Section VI

The Control of Availability

INTRODUCTION

We are concerned here with the legal controls on the production and distribution of psychotropic drugs for legal and illegal purposes. In a subsequent section we consider legal controls with respect to the user of such drugs, including use of the law to punish the unauthorized possession of drugs for purposes other than distribution. Many regard the offence of simple possession as an aspect of the control of availability and may well consider the distinction between control of availability and control of the user an artificial one. In recent years, however, there has been an increasing disposition among those concerned with the problem of non-medical drug use to draw a distinction, for policy purposes, between distribution and use. While it is emphasized that supply and demand are closely related, and both must be successfully dealt with if there is to be an effective effort to deal with the problem of non-medical drug use, there has been increasing recognition that a different public policy may be appropriate with respect to the user, particularly the drug-dependent person, than that which is appropriate for the trafficker. This recognition is reflected in the provisions of international conventions offering the possibility of non-punitive alternatives to punishment, albeit of a compulsory nature, for purposes of treatment, education and rehabilitation of drug "abusers". For this reason it is felt to be convenient to analyse the legal controls of availability and the user in separate sections.

Canadian drug control policy operates within a framework of international policy. That policy is expressed to some extent in the form of international agreements, but it is also a matter of on-going cooperation between governmental agencies. There is an international community of opinion on drug control problems that influences national policies. This follows inevitably from the fact that both legitimate trade and the illicit traffic in drugs are international in scope, and the policies of one country can have consequences for other countries. It is very difficult, if not impossible, for one country to pursue an effective control policy without cooperation from other countries. This is because of the widely dispersed sources of production

in the world, the great variety of routes of distribution, and the relatively porous nature of customs frontiers.

The non-medical use of drugs in various forms which give rise to social concern is a world-wide phenomenon. The relative importance of different kinds of drug use—the predominant drugs involved, the extent and patterns of use, the social and economic context of use—vary from one country to another, but the problem cannot be confined within national boundaries. The drugs used in one country often originate in other countries. Drug users travel from one country to another, influencing the spread of use where they go. Thus we have world-wide production and distribution of drugs being used for non-medical purposes and a great deal of mobility in drug-using populations. The problem can only be effectively grappled with on an international scale by cooperation between nations.

Countries which refuse to cooperate in the suppression of illicit production of harmful drugs within their borders can make it virtually impossible for other countries to prevent the creation of a large illegal source of supply within their own territories. Countries in which there is a large overproduction of drugs for medical purposes can be a source of diversion of drugs to non-medical purposes in other countries. Countries which refuse to cooperate in law enforcement can be a means by which drug offenders may escape effective control. It is therefore appropriate that we begin with consideration of the international control system.

INTERNATIONAL CONTROL POLICY

International Drug Control Agencies

The Economic and Social Council of the United Nations has the general responsibility for developing and supervising the administration of international drug control policy. From time to time it receives directives or requests for policy development from the General Assembly, and its decisions and recommendations are subject to approval by the latter. Four agencies play an important role in assisting it to discharge its responsibility: the Commission on Narcotic Drugs; the World Health Organization; the International Narcotics Control Board; and the Narcotics Division of the Secretariat of the United Nations (referred to in practice as the Division of Narcotic Drugs).

The Commission on Narcotic Drugs makes policy recommendations to the Council, the Secretary General and governments. It submits reports and draft resolutions for adoption by the Council and makes decisions for its own guidance or action, or as suggestions for action by governments. One of the most important functions of the Commission has been the development and supervision of the international agreements for drug control, in particular the *Single Convention on Narcotic Drugs, 1961*,[1] and the *Convention on Psychotropic Substances*, 1971.[2] The membership of the Commis-

sion consists of thirty states chosen from among those which are important in the production or manufacture of drugs and those in which drug dependency or the illicit traffic in drugs constitutes an important problem. Canada has been a member of the Commission from the beginning.

The World Health Organization (WHO) is required by the international conventions to provide the Commission on Narcotic Drugs with an assessment of drugs from a medical and scientific point of view and with recommendations as to the appropriate control measures, if any, to be adopted with respect to a particular drug. These technical findings and recommendations of the WHO are developed by its Expert Committee on Drug Dependence. From time to time this committee and others appointed by the WHO for special purposes publish reports on matters of concern in the drug control field.

Under the *Single Convention,* the International Narcotics Control Board (INCB) supervises the administration of the system of annual estimates of drug requirements for medical and scientific purposes and the annual statistical returns of quantities acquired and consumed. The Board's function is to keep a watch on the quantities of drugs in circulation for approved purposes, to survey the effectiveness of international efforts to suppress the illicit traffic, and to note, and attempt to remedy, any failure of a member state to comply with the control provisions of the Convention. Where the Board has reason to believe that the aims of the Convention are being seriously endangered by reason of the failure of a country to carry out its provisions, or that a country is in danger of becoming an important area for illicit production, distribution or use, it is empowered to investigate and call upon the government concerned to adopt remedial measures. If the government concerned fails to cooperate the Board may report with recommendations to the Council, the Commission and the General Assembly. If necessary, the Board may recommend an embargo on distribution to and from the country concerned. The Board has similar functions and powers under the *Convention on Psychotropic Substances,* 1971, although there are some important differences in the extent of the control measures under the two conventions.

The Division of Narcotic Drugs is a section of the United Nations secretariat which assists the other agencies in the preparation and implementation of control policy. It prepares documentation and carries out a variety of other functions of an investigative, informational and advisory nature.

The Requirements of the International Agreements

The *Single Convention on Narcotic Drugs, 1961,* to which Canada is a party, applies to the opiate narcotics, including opium, heroin, morphine, codeine, pethidine (meperidine) and methadone, to cocaine, and to cannabis and cannabis resin (that is, marijuana and hashish), and to extracts and tincture of cannabis. It does not apply to THC, which is governed by the *Convention on Psychotropic Substances,* 1971.

The general object of the *Single Convention* is to restrict the drugs covered by it to medical and scientific purposes. In its preamble the Convention observes that "the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes", but that at the same time "addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind".

To meet the two objectives of a controlled use of these drugs for medical and scientific purposes and the suppression of their use for other purposes, the Convention calls for a general system of controls to be adopted by the member states. The essential purpose of these controls is to assure that the production of narcotics is limited to the reasonable requirements of the member states for medical and scientific purposes and that there is no leakage from the legal supply required for such purposes to an illicit market.

The controls include a requirement of licence for manufacture, import, export, and internal distribution, and a requirement of medical prescription for the supply of drugs to individuals. They also require that those involved in manufacture and distribution keep records of their transactions which can be verified by government authorities.

As indicated above, the system calls for annual estimates of the requirements of drugs for approved purposes. The International Narcotics Control Board may fix the estimates for any party who fails to supply them. Parties are required to remain within their estimates, and their performance in this regard is verified by annual reports of quantities acquired and consumed. Amendments to the *Single Convention* adopted in March 1972[3] have strengthened the controls over the cultivation of the opium poppy and the production of opium for legitimate purposes.

