a maximum penalty of six months in prison or a $1,000 fine. For mescaline, LSD, and magic mushrooms, the maximum penalty is three years' imprisonment.

Although the CDSA is slightly less repressive than the previous law on drugs, at least when it comes to small amounts of cannabis, the number of drug cases reported by the police has been rising steadily for more than two decades in Canada. Erickson and her collaborators (2013) estimate the arrest rate for illicit drugs at 225 per 100,000 residents. Our analysis of Statistics Canada data indicates that police reported close to 57,000 drug-related offences in 1993, and almost twice that many, 109,000, in 2013 (see fig. 3.1) despite a steady decline in the overall crime rate (see fig. 3.2).

While 2 percent of all offences reported by the police in 1993 were drug-related, that proportion grew to 5 percent in 2013 (see fig. 3.3).

This is due primarily to arrests for simple possession of cannabis, which in 2013 accounted for 54 percent (58,965 offences) of all drug-related offences reported by police (see fig. 3.4). Ontario's Centre for Addiction and Mental Health (CAMH) estimates that more than 500,000 Canadians carry a criminal record for simple possession of cannabis (CAMH 2014).

A more in-depth analysis, however, actually reveals a downward trend in the proportion of all prosecuted offences that were drug-related. In 1995, 8 percent of prison sentences were for drug-related offences; in 2012, only 4 percent were. Drug-related offences resulting in probation dropped from 10 percent in 1995 to 4 percent in 2012; those resulting in fines slid from 10 percent in 1995 to 5 percent in 2012 (Statistics Canada 2013a). Simply put, more Canadians were being arrested but fewer were being sentenced.

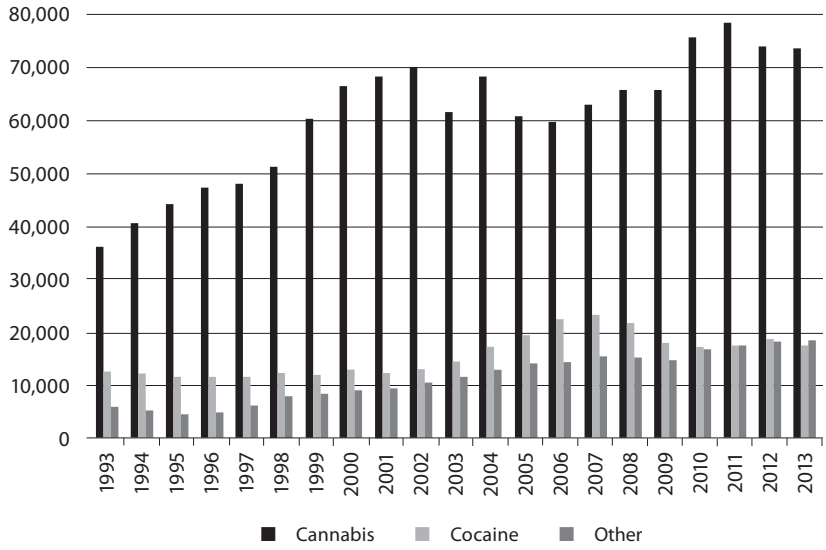

Figure 3.1. Drug-related offences reported by police in Canada from 1993 to 2013 (Statistics Canada 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009a, 2010, 2011, 2012a, 2013e, 2014).

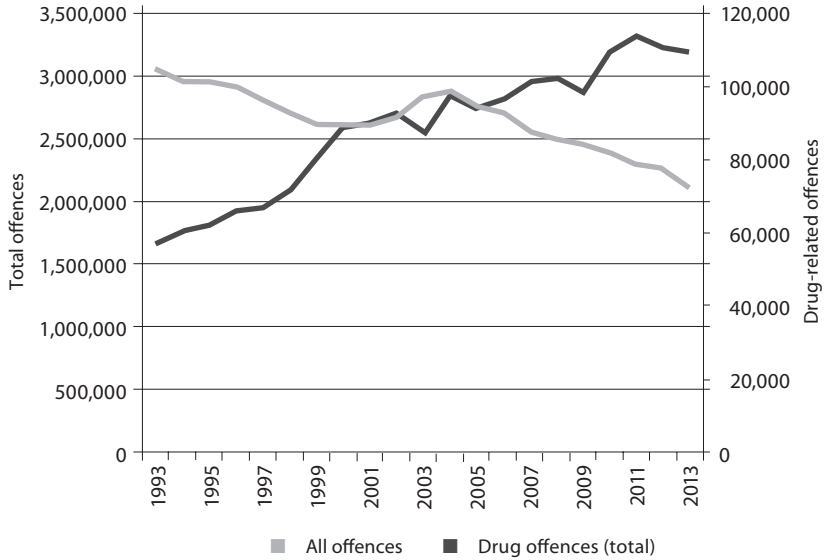

Figure 3.2. Offences reported by police in Canada from 1993 to 2013 and drug-related offences for the same period (Statistics Canada 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009a, 2009b, 2010, 2011, 2012, 2013e, 2014).

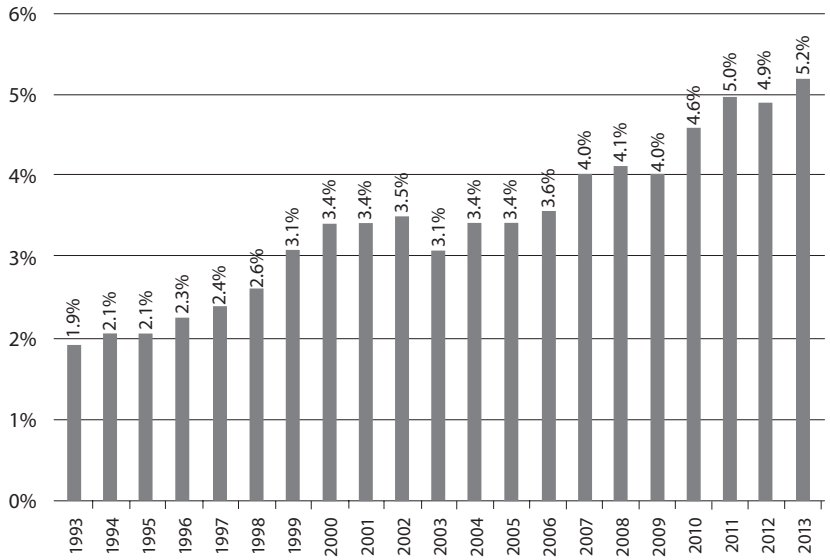

Figure 3.3. Drug-related offences as a proportion of total offences reported by police in Canada from 1993 to 2013 (Statistics Canada 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009a, 2009b, 2010, 2011, 2012, 2013e, 2014).

To better understand how existing laws affect drug users—particularly cannabis users, who are arrested in greater numbers than other drug users—we interviewed 165 regular users (who had consumed cannabis more than twice a month for at least five years) in four

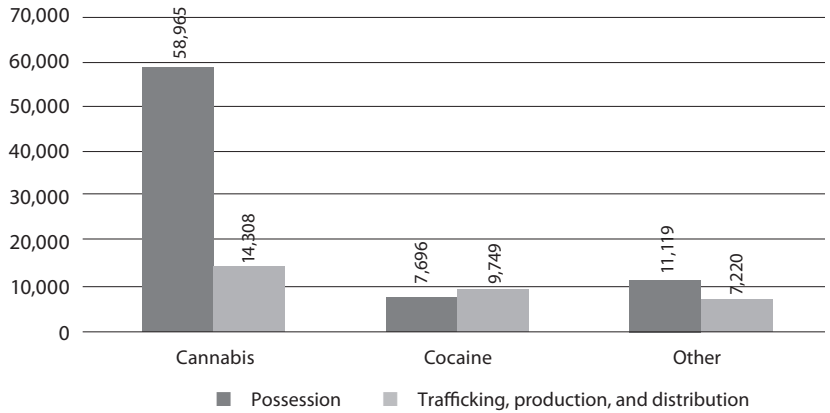

Figure 3.4. Number of police-reported offences related to possession, trafficking, production, and distribution of drugs in Canada in 2013, by substance (Statistics Canada 2014).

Canadian cities: Halifax, Montreal, Toronto, and Vancouver (Brochu et al. 2011). To be eligible for the study, users had to be relatively well integrated socially (regular employment or studies). More than half the participants reported annual household incomes over $35,000, which is much higher than the average income of previous samples made up of drug-dependent people in treatment. The interviews (which lasted between forty and seventy minutes) revealed that these users, who smoked an average of twice a day, were rarely arrested. When we read the existing legislation to them, the respondents were surprised and told us very clearly that neither their own experience nor that of people they knew was consistent with the law. We should point out that very few (10 percent) of the people in our sample used cannabis in public places. The vast majority used it at home (95 percent) or at a friend's place (78 percent).

To gain a deeper understanding of how the law affects cannabis users, we compared the number of self-reported users with the number of arrests for simple cannabis possession for years in which prevalence studies were conducted. Figure 3.5 substantiates the perceptions of the people interviewed by Brochu and his fellow researchers (2011) because the number of people arrested is miniscule (between 1 percent and 2 percent) compared to the number of people who reported using cannabis that same year (see fig. 3.6).

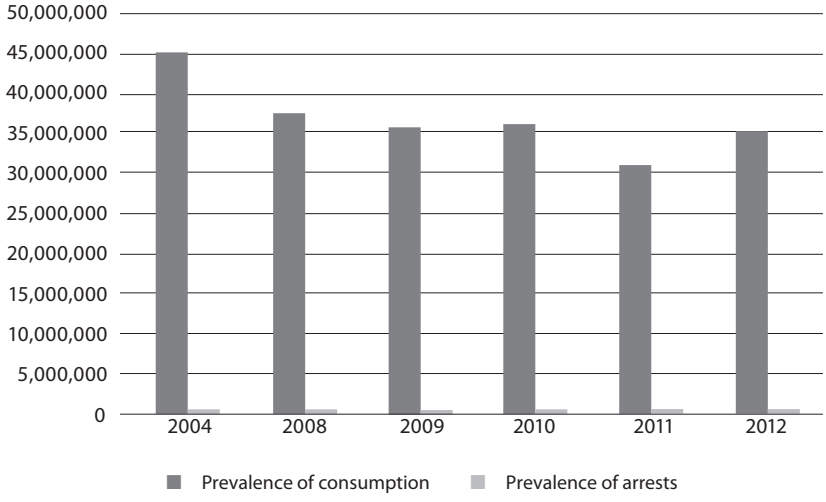

Figure 3.5. Prevalence of cannabis consumption and prevalence of arrests for simple cannabis possession from 2004 to 2012 in Canada (Health Canada 2013c; Statistics Canada 2009a, 2010, 2011, 2012, 2013c, 2013d, 2013e, 2014).