The drugs covered by the *Single Convention* are listed in four schedules. The principal one is Schedule I, which contains the major natural and synthetic opiate narcotics, cocaine and cannabis. Schedules II and III, which include certain of the less potent natural and synthetic opiate narcotics such as codeine and propoxyphene, are subject to somewhat less severe control regimes. Schedule IV contains drugs which are also included in Schedule I, such as cannabis and heroin, but with respect to which the parties are invited to adopt stricter measures, and in particular to restrict their use to *research* of a medical or scientific nature. In response to a recommendation by the World Health Organization, which was approved by the Commission on Narcotic Drugs in 1954, most states agreed to prohibit the manufacture and importation of heroin for medical purposes. The Canadian decision not to license the manufacture and importation of heroin went into effect on January 1, 1955.* Only a few parties to the *Single Convention*, including Great Britain, permit the use of heroin for medical purposes.

* *Debates*, House of Commons, Canada, June 1, 1954, p. 5313.

Drugs may be added to a schedule, removed from the Convention, or transferred from one schedule to another by the Commission on Narcotic Drugs, acting on the recommendations of the World Health Organization. The decisions of the Commission are subject to review by the Economic and Social Council at the request of any party.

The Expert Committee on Drug Dependence of the World Health Organization, in a series of annual reports, has attempted from time to time to throw light on the principles which govern its recommendations concerning control measures. In its Sixteenth Report the Expert Committee adopted a definition of "drug abuse" as, "Persistent or sporadic excessive drug use inconsistent with or unrelated to acceptable medical practice", and it defined "drug dependence" as "A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence".[4] In the same report the Committee indicated the following criteria for the decision as to whether a drug should be subject to control:

> There are two main conditions, at least one of which must exist for a drug to be considered in need of control:
>
> (1) The drug is known to be abused other than sporadically or in a local area and the effects of its abuse extend beyond the drug taker; in addition, its mode of spread involves communication between existing and potential drug takers, and an illicit traffic in it is developing;
>
> (2) It is planned to use the drug in medicine and experimental data show that there is a significant psychic or physical dependence liability; the drug is commercially available or may become so.
>
> If neither of these conditions is fulfilled, there is no need for an agent to come under consideration for control. [P. 11.]

The *Single Convention* requires the parties to it to make the following acts which have a bearing on availability punishable offences, when carried out intentionally and contrary to the provisions of the Convention: cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation. "Serious offences" are to be liable to "adequate punishment particularly by imprisonment or other penalties of deprivation of liberty".[5]

The *Convention on Psychotropic Substances,* 1971, applies to drugs not covered by the *Single Convention.* They are listed in four schedules. Schedule I contains the hallucinogens: DET, DMHP, DMT, LSD, mescaline, parahexyl (Pyrahexyl or Synhexyl), psilocine (psilocin or psilotsin), psilocybine (psilocybin), STP (DOM), and THC and all its isomers. Schedule II contains amphetamines and certain drugs with amphetamine-like action: amphetamine, dexamphetamine (dextroamphetamine), methamphetamine,

methylphenidate, and phenmetrazine. It also contains phencyclidine (PCP) which is not a stimulant and has no medical use in humans. It was originally introduced as an anesthetic and is now used only in veterinary medicine. PCP is commonly combined with LSD and is often represented as mescaline or THC on the illicit market in Canada. Pharmacologically this drug would be more appropriately included in Schedule I. Schedule III includes the short-acting barbiturates: amobarbital, cyclobarbital, pentobarbital, and secobarbital. It also includes glutethimide, which is a widely prescribed hypnotic. Schedule IV contains long-acting barbiturates, non-barbiturate sedative-hypnotics, minor tranquilizers and stimulant-anorectics: amfepramone (diethylpropion), barbital, ethchlorvynol, ethinamate, meprobamate, methaqualone, methylphenobarbital, methyprylon, phenobarbital, pipradrol and SPA. It is to be noted that Schedule IV does not include chlordiazepoxide (Librium®) and diazepam (Valium®), the two most widely used minor tranquilizers. These drugs were originally included in the draft protocol but were withdrawn over the strong objections of several states.

A psychotropic substance shall be considered for control under one of these schedules of the Convention if, in the opinion of the World Health Organization, it has the following attributes:

> (a) that the substance has the capacity to produce
>
> (i) (1) a state of dependence, and
>
> (2) central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or preception or mood, or
>
> (ii) similar abuse and similar ill effects as a substance in Schedule I, II, III or IV, and
>
> (b) that there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control....[9]

If the World Health Organization makes a finding to this effect, it is required to communicate to the Commission "an assessment of the substance, including the extent or likelihood of abuse, the degree of seriousness of the public health and social problem and the degree of usefulness of the substance in medical therapy, together with recommendations on control measures, if any, that would be appropriate in the light of its assessment".

Whereas under the *Single Convention* the Commission on Narcotic Drugs must either accept or reject the WHO recommendation as to appropriate control measures, under the *Convention on Psychotropic Substances* the Commission is free to adopt control measures different from those recommended by the WHO. On this point, the Convention provides:

> The Commission, taking into account the communication from the World Health Organization, whose assessments shall be determinative as to medical and scientific matters, and bearing in mind the economic, social, legal,

administrative and other factors it may consider relevant, may add the substance to Schedule I, II, III or IV. The Commission may seek further information from the World Health Organization or from other appropriate sources.[7]

In the case of a substance which is already included in one of the schedules, the Commission may decide, on the basis of the World Health Organization's opinion and the other factors indicated above, to transfer the substance from one schedule to another or to delete it from the schedules altogether.

As in the case of the *Single Convention,* decisions of the Commission on Narcotic Drugs with respect to the scheduling of drugs under the *Convention on Psychotropic Substances* are subject to review by the Economic and Social Council. There is also provision for relieving a party of certain obligations created by a decision of the Commission if it is unable to fulfil them. In such a case the party must, however, apply certain minimum controls.

The kinds of control contemplated by the *Convention on Psychotropic Substances* are similar to those under the *Single Convention*: licensing of manufacture and distribution, import and export permits, prescription, record-keeping, safeguards against theft or other diversion, inspection, and annual returns. An important difference between the two conventions is that the *Convention on Psychotropic Substances* does not require annual estimates of drug requirements.

The extent to which the various kinds of control are required under the *Convention on Psychotropic Substances* varies as between the different schedules. The strictest control measures are reserved for the hallucinogens in Schedule I. The parties are required to "prohibit all use" of such substances "except for scientific and very limited medical purposes by duly authorized persons, in medical or scientific establishments which are directly under the control of their Governments or specifically approved by them".[8] The Convention requires especially strict controls on their manufacture, distribution and possession for such purposes.

The parties are required to limit the manufacture, distribution and use of the drugs in Schedules II, III and IV to medical and scientific purposes. The drugs in these schedules, unlike those in Schedule I, are to be generally available for medical purposes, but in most cases subject to prescription. Their manufacture, import, export and other distribution are to be under licence or other similar control measures. The import and export of substances in Schedule I are to be carried out by governmental agency. In addition, there must be with respect to the drugs in Schedules I and II a prior exchange of authorizations between the governments of both the exporting and importing countries. This requirement is essentially the same as that provided by the *Single Convention* and is stricter than that required for the substances in Schedule III. It is sufficient, with respect to the latter, for the

government of the exporting country to send the authorities of the importing country a copy of the exporter's declaration within ninety days of the shipment. There is no special requirement for the import and export of the drugs in Schedule IV. A party to the Convention may, however, notify all other parties through the Secretary General that it prohibits the import into its country of one or more of the substances in Schedules II, III and IV. (It has direct control over the import of substances in Schedule I.) If a party has been notified of such a prohibition, it shall take measures to ensure that none of the substances specified in the notification is exported to the country of the notifying party. The desire for such international cooperation with respect to importation was one of the chief concerns behind the development of the *Convention on Psychotropic Substances.*

The Convention requires that records be kept by manufacturers, importers, exporters and wholesale distributors of drugs acquired, held in stock and disposed of by them. In the case of drugs in Schedule II (primarily amphetamines and drugs with amphetamine-like action), detailed records must also be kept by pharmacists, hospitals and scientific institutions of acquisition and disposal. In the case of drugs in Schedule III (short-acting barbiturates and drugs with similar action), parties are merely required to assure that information concerning acquisition and disposal by such persons or institutions is readily available. In the case of drugs in Schedule IV (various other sedatives and stimulants) the requirement is merely that manufacturers, importers and exporters keep records showing quantities manufactured, exported and imported.

The parties are required to furnish to the International Narcotics Control Board annual reports of quantities manufactured, exported, imported and held in stock by manufacturers, in the case of substances in Schedules I and II, and of quantities manufactured, exported and imported in the case of substances in Schedules III and IV.

The parties are further required to maintain a system of inspection of manufacturers, exporters, importers, and wholesale and retail distributors of psychotropic substances and of medical and scientific institutions which use these substances, and to assure that there is adequate precaution against theft or other diversion of drugs.

Apart from the very specific and strict controls applicable to the substances in Schedule I, the terms of the *Convention on Psychotropic Substances* appear to offer more flexibility to the parties than those of the *Single Convention.* Subject to the specific requirements referred to above, the general obligation of a party is to "limit by such measures as it considers appropriate the manufacture, export, import, distribution and stocks of, trade in, and use and possession of, substances in Schedules II, III and IV to medical and scientific purposes".[9] There is some flexibility with respect to the necessity of prescription in the case of substances in Schedules III and IV. Finally, article 22 of the Convention with respect to penal provisions does not indicate the specific kinds of conduct which must be made a

punishable offence, as does article 36 of the *Single Convention.* Instead, it refers generally to any action contrary to such legislation and regulations as the parties see fit to adopt in fulfilment of their obligations under the Convention. This would appear to offer more flexibility as to the choice of conduct which must be made a punishable offence. Paragraph 1.(a) of article 22 provides:

> 1. (a) Subject to its constitutional limitations, each Party shall treat as a punishable offence, when committed intentionally, any action contrary to a law or regulation adopted in pursuance of its obligations under this Convention, and shall ensure that serious offences shall be liable to adequate punishment, particularly by imprisonment or other penalty of deprivation of liberty.

Paragraph 1.(b) of article 22, which contemplates non-penal provisions of control for the user of psychotropic substances will be referred to in Section VII of this report, *Control of the User.*

CANADIAN LEGISLATIVE AND ADMINISTRATIVE PROVISIONS WITH RESPECT TO THE CONTROL OF AVAILABILITY

The Narcotic Control Act

The controls called for by the *Single Convention on Narcotic Drugs, 1961,* are provided in Canada primarily by the *Narcotic Control Act*[10] and the *Narcotic Control Regulations* made under the Act. The Act applies to the opiate narcotics, including heroin, to cocaine, and to cannabis in all its forms.*

The Act is framed in the traditional criminal law form, consisting of prohibitions, penalties and provisions concerning enforcement. It prohibits unauthorized importing and exporting, trafficking, possession for the purpose of trafficking, simple possession, and cultivation. The Regulations prescribe the conduct that is authorized with respect to the drugs covered by the Act. They establish a system of control over the distribution and use of the drugs for medical or scientific purposes. The system consists of licensing, prescription, record-keeping, safeguards against loss or theft, reporting, inspection and audit.

Licensed dealers.[11] A licence is required from the Minister of National Health and Welfare to engage in the manufacture or distribution of narcotics. A permit is required for the importation or exportation of narcotics and is valid only for the particular transaction for which it is issued. A licensed dealer may supply a narcotic drug only to another licensed dealer, a pharmacist, a practitioner (doctor, dentist or veterinarian), a hospital or another person authorized by the Act or Regulations to have possession of such a drug. He may only supply a drug upon receipt of a signed written order, and he must verify the signature of the person from whom he received

* See footnote concerning PCP on page 80.

the order, if it is unknown to him. He must keep a record of the full particulars of all drugs in which he deals, including name, quantity, sources and destination. The premises, manufacturing processes and conditions of storage, technical staff, inventories, and records of a licensed dealer are all subject to inspection by inspectors of the Department of National Health and Welfare. A licensed dealer must keep full and complete records for a period of at least two years in a form suitable for audit, and must supply the Department with any further information which it requires. He must notify the Department promptly of any changes in his technical staff, his manufacturing or storage premises, and his process and conditions of manufacture or storage. A licensed dealer must provide such protection against loss or theft of narcotics in his possession as may be required by the Minister and must report to the Minister any loss or theft of a narcotic within ten days of its discovery.

Pharmacists.[12] Pharmacists must keep full records of the drugs received by them, showing names, quantities, dates of receipt and particulars of the person from whom they are received. A pharmacist must not dispense any narcotic unless he has first received an order or prescription from a practitioner. The general rule with respect to narcotics is that a prescription must be in written form and signed by the practitioner, but there is a category of narcotics that may be dispensed on oral prescription. (Certain preparations containing codeine phosphate may be dispensed without prescription.) When the prescription is in writing the pharmacist must verify the signature of the practitioner if it is not known to him. In the case of an oral prescription the pharmacist must take reasonable precautions to satisfy himself that the person giving the prescription is a practitioner. A pharmacist may not refill a prescription for a narcotic. Pharmacists must keep a record of the particulars of all written and oral prescriptions filled by them and must send this information to the Department at regular intervals. The records of a pharmacist's transactions involving narcotic drugs must be kept for a period of at least two years and be available for inspection and audit at any time by inspectors of the Department. Like licensed dealers, pharmacists must take certain precautions against loss or theft of narcotics and must report any such loss or theft within ten days of its discovery.

Practitioners. A practitioner must not prescribe, administer, give, sell or furnish a narcotic to a person or animal unless the person or animal is a patient under his professional treatment and the narcotic is required for the condition for which the person or animal is receiving treatment.[13] In any prosecution for violation of this regulation the burden of proving these facts is on the practitioner. (In practice, there have been few prosecutions of practitioners in recent years; the Department generally takes the administrative action referred to below.) Practitioners must keep records in certain cases of drugs which they furnish for self-administration. They must also furnish such information as the Department may from time to time require concerning narcotic drugs in their possession or prescribed or administered

by them. Such records as they are required to keep must be retained by them for a period of at least two years and be available for inspection at any time by inspectors of the Department. Like licensed dealers and pharmacists, practitioners must take adequate steps to protect narcotics in their possession from loss or theft and must report any such loss or theft to the Department within ten days of its discovery.

Hospitals.[14] Hospitals must keep written records of narcotics received and dispensed by them. Such records must be kept for a period of at least two years and be available for inspection by inspectors of the Department. Hospitals must take precautions against loss or theft of narcotics and report any such loss or theft to the Department within ten days of its discovery. Narcotics may only be dispensed or administered in a hospital to a person who is under treatment as an inpatient or outpatient and upon the prescription or authorization of a practitioner.