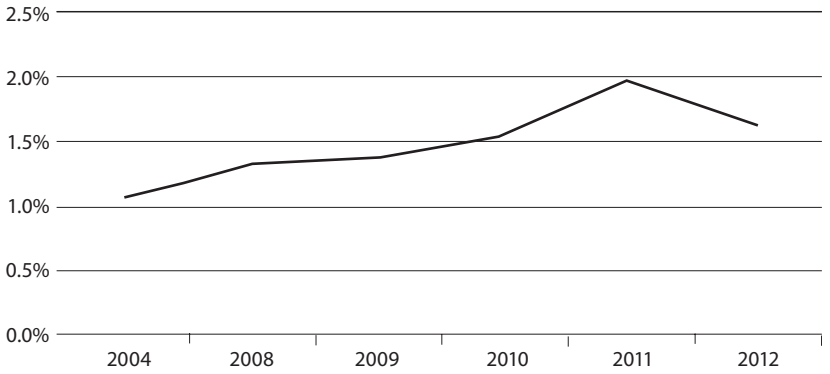

Figure 3.6. Simple cannabis possession offences as a percentage of the number of cannabis users in Canada from 2004 to 2012 (Health Canada 2013c; Statistics Canada 2009a, 2010, 2011, 2012, 2013c, 2013e, 2014).

This suggests that the individuals arrested under the CDSA are either the most visible users (other offences, consumption in public places) or the most marginalized (criminal record, homeless).

The percentage of arrests varies from one Canadian province to another. In 2012, the rate of cannabis-related offences as a percentage of the number of users was 1 percent on Prince Edward Island but more than twice that (3 percent) in Saskatchewan (table 3.1). This federal law appears to be less strictly enforced in some provinces than in others.

The CDSA has not gone unchallenged. In 2000, *R. v. Parker*, which involved a person with epilepsy who wanted legal access to cannabis to ease his suffering, led to the implementation of the Marihuana Medical Access Regulations, replaced in 2013 by the Marihuana for Medical Purposes Regulations (MMPR), which were themselves replaced by the Access to Cannabis for Medical Purposes Regulations in 2016. The regulations set out the conditions for access to and production of dried marijuana for medical purposes. To register with a licensed producer, individuals must follow this procedure: (1) consult with a doctor, (2) obtain a medical document stipulating the daily quantity authorized, and (3) register as a client and order the quantity required from a licensed producer.[18] In other words, under the regulations, Canadians may purchase marijuana for medical purposes if a doctor agrees to sign an official document authorizing them to purchase a specific quantity of the substance from a licensed producer (Nasr and Phillips 2014). At the time of writing, there were thirty-five licensed marijuana growers in Canada, seventeen of them

Table 3.1. Number of cannabis-related offences and number of cannabis users (previous twelve months) reported in 2012 in Canada, by province.

Provinces[1]	Number of cannabis-related offences	Number of cannabis users	Offences as a percentage of cannabis users
Newfoundland and Labrador	854	57,953	1.5%
Prince Edward Island	186	15,388	1.2%
Nova Scotia	2,378	114,352	2.1%
New Brunswick	1,300	64,345	2.0%
Quebec	14,825	727,565	2.0%
Ontario	22,123	1,220,492	1.8%
Manitoba	1,935	165,004	1.2%
Saskatchewan	3,449	110,930	3.1%
Alberta	7,412	443,316	1.7%
British Columbia	17,670	626,977	2.8%

1 Prevalence of cannabis users is available for Canadians provinces, not territories.
Sources: Health Canada (2012) and Statistics Canada (2013a, 2013c).

in Ontario. Health Canada regularly updates the number of licensed producers on its website.[19] The 2013 regulations were challenged in Federal Court, which in February 2016 struck down the provisions prohibiting patients from growing their own marijuana at home. Justice Michael Phelan found the MMPR to be unconstitutional, so some 40,000 Canadians with prescriptions for medical marijuana can now grow their own plants at home under the Access to Cannabis for Medical Purposes Regulations.

Europe

A number of European countries have adopted a more tolerant approach to drug users. In the United Kingdom, police can refer offenders to treatment services. Other countries, such as France, Norway, and the Republic of Malta, suspend prosecution while individuals attend courses on the dangers of drugs or motivational interviewing sessions (EMCDDA 2015). Let us take a brief look at the Netherlands and Portugal as examples of countries that have opted for liberalization.

The Netherlands

Contrary to what many tourists think, buying and possessing cannabis is not legal in the Netherlands, but it has been tolerated since 1976. People can purchase cannabis for personal use (less than 5 g) in one of the many coffee shops (businesses with special licences) that are open about what they sell, even though advertising is forbidden. Most of these establishments have a bar serving non-alcoholic beverages and a counter for cannabis sales. There is usually a menu with a variety of cannabis and hashish options. Prices vary from one coffee shop to the next, but one can generally purchase a gram of one's favourite strain for €5. Bongs are generally available upon request. More information about coffee shops is available on the City of Amsterdam's official website. At the time of writing, the website offered the following information:

> Coffee shops are, first and foremost, social spaces. They exist for the sale and consumption of cannabis, but they are also about atmosphere and meeting people, just like cafés and bars. Coffee shops are an integral part of Amsterdam's urban landscape; they contribute to the city's charm and reputation for tolerance. Coffee shops invite patrons to enjoy an alternative ambiance even if they are there just to drink coffee. Alcoholic beverages are generally prohibited, but coffee and tea are available, often alongside a variety of baked goods. People can hang out, have a good time, watch the world go by, read a magazine, and cross paths with a diverse mix of people.[20]

Coffee-shop cannabis sales do not have legal status but are tolerated to a point. A coffee shop can be shut down for selling to minors, if its clients disturb the peace, if it sells more than the maximum amount per transaction, or if so-called hard drugs are found on the premises.

Consumption in public places is subject to relatively strict regulation. Users may not disturb the peace or consume cannabis in the presence of minors. Possession in excess of 5 g is subject to a fine; possession in excess of 30 g is an indictable offence.

It is important to note that the Netherlands' liberal cannabis policy has not been associated with an increase in cannabis use. The Dutch model has, however, separated marijuana sales from sales of other drugs (CAMH 2014; Van Ooyen-Houben 2008). A study comparing the prevalence of cannabis use among high school students in

the United States, Canada, and the Netherlands found no difference between the three countries (Simons-Morton et al. 2010). If we were to criticize anything, it would be that, as with decriminalization measures elsewhere, cannabis production is illegal in the Dutch regulatory framework, which leaves the supply part of the equation and its attendant profits in the hands of criminal organizations.

Portugal

Portugal opted for a different model: decriminalization of all drugs (CAMH 2014; Greenwald 2009). Drug use is still prohibited in Portugal, but the possession of small quantities was decriminalized on November 29, 2000 (effective July 1, 2001) (Domosławski 2011). It is important to note that a de facto decriminalization policy had been in place since the 1990s, and fines were the typical penalty for drug possession (Laqueur 2014). The law does not distinguish between so-called hard and soft drugs (Greenwald 2009), and authorizes the possession of amounts sufficient for one person for ten days (e.g., 1 g of heroin, 2 g of cocaine, 5 g of hashish, 25 g of cannabis). Violations of the rules are considered administrative, not criminal, offences. In keeping with a public-health orientation, violations are now adjudicated by "commissions for the dissuasion of drug addiction." Three-member commissions in each region are made up of legal advisors, medical professionals, and social workers. Commission members try to understand the user's family background and economic situation, reasons for drug use, drug use history, and whether there are addiction issues (Domosławski 2011). If addiction is a factor, users are referred to treatment services. If not, in the case of a first offence, the proceedings are suspended for two years once the offender has been informed of the dangers of drug abuse and the consequences of repeat offences. In the case of a repeat offence, the commission may impose fines ranging from €25 euros to €150, as well as non-monetary penalties (community service) (Greenwald 2009; Senate of France 2002). Significantly, from both the offender's and society's perspective, the commission process does not carry the same stigma as a criminal conviction (Domosławski 2011). Acquiring and possessing small quantities of drugs for personal use is tolerated. The law is designed to help drug-dependent people get treatment.

Once the new drug law came into force, far fewer individuals faced criminal charges, which relieved Portuguese courts of a

substantial portion of their workload, and there was no increase in the prevalence of problem substance use (CAMH 2014; EMCDDA 2011; Greenwald 2009; Hughes and Stevens 2010; Quintas 2011; Tavares and Portugal 2012). Although substances became more accessible (cheaper), and drug use increased slightly (though no more in Portugal than in Spain and Italy), decriminalization has enabled public health authorities to intervene with heavy users earlier and has enhanced collaboration among addiction service providers (Domosławski 2011; Hughes and Stevens 2007, 2010). Finally, reported recidivism rates are surprisingly low (8 percent) (Domosławski 2011).

One drawback may be that a substantial majority (74 percent) of the individuals appearing before the commissions were arrested for cannabis possession (Domosławski 2011). Certainly cannabis is the most prevalent drug, but are these the people most in need of a conversation with commission members? It is also important to note that, although monetary fines are relatively small and are imposed infrequently, they can have a much greater negative impact on people from underprivileged socio-economic backgrounds (Domosławski 2011). Lastly, it is worth pointing out that consumers still have no choice but to do business with the criminal element because cultivating and selling drugs remains illegal. Nevertheless, Portugal stands out for two reasons. First, it decriminalized *all* drugs, thus eliminating the artificial distinction between soft and hard drugs. Second, and most importantly, Portugal's policy is truly public-health driven.