Special regulations governing methadone. These regulations are described in Appendix G.1 *Methadone Control Program of the Government of Canada,* and are the subject of commentary in Section IX. Briefly, they require that a physician must be specially authorized by the Minister to be able to prescribe or administer methadone. Licensed dealers, pharmacists and hospitals can only act with respect to methadone on the prescription or order of a physician who has been so authorized.

Administrative action in the case of violation of the regulations by practitioners or pharmacists. The Parliament of Canada can control the availability of drugs (and thus the capacity of physicians and others to make use of them) through the exercise of its criminal law power, and to some extent, its power to regulate trade and commerce, but the general power to regulate the practice of medicine and pharmacy and to establish and regulate hospitals is provincial. Such regulation is carried out through the governing bodies of these professions in the provinces. Thus a full control over physicians and pharmacists with respect to the distribution of drugs requires provincial cooperation as well as federal action. Where the federal administrative authorities are of the opinion that practitioners or pharmacists are guilty of abuse in the distribution, prescription or administration of narcotics they may, after investigation and consultation with the provincial licensing authorities, impose conditions upon their right to purchase drugs.[15] The provincial licensing authority may take such action as it sees fit consequent upon the information furnished to it by the federal authorities.

Authorizations for purposes of research and drug identification and analysis.[16] The Department may authorize the purchase, possession and administration of narcotics for scientific purposes. Departmental procedures and policy with respect to approval of research proposals are discussed in Section XII *Research and Information.* The essential point to be noted here is that scientific research with respect to narcotics is controlled by ministerial discretion through control over the availability of the drugs required for

research. The Department may also authorize the possession of narcotics for purposes of drug identification or analysis. The Regulations permit any person to deliver a narcotic to a practitioner of medicine or to his agent for delivery to the Minister or his agent or to an analytic facility approved by him. (Formerly this right was restricted to a patient who was being treated for drug effects by the doctor to whom the drug was delivered.) We shall comment on facilities for drug identification and analysis in Section XII.

Summary of persons authorized to be in possession of narcotics.[17] The following persons are authorized to be in possession of narcotics when they have obtained them in accordance with the Regulations: licensed dealers, pharmacists, practitioners, hospitals, persons entitled to be in possession for purposes of research or drug identification or analysis, inspectors, police and members of the technical or scientific staff of a federal or provincial government department or a university, when such possession is required for their employment, and persons who are in possession for their own use, when they have obtained the narcotics from a practitioner or pharmacist.

"Prescription shopping".[18] It is forbidden for a person who has obtained a prescription or a narcotic to seek or receive another prescription or a narcotic from a different practitioner without disclosing to that practitioner particulars of every prescription or narcotic that he has obtained within the previous thirty days. This regulation is directed against the practice that is referred to as "prescription shopping", or "double doctoring".

Penalty for violation of Narcotic Control Regulations.[19] Any violation of the *Narcotic Control Regulations* is punishable on summary conviction by a fine not exceeding $500 or by imprisonment for a term not exceeding six months or by both fine and imprisonment.

The prohibitions in the Narcotic Control Act. In fulfilment of the obligation under the *Single Convention* to make certain unauthorized acts of production and distribution of narcotics punishable offences, the *Narcotic Control Act* prohibits unauthorized importing and exporting, trafficking, possession for the purpose of trafficking, and cultivation of the opium poppy. Unauthorized importing and exporting are indictable offences punishable by a maximum of life imprisonment and a minimum of seven years.[20] Trafficking and possession for the purpose of trafficking are indictable offences punishable by a maximum of life imprisonment.[21] Unauthorized cultivation of opium poppy is an indictable offence punishable by a maximum of imprisonment for seven years.[22] There is also liability to fine in any amount for all these offences.[23] Reference is made to Appendix F.3 for further details of the law with respect to these offences.

The Food and Drugs Act

The controls on availability called for by the *Convention on Psychotropic Substances*, 1971, are generally provided for in Canada by the *Food and Drugs Act*[24] and the *Food and Drug Regulations*.

With certain exceptions, the strong hallucinogens in Schedule I of the Convention are controlled under the designation of "restricted drugs" by the provisions of Part IV of the *Food and Drugs Act* and Part J of the *Food and Drug Regulations*. Schedule H (formerly Schedule J) of the Act lists the following restricted drugs: LSD, DET, DMT, MDA, MMDA, LBJ, harmaline, harmalol, STP(DOM) and various forms of dimethoxyamphetamine.

There are, however, important differences in the specific drugs covered by the international and Canadian drug schedules. THC and its isomers are included in Schedule I of the *Convention on Psychotropic Substances,* 1971, while cannabis and cannabis resin are governed by the *Single Convention on Narcotic Drugs, 1961*. All three forms of cannabis are presently regulated in Canada by the *Narcotic Control Act*. The drugs which Schedule I of the *Convention on Psychotropic Substances* and Schedule H of the *Food and Drugs Act* have in common are LSD, DET, DMT, and STP (DOM). A notable difference is that mescaline is in Schedule F of the *Food and Drug Regulations,* to which a less strict control regime applies than to the restricted drugs in Schedule H, and psilocybin is not included in any Canadian schedules.

Under the Act and Regulations the restricted drugs are not legally available for general medical use. The Regulations make provision, however, for the distribution and possession of these drugs for purposes of research in the form of clinical or laboratory investigation. There is also the same provision as in the case of narcotic drugs for possession of restricted drugs for purposes of identification and analysis.[25]

Essentially the same controls are applied to the restricted drugs to permit their use for the above purposes as are applied to the drugs governed by the *Narcotic Control Act*. Dealers may be licensed for the manufacture and distribution of restricted drugs for such purposes.[26] (At the present time, the only licensed dealer is within the government.) Licensed dealers may, with the permission of the Minister, sell restricted drugs to research institutions and hospitals for purposes of clinical and experimental investigation. Such institutions must keep records available for inspection of all restricted drugs received and used by them. Licensed dealers must keep detailed records of all restricted drugs handled by them. These records must be kept for a period of at least two years in a form suitable for auditing. A licensed dealer must permit inspection of his premises, processes and conditions of manufacture and storage, the qualifications of his technical staff, and his records. He must also supply any further information and permit any further inspection or audit that the Minister may require. He must take the same precautions against loss or theft as licensed dealers in narcotics.

Under Part IV of the *Food and Drugs Act*[27] trafficking and possession for the purpose of trafficking in restricted drugs are criminal offences punishable as follows:

> Upon summary conviction, by imprisonment for a term not exceeding eighteen months; and
>
> Upon indictment, by a term of imprisonment not exceeding ten years.

Trafficking under the *Food and Drugs Act* includes unauthorized importing or exporting. Reference is made to Appendix F.3 for further details on the law concerning these offences.

Some of the drugs in Schedules II, III and IV of the *Convention on Psychotropic Substances* are regulated as "controlled drugs" under Part III and Schedule G of the *Food and Drugs Act,* and some are regulated under the less strict controls of Schedule F of the *Food and Drug Regulations.* Schedule G of the Act, which includes the barbiturates as well as the amphetamines, lists the following drugs: amphetamine, barbituric acid and its derivatives, benzphetamine, methamphetamine, pentazocine, phendimetrazine, and phenmetrazine, and their respective salts.* Thus it includes Preludin® (phenmetrazine) but not Ritalin® (methylphenidate), which is included in Schedule II of the Convention but in Schedule F of the *Food and Drug Regulations.*

The short-acting barbiturates in Schedule III of the Convention—amobarbital, cyclobarbital, pentobarbital, and secobarbital—are included in the general reference to barbituric acid derivatives in Schedule G of the *Food and Drugs Act.* The hypnotic glutethimide, which is also in Schedule III of the Convention, is in Schedule F of the *Food and Drug Regulations.*

A few of the drugs in Schedule IV of the Convention—barbital, phenobarbital, and methylphenobarbital—are covered as "controlled drugs" by Part III of the *Food and Drugs Act.* The remainder are for the most part in Schedule F of the *Food and Drug Regulations.* The hypnotic chloral hydrate and the minor tranquilizers Librium® (chlordiazepoxide) and Valium® (diazepam), which were originally included in Schedule IV of the draft convention but later deleted, are all covered by Schedule F of the Regulations.

Controlled drugs under Part III of the Act are subject to essentially the same controls over their availability for medical and scientific purposes as those which govern the narcotics under the *Narcotic Control Regulations.* These include a licence for manufacturers and distributors, import and export permits, the requirement of prescription, record-keeping, safeguards against loss or theft, reporting, inspection and audit.[28] The main differences are that as a general rule a prescription for narcotics must be in writing, whereas it may be oral for controlled drugs, and a pharmacist may not refill a prescription for a narcotic, whereas he may refill one for a controlled drug if the physician has given explicit instructions for this purpose in the prescription.

Trafficking and possession for the purpose of trafficking in controlled drugs are punishable on summary conviction by imprisonment for a term not exceeding 18 months and upon indictment by imprisonment for a term not exceeding ten years.[29] Reference is made to Appendix F.3 for the law concerning these offences.

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* See footnote concerning methaqualone on page 102.

Special controls on the medical use of the amphetamines and amphetamine-like drugs. Under the controlled drug regulations the physician has until recently been the judge of the medical treatment for which these drugs are appropriate. The sole requirement has been that they be prescribed or administered for *bona fide* medical treatment and not for non-medical purposes. Recently, however, the Federal Government has gone further and has limited the medical uses for which the amphetamines and amphetamine-like drugs listed in Schedule G may be prescribed or administered.[30] Amphetamine, benzphetamine, methamphetamine, phenmetrazine, and phendimetrazine and their respective salts are classified as "designated drugs", and their use is confined to treatment of the following conditions in humans: narcolepsy, hyperkinetic disorders in children, mental retardation (minimal brain dysfunction), epilepsy, parkinsonism and hypotensive states associated with anesthesia. Their use in the treatment of animals is to be confined to the condition of depression of cardiac and respiratory centres. Full particulars of the use of these drugs in treatment, including name, address, age and sex of the patient, are to be furnished to the Minister of National Health and Welfare through the Bureau of Dangerous Drugs. If the treatment is to last more than thirty days practitioners are required to consult another practitioner for confirmation of the diagnosis of the patient's illness. The Minister may exceptionally grant authorization for the use of these drugs for other purposes if he considers such use to be in the public interest or the interest of science. These restrictions on the medical use of amphetamines and certain amphetamine-like drugs were developed by the government after consultation with advisory panels of medical experts.

As in the case of narcotics and restricted drugs, provision exists to permit the possession of controlled drugs for purposes of identification or analysis.[31]

Schedule F drugs. The drugs covered by Schedule F of the *Food and Drug Regulations*[32] are required for medical purposes. They are subject to the same general conditions* concerning quality, safety and accurate labelling as other drugs, and they may only be sold to a member of the public upon prescription. They may be sold without prescription to a drug manufacturer, a practitioner, a wholesale druggist, a registered pharmacist, a certified hospital, a federal or provincial government department, or any person authorized by the Director of the Health Protection Branch of the Department of National Health and Welfare.

The Regulations do not require a licence or permit for the manufacture, distribution, importation or exportation of a Schedule F drug. The only persons, however, who are permitted to import such a drug are practitioners, drug manufacturers, wholesale druggists, registered pharmacists and residents of a foreign country while visitors in Canada.

* All new drugs must comply with the Department's requirements of safety and efficacy before being put on the market.

The Regulations do not require the same record-keeping and accounting for inventories as in the case of narcotics, restricted drugs and controlled drugs although to some extent manufacturers and importers must keep records of distribution to facilitate recall of drugs. There is, however, no reporting of inventories as in the case of narcotics, controlled drugs and restricted drugs. Pharmacists must retain written prescriptions for a period of at least two years, and where the prescription is oral, the pharmacist must immediately reduce it to writing and keep the written record for a period of at least two years. Pharmacists are not required, however, to make regular reports of their transactions to the Department, as in the case of narcotics and controlled drugs. A prescription for a Schedule F drug must not be refilled unless the practitioner so directs, and it must not be refilled more than the number of times prescribed by the practitioner. A written record must be made on the original prescription of the date of refill, the quantity of drug dispensed, and the name of the person who has refilled the prescription.

The sale of Schedule F drugs to a member of the public without prescription is a punishable offence, but it does not carry as severe penalties as trafficking or possession for the purpose of trafficking in narcotics, controlled drugs or restricted drugs. It is punishable as follows:

> On summary conviction for a first offence by a fine not exceeding five hundred dollars or by imprisonment for a term not exceeding three months, or both, and for a subsequent offence by a fine not exceeding one thousand dollars or by imprisonment for a term not exceeding six months, or both; and
>
> On indictment, by a fine not exceeding five thousand dollars or by imprisonment for a term not exceeding three years, or both.[33]

To "sell" is defined by the *Food and Drugs Act* as including "sell, offer for sale, expose for sale, have in possession for sale, and distribute".[34] As in the case of controlled drugs in Schedule G of the Act, it is not an offence to be in unauthorized possession of Schedule F drugs for personal use.

Apart from the difference in the severity of the maximum penalties for illegal distribution, the chief differences in the regulations governing Schedules F and G is that manufacturers and dealers of Schedule F drugs do not require to be licensed, and there is no monitoring of their inventories, and pharmacists are not required to make regular reports of prescriptions to the Department.

The *Convention on Psychotropic Substances,* 1971, calls for more strict controls in some respects and less strict in others than the controls which presently apply to drugs on Schedule F of the *Food and Drug Regulations.* All but one of the drugs in Schedule III of the Convention—glutethimide—are presently regulated in Canada as controlled drugs under Schedule G of the *Food and Drugs Act.* The regulations applicable to the controlled drugs fully meet the requirements of the Convention with respect to drugs on Schedule III, with the possible exception of the special requirements concerning export. Glutethimide and the drugs in Schedule IV of the Convention

which are presently in Schedule F of the *Food and Drug Regulations* are subject to stricter controls concerning record-keeping by manufacturers, importers and exporters than those which apply under Schedule F but to less strict controls concerning record-keeping by pharmacists. The Convention requires that records be kept by manufacturers, importers and exporters of drugs manufactured, imported and exported (although not, as in the case of drugs in Schedules II and III, of disposals as well as acquisitions), whereas no such records are presently required for these drugs by the Canadian regulations. On the other hand, the Canadian regulations require pharmacists to keep records of prescriptions for the drugs in Schedule IV of the Convention, whereas there is no such requirement under the Convention. In the case of drugs in Schedules III and IV, a party to the Convention is also required to make annual reports to the International Narcotics Control Board of the quantities of such drugs manufactured, imported and exported.