* * *

Many European countries have changed their cannabis laws since the early 2000s. The European Monitoring Centre for Drugs and Drug Addiction, or EMCDDA, carried out an interesting exercise that involved compiling and comparing the prevalence of psychoactive substance use before countries relaxed their laws or, conversely, began to impose harsher penalties. The EMCDDA's 2011 report concludes that new laws have very little impact on people's drug use. This suggests that enforcing tough laws may not be the best way to curb consumption, since they do almost nothing to deter people from using drugs.

The Americas

Strikingly different approaches prevail in the Americas. Whereas decriminalization is the most common liberalization policy in Europe, the spread of cannabis legalization has been slow in North America, often contrasting sharply with more repressive measures in neighbouring jurisdictions. The following is a brief overview of the situation in a number of countries, including, of course, Canada and the United States.

The United States

At the time of writing, twenty-three states and the District of Columbia have legalized cannabis for medical purposes (INCB 2015). In November 2012, four states and the District of Columbia took their drug liberalization policies a step further. Adults in those jurisdictions are now permitted to consume cannabis recreationally. In those states, cannabis is now treated like alcohol and tobacco despite a federal statute that prohibits the production, trafficking, and even possession of cannabis (INCB 2015). In a number of states, it is now legal to grow a certain number of plants per individual and, in some states, even to sell cannabis. Licensed shops can sell up to 28 g to adults (aged twenty-one or older with ID) for consumption in their own homes. Consumption in public places is prohibited. Washington State's legalization model is slightly different. As of June 2014, people can buy up to 28 g of marijuana from a licensed retailer, but only people who use cannabis for medical purposes can grow their own. In contrast, in the District of Columbia, retail sales are permitted for medical use only; recreational users must grow their own plants (up to three mature plants at a time). Oregon phased in Colorado's model: in 2015, it authorized the cultivation of up to four plants per household; in 2016, it legalized retail sale for recreational use.

Colorado was the first state to legalize cannabis for recreational use in the United States and now serves as a model to several others. Let us look briefly at its legalization model. First of all, the government does not produce cannabis but authorizes the cultivation, processing, and sale of it. When we visited Colorado in February 2016, the City of Denver had issued 557 licences for cultivation, 121 licences for marijuana-infused product manufacturing (chocolates, candies, cookies, juices, etc.), 326 retail sales licences in 215 stores, and 9 licences for

private laboratories that analyze the THC content of retail products. According to a March 10, 2014, article in the *Huffington Post*, the state collected $2 million in a single month thanks to cannabis legalization. That kind of revenue could make legalization attractive to governments that are constantly looking for new sources of income. It is our belief, however, that drug policies should not be profit-driven because things could get out of hand. There are ethical considerations involved, and governments must understand that legalization has to go hand in hand with regulation (licensing, inspection, and such) and adequate and effective prevention.

Uruguay

In December 2013, Uruguay passed an act regulating the importation, production, stocking, sale, and distribution of cannabis (INCB 2015). According to Room (2014), the act, which met with strong internal opposition, "permits three forms of cultivation: up to six plants at home; through users' co-operatives . . . and for licensed producers who must sell to the government" (p. 346). The law also allows individuals who add their names to a confidential registry (fingerprints are used as ID) to purchase up to 40 g per month from a licensed club or pharmacy. Uruguay wants to prevent pot tourism, so foreigners cannot sign up for the registry.

These legalization measures came into force too recently for us to assess their impact. Nevertheless, as the International Narcotics Control Board states in its 2015 report, "The Board notes that this legislation is contrary to the provisions of the international drug control conventions, specifically article 4, paragraph (*c*), and article 36 of the 1961 Convention as amended by the 1972 Protocol and article 3, paragraph (1) (*a*), of the 1988 Convention" (p. 62).[21]

Canada

In Canada, a commission and two committees were set up to analyze federal laws and policies and make recommendations to improve them.

The first, the Commission of Inquiry into the Non-Medical Use of Drugs chaired by Judge Le Dain (the Le Dain Commission), visited twenty-seven cities and twenty-three universities from 1969 to 1972. The commissioners heard from 639 witnesses and read 14,600 articles,

books, and briefs. Their analysis quickly led them to conclude that cannabis should be treated differently from other illegal drugs, so they prepared a separate report for it affirming that there was no scientific basis for cannabis prohibition, which was costly and ineffective. The commissioners recommended removing the prohibition against cannabis possession (Commission of Inquiry into the Non-Medical Use of Drugs 1972). In its final report (1973), the commission recommended gradually decriminalizing non-medical use of drugs, repealing criminalization of simple possession of cannabis, reducing penalties for other cannabis-related offences, and maintaining other penalties for drug offences. For opiate-dependent people, the commissioners recommended improving access to treatment rather than criminal sanctions. Finally, the commissioners recommended that Canada adopt policies to discourage the non-medical use of drugs and that sanctions fit the crime. Two minority reports were issued, one by Commissioner Bertrand and the other by Commissioner Campbell. The former endorsed a more liberal orientation, advocating for drug legalization; the latter took a more conservative view of the problem and called for a tougher stance on enforcement. The commission's work was a representation of the broader conversation happening in the late 1960s about the relevance of Canada's drug policies, particularly those relating to cannabis. It resulted in a modest bill to relax penalties for simple possession of cannabis, Bill S-19, which was introduced and passed in the Senate in 1974 but did not get past first reading in the House of Commons (Bryan and Crawshaw 1988).