Over-the-counter drugs. Over-the-counter drugs are those drugs used for medical purposes which are not on any schedule of the *Food and Drugs Act.* They are subject to the general regulations concerning manufacturing, packaging, labelling, advertising and sale, but they do not require prescription, and dealers in them do not have to be licensed. Nor is there any requirement of record-keeping and reporting. A special category of the over-the-counter drugs are the proprietary or patent medicines—those which are not found in any recognized pharmacopoeia or formulary, or upon the label of which is not printed in a conspicuous manner the true formula or list of medical ingredients contained in them (in other words, those with a secret formula). They are governed by the *Proprietary or Patent Medicine Act.*[35] Basically, this Act is concerned with prohibiting the use of certain drugs in such medicines and requiring clear notice of the use of other drugs which are listed in the Schedule of the Act. Manufacturers of such secret formula medicines, and their agents, must obtain a certificate of registration from the Minister of National Health and Welfare. To obtain such a certificate they must furnish the Minister with certain information concerning the medicines which they propose to sell. Manufacturers must apply for annual licences to sell their medicines. It is forbidden to manufacture or distribute a proprietary or patent medicine containing opium or its derivatives for internal use. It is also forbidden to manufacture or distribute such a medicine if it contains cocaine or if it contains alcohol in excess of the amount required as a solvent or preservative, or which is not sufficiently medicated to make it unfit for use as a beverage. The quantity used of other drugs listed in the Schedule of the Act must not exceed that approved by an Advisory Board appointed by the Minister of National Health and Welfare. The Board also prescribes the maximum single and daily doses of any product containing a drug on the Schedule. The Act provides for the kind of information that must be shown on labels and the kinds of advertising or claims of efficacy that are forbidden.

Prohibited drugs. The *Food and Drugs Act*[36] prohibits the sale for any purpose of the drugs listed in Schedule F (formerly H) of the Act (as distinct

from Schedule F of the Regulations). At the present time the only drug listed in this schedule is thalidomide. (LSD was once in this schedule.) The manufacture, importation and distribution of other drugs, such as heroin (and cannabis, for all purposes other than research) are effectively prohibited by the administrative decision not to grant a licence or permit for such purpose.

The Criteria Governing the Scheduling of Drugs for Control Purposes

There has been no attempt to formulate and express clear criteria for the scheduling decisions which must be taken by the administrative authorities. Basically, however, such decisions would appear to be guided by consideration of a drug's necessity or utility for medical purposes, its potential for producing harm, and its actual and potential "abuse" for non-medical purposes. The authorities tend to base their decisions on what they judge to be the actual extent of the problem presented by each drug rather than on the application of a set of general criteria. On the whole, the Canadian approach tends to be a pragmatic one, although as indicated above, there is a fairly comprehensive framework of controls into which drugs can be placed, according to the particular problems which they present. (In addition to the schedules of the *Food and Drugs Act* which have been referred to, there are other schedules which are not of importance for our purposes.)

The kinds of issue confronting the authorities are reflected in the decision to place Preludin® on Schedule G of the *Food and Drugs Act* as a "controlled drug", but to leave Ritalin® and certain other amphetamine-like compounds as prescription drugs subject to less strict controls on Schedule F of the *Food and Drug Regulations.* A further example is the growing problem presented by the non-medical use of PCP (phencylidine), which, at the time of preparation of this report, was still on Schedule F of the Regulations, although the possible necessity of re-scheduling it was being given careful consideration by the Department.*

Administration of the Canadian Controls on Availability for Medical and Scientific Purposes

The Bureau of Dangerous Drugs of the Health Protection Branch of the Department of National Health and Welfare is responsible for administering the controls on the availability for medical or scientific purposes of narcotics, controlled drugs and restricted drugs. The Bureau is headed by a Director who reports to the Director General, Drugs Directorate of the Health Protection Branch.

Licensed dealers and pharmacists make regular reports to the Bureau with respect to their transactions in narcotics and controlled drugs. Licensed

* PCP was transferred in June 1973 from Schedule F of the *Food and Drug Regulations* to the Schedule of the *Narcotic Control Act.*

dealers report monthly and pharmacists report every two months. Practitioners and hospitals also report their administration of methadone. In addition, the records and inventory of all those who are required to keep records by the *Narcotic Control Regulations* and the *Food and Drug Regulations* are subject to unannounced inspection and audit. The Bureau of Dangerous Drugs has a force of about thirty-five inspectors for such purposes. (This is in addition to the large force of inspectors in the Department for other purposes under the *Food and Drugs Act.*) The policy is to inspect all outlets at least once a year, although it is difficult to meet this objective. There are about 200 licensed dealers in narcotics, about 250 licensed dealers in controlled drugs and about 4700 pharmacies. An increasing amount of the time of inspectors is also taken up assisting the police in the investigation and preparation of cases of forged prescriptions, "double doctoring" and theft.

Prescriptions are monitored in the Bureau by a special staff divided into working groups of four. The Bureau receives notice of over three million prescriptions a year. The monitoring system is not automated, and although the staff have developed considerable skill and judgment in detecting abuses, the system has serious limitations. When the "work sheets" compiled to show the prescription records of individual patients are filed away (or "passed along", in the words of the Bureau) they are for all practical purposes irretrievable. Consideration is presently being given to the possible automation of the system.

Surveillance of distributors of drugs on Schedule F of the *Food and Drug Regulations,* including pharmacies, to make sure that they are complying with the Regulations is carried out by another branch of the Department of National Health and Welfare. For example, inspectors appear from time to time as members of the public to make sure that pharmacists are not selling Schedule F drugs without prescription. In cases of first offence there is usually a report to the provincial regulatory body. In cases of second offence there is a prosecution.

Other Legal Controls on Availability

For the details of federal and provincial controls on the availability of alcohol and tobacco the reader is referred to Appendices B.6 and B.9. (There is omission, in Appendix B.6, of reference to the *Canada Temperance Act,* a federal statute which provides for prohibition of sale of alcohol in any municipality in which it is approved by referendum. For the constitutional basis of this statute see Appendix F.1 *The Constitutional Framework.*)

Volatile solvents are subject to certain federal regulations requiring warning of danger, and in one case to provincial legislation prohibiting their distribution (and use) for purposes of intoxication (see Appendix B.8).

There are miscellaneous provisions in provincial laws governing the availability of drugs for medical purposes. Provincial pharmacy acts, for

example, stipulate the drugs which may be distributed only by pharmacists. They also generally stipulate the drugs which may be sold only on prescription, although this raises a possible question of conflict with the federal legislation. In case of conflict between federal and provincial provisions on this point the federal provisions will prevail (see Appendix F.1 *The Constitutional Framework*).