Thirty years later, two important committees were established to study Canada's drug legislation once again: the Senate Special Committee on Illegal Drugs and the House of Commons Special Committee on the Non-Medical Use of Drugs.

The Senate Special Committee on Illegal Drugs (2002) heard from 234 experts and studied the twenty-three reports it received. Among other things, it found that: (1) the vast majority of cannabis users use the drug on an experimental or occasional basis (10 percent become regular users, and 5 percent to 10 percent develop a dependence); (2) cannabis is less harmful than alcohol and tobacco; (3) cannabis does not lead to the use of so-called hard drugs; and (4) cannabis prohibition is a significant drain on the public purse, particularly in terms of law enforcement. The committee concluded its report with a series of recommendations, including the adoption of an integrated drug policy (recommendation 5), the legalization of cannabis for

therapeutic and recreational use (recommendation 6), and amnesty for any person convicted of possession of cannabis under current or past legislation (recommendation 7).

A few months later, the House of Commons set up the Special Committee on the Non-Medical Use of Drugs (2002). Committee members heard from 222 witnesses in ten Canadian cities. In its report, the committee expressed concern about the lack of good data on the use and harmful use of substances, which was a barrier to the development of optimal drug policies. The committee nevertheless concluded that "the consequences of a criminal conviction for simple possession of a cannabis product are disproportionate to the potential harms associated with personal use" (p. 129). The report ended with thirty-nine recommendations, including decriminalization of simple possession of cannabis. The committee recommended "that the Minister of Health and the Minister of Justice propose appropriate amendments to the *Controlled Drugs and Substances Act* and/or the *Criminal Code* to provide a wider range of sentencing options, including treatment, for substance-dependent individuals involved with the criminal justice system" (p. 101). Another notable recommendation was that "Correctional Service Canada undertake, as a pilot project, the establishment of two federal correctional facilities reserved for offenders who wish to serve their sentence in a substance-free environment with access to intensive treatment and support" (p. 106).

In the wake of the two reports, a bill to decriminalize the simple possession of cannabis was drawn up. Under Bill C-17 (2004), an individual caught with 15 g or less of cannabis would have been fined $150 ($100 for a person under eighteen). The fine for possession of a gram or less of cannabis resin (hashish) would have been $300 ($200 for a minor). The maximum punishment for possession with aggravating circumstances would have been $400 for an adult and $250 for a person under eighteen. However, because of a leadership change within the party in power, an election, and the arrival of a new, more conservative, governing party, the bill was never passed.

Despite these repeated calls for more lenient policies with respect to drug users, little has been done, and law enforcement costs in Canada now exceed $2 billion per year (Rehm et al. 2006). In 2015, Canada elected a Liberal government that promised to legalize cannabis, so the coming years could bring a number of developments on this score.

Different Concepts and Approaches

The Observatoire français des drogues et des toxicomanies produced a glossary of various legislative alternatives to repression (Obradovic 2011). Here are a few terms and brief definitions:

Legalization: Also known as *regulation*, legalization means making a particular behaviour legal. Under legalization, production, distribution, and possession are permitted, although they may be regulated by the government. This is the scenario in Uruguay.

Depenalization: Relaxing criminal sanctions. Depenalization may be de jure or de facto. In the first case, penal sanctions are removed from the law itself. De facto depenalization means not enforcing the sanctions provided for by law.

Decriminalization: Removing a behaviour from the sphere of criminal law. This is the case in Portugal.

As we can see, different legislative approaches are possible. Some people advocate for cracking down on dealers, and even users, while others prefer a more liberal stance. What factors inform an individual's or a society's position on this issue? Beauchesne (2011) produced an excellent analysis of the relationship between social values and drug-related criminal policies. Canadian laws have clearly been grounded in *legal moralism*: a virtuous state has a duty to impose the moral values of a particular group on the whole community for its own good, even if that means promulgating restrictive laws. Typically, drug users are blamed for their own problems: they get what they deserve. Where moral entrepreneurs' good advice fails to have the desired effect, criminal justice must step in to contain drug users' moral defects.

According to Beauchesne, the majority report of the Le Dain Commission exemplifies a somewhat more liberal position she calls *legal paternalism* because it views drug addicts not as people with moral defects who need to be put back on the straight and narrow but as people who are "sick." Here again, the "father knows best" state embarks on a social mission, forcing sick people to accept treatment or face criminal sanctions.

A third philosophy, which Beauchesne calls *legal liberalism*, is embodied in the Bertrand minority report of the Le Dain Commission and, more recently, the 2002 report of the Senate Special Committee on Illegal Drugs. Legal liberalism is rooted in humanism, social responsibility, and respect. The state is responsible for creating a safe

environment while protecting individual freedoms, so it must provide a safe environment for people to use drugs if that is what they choose to do.

Normalizing the Relationship With Users

Because psychoactive substances affect the central nervous system, mood, cognition, perception, and actions, their use must be regulated. Governments do this for tobacco and alcohol, and they must do it for cannabis, cocaine, and heroin. The issue is how best to regulate drugs that are currently illegal. Penal control has held sway for a century with its attendant deleterious effects (such as huge profits for criminals; no quality control for the drugs people use; development of new, stronger products; and marginalization of users). Given that the majority of young Quebeckers have consumed at least one illicit drug, if only experimentally, that the most commonly used illicit substance is cannabis, and that the majority of cannabis users will never become dependent on it, society should normalize its relations with drug users. In our view, normalization is the best way to prevent dependence.