The regulation of advertising is discussed in Section XIV *The Mass Media.*

LAW ENFORCEMENT AGAINST ILLICIT PRODUCTION AND TRAFFICKING

International Cooperation

The parties to the international conventions are generally committed to cooperate with one another and with the international drug control agencies to suppress the illicit traffic in drugs. In particular, the conventions contain provisions designed to assure that drug offenders will be subject to extradition. These provisions have been strengthened by the amendments to the *Single Convention* adopted in March 1972. There is increasing international cooperation between law enforcement and customs officials in the fight against trafficking. INTERPOL (The International Criminal Police Organization) plays an important role in this police cooperation. It is an intelligence and communications centre engaged in the analysis and distribution of information which is sent to it by member police forces throughout the world. The United States Bureau of Narcotics and Dangerous Drugs maintains many agents abroad who work with the authorities of other countries. There is particularly close cooperation between the law enforcement authorities of Canada and the United States.

In addition to law enforcement, the international control agencies have recognized the necessity to encourage economic and social development that will reduce the reliance on the illicit production of drugs in many underdeveloped areas of the world. This and other aspects of a more comprehensive approach to the international drug problem are reflected in the development of a Plan for Concerted Action, involving a great variety of research and developmental projects, and the establishment of a United Nations Fund for Drug Abuse Control to assist with the financing of these initiatives.

Enforcement in Canada

The R.C.M. Police.[37] The R.C.M. Police have attempted in recent years to free themselves for concentration on trafficking by encouraging local police forces to assume a greater responsibility for other aspects of drug law enforcement. The primary responsibility for enforcing the law against simple possession, particularly in the "soft drug" field, has been shifted to local

police forces. The latter do not have to rely, as they formerly did, on the R.C.M. Police for preparation and conduct of these cases. This development has made the resources of the R.C.M. Police more adequate for enforcement against trafficking. The number of personnel in the R.C.M. Police drug squad (in addition to the personnel in general enforcement) has increased in recent years as follows: 1969/70 – 106; 1970/71 – 160; 1971/72 – 196; 1972/73 – 311.[38] Although the R.C.M. Police could always use more personnel in law enforcement against trafficking, there is no suggestion at the present time that the Force is seriously undermanned for this task.

Customs. In Canada the Customs service does not perform an independent investigational function to the same extent as in the United States. The R.C.M. Police train customs officials in the drug area. They keep them up to date on known smuggling techniques and on suspected shipments of drugs coming into the country. Under the *Customs Act* officers have the power of personal search if they have reasonable and probable grounds for believing that an offence has been committed. There must be good advance intelligence to permit the customs officer to exercise this power with discrimination. It would not be practicable to subject all passengers to the inconvenience of personal search.

Convictions and seizures involving narcotics. The statistics with respect to convictions in recent years for trafficking offences and seizures involving drugs other than cannabis under the *Narcotic Control Act* reflect a fairly constant or stable level of law enforcement until 1972, when there is a very marked increase. This is a purely quantitative impression, since it is virtually impossible to determine the strategic impact on availability of particular convictions and seizures. There is also a considerable time interval between arrest and conviction. Judging from the number of convictions, there was an apparent decline in law enforcement effectiveness in 1971. The total number of convictions for the offences of trafficking and possession for the purpose of trafficking in drugs other than cannabis under the *Narcotic Control Act* are as follows: 1970 – 204; 1971 – 158, and 1972 – 322.

In recent years seizures of heroin recorded by the R.C.M. Police (and these represent virtually the total amount of such seizures in the country) were as follows: fiscal year 1969/70 – 37.9 lbs.; 1970/71 – 58.4 lbs.; 1971/72 – 195.1 lbs.[39] Officers of the Force state that this increase in the amount of heroin seized is in part the result of closer cooperation between Canada, the United States and France. Such cooperation has also resulted in the arrest of more high-level heroin distributors than in the past. Some sense of the relative size of the total amount seized may be gathered from the R.C.M. Police estimate that the annual requirement of heroin for the number of heroin-dependent persons in the country is 76 kilos, or approximately 167 lbs. At the same time, this quantity is very small in relation to the total amount available for supply of the North American market.

Surprisingly enough, there have been very few convictions in recent years for the unauthorized importing or exporting of narcotics. Most of the convictions for importing have involved cannabis. The number of convictions for importing or exporting narcotics (all of which, with only one exception, involved heroin) from 1969 to 1972 is as follows: 1969 – 4; 1970 – 2; 1971 – 3; 1972 – 2. In the same years the convictions for importing or exporting cannabis (marijuana and hashish) were as follows: 1969 – 6; 1970 – 26; 1971 – 22; 1972 – 33.

Explanations given for the comparatively few convictions for the importing of narcotics are that the requirements of the illicit market do not necessitate very many importations, that importation is very difficult to detect, and that the police often prefer to permit the courier to pass through customs in an attempt to apprehend the principals involved in the local distribution system. Such cases are sometimes dealt with on the basis of conspiracy.

Conspiracy to commit an indictable offence under the *Narcotic Control Act* (or the *Food and Drugs Act*) is an indictable offence under the *Criminal Code*[40] and carries the same penalties as the offence under the Act. Conspiracy is the chief means of convicting leading members of a trafficking operation. It is virtually impossible to apprehend leading traffickers in the act of importation or trafficking since they are usually careful to have no contact with the drug, but on a charge of conspiracy it is sufficient to prove participation in an unlawful agreement even if there was not participation in the actual offence of importing or trafficking. At this level of distribution conspiracy is generally a difficult case to make, often requiring a considerable expenditure of time and money. In other cases, it would appear to be a relatively easy way to proceed. A high proportion of the conspiracy cases in recent years have concerned cannabis, many of them relatively minor cases of trafficking.

The usual procedure in conspiracy cases is for the prosecution to lay charges under the *Narcotic Control Act* (or the *Food and Drugs Act*) as well. If the Crown succeeds on the conspiracy charge it usually withdraws the other charges. If it fails on the conspiracy charge it may proceed on the other charges, although it does not as a general rule do so.

To break up a local distribution "syndicate" or organization by conspiracy it is generally necessary to establish an unlawful agreement between the "top men" who direct it, the "back-end man", who takes possession of the drug supply when it is brought into the city, packages it in appropriate units and leaves it in places to be picked up by the middlemen, and the "front-end man", who is informed of these places and makes the contact with the middlemen, exchanging information of location for the price of sale. Generally, the top men have no contact with the drug supply nor with middlemen, but sometimes they have to act as the front-end men, and in such cases they become more vulnerable to detection and apprehension. Every effort is made to preserve the anonymity of the back-end man and to keep him above suspicion. For this reason he is often a person with a respectable

position and without a criminal record. Often the back-end man will be kept out of contact with the front-end man. If the top men are careful to act only through agents in arranging for shipment of the drugs from the point of importation and in other contacts and not to act as front-end men, and the back-end man is kept out of contact with the front-end man or with middlemen, it is very difficult to establish a conspiracy that can break up the organization.

The tables in Appendix E *Conviction Statistics for Drug Offences* indicate the relative severity with which the law has been applied in trafficking cases involving heroin. (See Tables E.16 to E.21 inclusive.) In 1970 out of a total of 180 convictions for trafficking and possession for the purpose of trafficking, 173 were disposed of by imprisonment, and in 1971 the proportion was 114 out of 121. In 1972 the proportion of convictions disposed of by imprisonment was essentially similar. The majority of the sentences—over 60 per cent—are for periods between one and six years.