As summarized by Parker (2005), "the concept of normalization was first utilized in respect of creating 'normal' living conditions for people with learning difficulties" (p. 205). As applied to our field of study, normalization refers to how deviant individuals—drug users, in this case—can be "included in many features of everyday life" (ibid.).

A harm reduction philosophy is an essential first step toward normalization. Harm reduction represents a major paradigm shift because it means redirecting resources away from persecuting users and toward providing a harm-free context of use (Gillet and Brochu 2006; Quirion 2001; Rozier and Vanasse 2000). As the name implies, harm reduction strategies focus on the consequences of use rather than the drug use itself (Fischer 2005). As such, the main objective of intervention is not abstinence or reduced consumption, though neither of those outcomes is ruled out if that is what the user wants. Abstinence is therefore not a prerequisite for action or a short- or medium-term objective. The fundamental values of this approach are humanism and pragmatism (Brisson 1997), so its supporters advocate for measures that combat the harmful effects of drug use. Humanism favours actions that respect individuals and their choices and reach out to people where they are. Pragmatism means taking effective

action to tackle the most urgent and harmful consequences of drug use. Harm reduction may involve making clean paraphernalia available to users (at needle and syringe exchange sites or through mobile sterile injection equipment distribution), opening safe consumption sites (with supervised injection services), or offering substitute drugs (e.g., methadone, buprenorphine, and L-alpha-acetylmethadol) or even medically prescribed heroin (as in the NAOMI project in Montreal and Vancouver). In many cases, such strategies have a major public health impact (Magrinelli Orsi and Brochu 2009b) and do not produce undesirable effects such as an increase in drug use or crime (Lasnier et al. 2010).

According to some studies (Brochu et al 2011; Cheung and Cheung 2006; Duff et al. 2012; Parker, Williams, and Aldridge 2002), there are signs that normalization is slowly taking place: high usage rates reported during major prevalence studies, substantial recreational use characterized by decision-making based on cost-benefit analyses, availability of drugs, and tolerance and accommodation on the part of non-users.

Nevertheless, Canadian policies in 2015 retain their prohibitionist slant, still seeking to control drug use through punitive, stigmatizing measures. This approach to managing a non-issue is not only ineffective as a deterrent, but also unsuited to the needs of the vast majority of users who are capable of managing their consumption (Erickson 2005). Existing North American drug policies generally attempt to address the most serious cases at the expense of the majority of users who engage in moderate recreational consumption (Erickson 2005; Parker 2005).

Certainly, the sale and use of drugs calls for some regulation with respect to the products themselves (quality, potency), context of use (points of sale, business hours), and who can buy them (age, primarily), but should anyone get a criminal record just for using drugs? Is jail really the best way to treat an addict? This is not how we treat people who use tobacco and alcohol, two substances whose socioeconomic and public health repercussions far outweigh those of illicit drugs (Rehm et al. 2007).

* * *

For a century, psychoactive substances were a thriving business. The twentieth century ushered in a new era of control over these products

and their users. The conversation about illicit drugs tends to focus on one substance: cannabis. It is, after all, the most widely used and controlled substance globally, as illustrated by Canadian arrest statistics. The fact is that most cannabis users limit themselves to occasional use and do not develop a dependence on it or any other substance. As a result, numerous reports have called for more lenient policies on certain drugs and on cannabis in particular.

Still, many countries, including Canada, continue to view illicit drug users as depraved or dissolute and treat them as offenders in the eyes of the law. Society may impose criminal sanctions to punish addicts and make them realize the harm they are doing to themselves, or, if it believes that the greater good (e.g., lowering costs, minimizing the spread of disease) is better served by treating addicts, it may offer (with varying degrees of coercion) services addicts need. Its approach is motivated more by economics than by humanism. This is clear from an analysis of the reasoning over the past twenty years that has led to funding for programs for drug-dependent people in Canada.

Like it or not, drug users are part of society and have the same rights as everyone else. They are human beings too. While circumstance, opportunity, and limitations may have led them down a different path, should we further marginalize them as a result? No. Rather, we must seek to understand their needs and their abilities and to walk alongside them. That is one of the goals Portugal's drug policy achieves.

As we have seen in Portugal and some American states recently, measures that take a more liberal approach to drug users appeal to people, many of whom have experimented with cannabis in what turned out to be just another harmless life experience. This indicates that normalization of drug use is gradually taking hold.

In the nineteenth century, drugs were widely and sometimes aggressively marketed. In the twentieth century, efforts to control drugs via criminalization marginalized countless users. Let us hope that the twenty-first century will witness the normalization of society's relationship with people who use substances that are, for the time being, illicit.

While simple possession of a drug for personal use may be a crime under existing laws, some users engage in other crimes. In the chapters that follow, we will examine why.