The range in sentencing for trafficking offences involving the opiate narcotics undoubtedly reflects the fact that a large proportion of the offenders are opiate-dependent persons on the lower levels of the distribution system. There is probably an understandable reluctance to apply the same severity to the opiate-dependent person who engages in a certain amount of trafficking to obtain the money to support his habit as seems appropriate for the non-addict trafficker who is motivated entirely by profit.

A study of the background of 329 inmates of federal penitentiaries classified as "drug addicts" as of August 30, 1972, shows that a high proportion of them had been convicted of a trafficking offence. There had been a total of 348 convictions for trafficking offences among such drug-dependent offenders, and trafficking offences made up about 44% of the total number of convictions which they had received under the *Narcotic Control Act*.[41] There is every reason to believe that law enforcement against trafficking makes a particularly heavy impact against the drug-dependent trafficker.

The actual severity of sentences in practice depends on the policy with respect to parole. The proportion of a sentence which must be served, as a general rule, before an offender can be eligible for parole is indicated in Appendix K *Parole of Heroin Dependents in Canada*. For the majority of the sentences, this period would range from about three months to two years. In the case of longer sentences, a "Study on Drug Traffickers" in federal penitentiaries indicated the following periods served before parole:

> On sentences between 15 and 20 years—one served between two and three years; one served between three and four years; two served between four and five years; and one served between five and six years;
>
> On sentences between 10 and 15 years—three served between two and three years; four served between three and four years; and five served between four and five years;

On sentences between six and ten years—three served between one and one and a half years; eighteen served between two and three years; and two served between three and four years;

On sentences between five and six years—three served between six and nine months; one served between one and one and a half years; eleven served between one and a half and two years; six served between two and three years; and two served between three and four years.[42]

Some public officials have called for a stricter policy with respect to the parole of drug traffickers.

Restricted drugs. It is extremely difficult for the police to make an effective impact upon the illicit supply of the strong hallucinogens. The clandestine laboratories in which they are manufactured and the substances themselves are difficult to detect. LSD is odourless, colourless and tasteless, and because of these properties, and its great potency, it can be smuggled in a variety of inconspicuous guises. Most of it is sold, however, in tablet form. (See Appendix B *Legal and Illegal Sources and Distribution of Drugs.*) Important seizures of laboratories[43] and quantities of drugs are made from time to time, but the underground laboratories are able to keep up with demand. Moreover, there does not appear to be any effective way of preventing the underground laboratories from having access to the materials from which LSD is manufactured.

The category of restricted drugs under the *Food and Drugs Act* was not created until August 1969. Since then, convictions for the offences of trafficking and possession for the purpose of trafficking in restricted drugs appear to have risen to a peak in 1971 and declined significantly in 1972, as indicated by the following figures: 1970 – 634; 1971 – 670; 1972 – 493. (See Appendix E, Tables E.48 to E.50 inclusive.) However, this represents a larger number of convictions for trafficking offences in these years than in the case of the opiate narcotics, cocaine, or the controlled drugs (amphetamines and barbiturates), and it is exceeded only by the number of convictions for trafficking offences involving cannabis. The comparative figures in the four categories are as follows:

Drug Category	*1970*	*1971*	*1972*
Narcotics	203	158	322
Cannabis	802	1009	910
Controlled	112	157	294
Restricted	634	670	493

In 1971, almost 90 per cent of the convictions for trafficking offences in restricted drugs involved LSD, and the balance involved MDA. In 1972 the proportion for LSD dropped to about 67 per cent and the proportion for MDA rose to over 30 per cent. In the case of LSD, about 55 per cent

of the persons convicted were under 21 years of age. In the case of MDA, the proportion under 21 years of age was 41 per cent.

In 1972, about 29 per cent of the cases involving trafficking and possession for the purpose of trafficking in LSD were disposed of by fine, probation or suspended sentence, and absolute or conditional discharge. About 88 per cent of the sentences to imprisonment were for periods under two years, and all but one of them were under five years. (See Tables E.62 and E.65.)

Controlled drugs. It is impossible to estimate the extent of diversion of controlled drugs from legal sources to the illicit market. It is known, however, that virtually all of the supply for the intravenous use of 'speed' comes from illicit manufacture. 'Speed' can be quite easily and cheaply manufactured in clandestine laboratories which are difficult to discover. The law enforcement task of suppressing the illicit market in 'speed' is therefore a particularly difficult one. It is also difficult to detect the apparently large quantities of amphetamine and amphetamine-like drugs for oral consumption which are diverted to the illicit market. For details on these matters the reader is referred to Appendix B *Legal and Illegal Sources and Distribution of Drugs.*

The convictions for trafficking and possession for the purpose of trafficking in amphetamines and amphetamine-like drugs have increased in recent years as follows: 1970 – 77; 1971 – 130; 1972 – 277. (See Tables E.39 to E.41 inclusive.) The overwhelming majority of these cases have involved methamphetamine or 'speed', as follows: 1970 – 64; 1971 – 123; 1972 – 248. There have been few convictions involving other amphetamines, and the total number has actually declined, as follows: 1970 – 13; 1971 – 5; 1972 – 7. In 1972 there were 22 convictions for trafficking offences involving Preludin® (phenmetrazine).

Convictions for trafficking offences involving barbiturates in these years have been much fewer than in the case of the amphetamines, and have been declining, as indicated by the following figures: 1970 – 36; 1971 – 27; 1972 – 17.

Most of the convictions for trafficking offences involving methamphetamine have occurred in Ontario, as indicated by the following percentages: 1970 – 68.7%; 1971 – 82.9%; 1972 – 82.2%. The other convictions were distributed fairly evenly across the country. These figures reinforce the impression that 'speed' is primarily, although by no means exclusively, an Ontario problem. The concentration in Ontario of convictions involving 'speed' is proportionately greater than the concentration of heroin convictions in British Columbia.

The relatively few convictions for trafficking offences involving other amphetamines (presumably for oral use) are distributed across the country without any particular concentration.

The pattern of sentencing for trafficking offences involving controlled drugs (both amphetamines and barbiturates) is, as one would expect, less

severe than for trafficking offences involving heroin. (See Table E.44.) A higher proportion of the sentences to imprisonment for the controlled drugs are under two years. In 1972, 228 out of 257, or 80.9 per cent of the cases of imprisonment for trafficking offences involving controlled drugs were in this range, whereas only 55 out of 278, or 19.8 per cent of the cases of imprisonment in trafficking offences involving heroin were in the same range. All sentences for controlled drugs were for periods under six years.

CONCLUSIONS AND RECOMMENDATIONS

Relative Effectiveness of Law Enforcement Against Trafficking

In Section V we commented on the difficulty faced by the law enforcement authorities in attempting to make an effective impact upon the illegal production and distribution of opiate narcotics, in particular heroin. The prospects, as we suggested there, are extremely discouraging. These difficulties are described in detail in Appendix B *Legal and Illegal Sources and Distribution of Drugs*. From time to time massive seizures and arrests may result in shortages of supply but they are of brief duration. In the late 1950s and early 1960s a series of conspiracy cases in North America broke up some leading trafficking organizations and led to street shortages, or "panics", which significantly reduced the number of heroin users. But other leaders stepped in to take the place of those who were arrested, and supply was eventually restored. Trafficking practices became