Notes

1. An association of English merchants, originally trading in spices and later importing Chinese tea, which held a monopoly on trade with Southeast Asia.
2. One chest equalled 64 kg.
3. Translation of "Durant la période qui sépare le premier édit de prohibition de 1729 du durcissement de la politique répressive des autorités impériales au tournant des années 1800-1810, une distinction était établie entre l'opium à fumer et l'opium médicinal. Alors que la fabrication, le commerce et la vente de l'un étaient interdits, l'autre était une substance légale."
4. Prohibition was first enacted in 1729 but opium imports continued (Wikipedia 2017).
5. Translation of "En juin 1840, une flotte britanno-indienne arrive au large des côtes chinoises. Les attaquants disposent d'une immense supériorité en armement et Canton tombe rapidement. Les troupes de Sa Majesté remontent le Yang-Tsé, prennent le contrôle du trafic sur le fleuve et privent ainsi le budget impérial des taxes que ce commerce lui procurait. Au bout de deux ans, les Qing plient."
6. Translation of "une escadre britannique remonte le Yangzi Jiang jusqu'à Nankin, obligeant le gouvernement de l'empereur Daoguang à capituler et à signer le traité de Nankin le 29 août 1842."
7. The drug trade had grown so large that people in England began to speak out against it. A Quaker-inspired lobbying group called the Anglo-Oriental Society for the Suppression of the Opium Trade was created.
8. Quakers in Great Britain and American missionaries returning from the Far East (Nadelmann 1990, 503).
9. Associations of doctors and pharmacists (ibid., 505).
10. Translation of "À cette époque, où le Chinois était synonyme d'« immonde opiomane » et de « péril jaune », les États-Unis votèrent, sous la pression des syndicats, les « exclusion laws », des lois visant à protéger les travailleurs américains."
11. Translation of "À la fin du XIXe siècle, toutefois, dans l'Ouest canadien, des groupes moraux puritains réclament des restrictions majeures dans ces domaines. Des évangélistes méthodistes, surtout, clament bien haut que les valeurs autres que protestantes, ou encore l'athéisme, ne doivent pas être tolérés, car cela amènera la destruction de la puissance anglo-saxonne. L'alcool, le sexe et l'opium sont, à cet égard, considérés comme les trois sources majeures de vice et de péché qui menacent la famille et le mode de vie anglo-saxon protestant…et blanc."
12. Germany, Austria-Hungary, China, United States of America, France, Italy, Persia [now Iran], Japan, Netherlands, Portugal, United Kingdom, Russia, and Siam [now Thailand] (UNODC 1959).
13. Translation of "La Commission vota neuf résolutions, qui peuvent sembler n'être que des vœux pieux, mais qui constituaient à l'époque un progrès phénoménal. Dans ces textes, la Commission reconnaissait le droit de la Chine de supprimer totalement l'abus et la production d'opium (résolution no 1). Elle recommandait la fermeture immédiate des fumeries (résolution no 7) et l'adoption de mesures draconiennes pour contrôler la production, la vente et la distribution de l'opium et de ses dérivés à l'échelon national (résolution no 5). Elle reconnaissait aussi la nécessité de prendre des mesures raisonnables pour empêcher l'expédition d'opium dans les pays qui en avaient interdit l'importation (résolution no 4)."
14. Used to manufacture heroin.
15. It is estimated that more than 60,000 people have been killed since the start of the war (translation of "On estime à plus de 60 000 le nombre de morts depuis le

début de cette guerre" [Légaré-Tremblay 2014]).

16. Translation of "Cette violence s'accompagne d'une création de nouvelles identités culturelles largement imprégnées des valeurs véhiculées par les réseaux criminels. La« narco-culture » glorifie le mode de vie des narcotrafiquants à travers des manifestations artistiques populaires, comme la musique et les telenovelas. Dans les narco-corridos (« chansons malades »), les criminels sont considérés comme des héros, des nouveaux riches qui triomphent dans un pays où domine la pauvreté."
17. Harm reduction was one of the four pillars of the National Drug Strategy, first released in 1987.
18. See http://www.hc-sc.gc.ca/dhp-mps/marihuana/access-acceder-eng.php.
19. See http://www.hc-sc.gc.ca/dhp-mps/marihuana/info/list-eng.php.
20. Translation of "Les coffee shops sont avant tout des lieux de convivialité ; leur fonction première est certes la vente et la consommation de cannabis, mais ils sont également des lieux d'atmosphère et de rencontre, tout comme les cafés ou les bars. Ces lieux font partie intégrante du paysage urbain d'Amsterdam, et confèrent à la ville son ambiance de tolérance et son charme. Les coffee shops offrent la possibilité de profiter d'une ambiance alternative, même si l'on n'y consomme qu'un simple café. Les boissons alcoolisées sont généralement prohibées, et l'on y boit des sélections de thé et café accompagnés bien souvent de gâteaux et tartes divers. On peut y passer un bon moment, admirer la vue sur la rue, lire un magazine, rencontrer une population cosmopolite." Accessed May 20, 2017, http://www.amsterdam.info/fr/coffeeshops/.
21. The 1961/1972 Convention is here: https://treaties.un.org/doc/Publication/UNTS/Volume%20976/volume-976-I-14152-English.pdf. The 1988 Convention is here (p. 127): https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf.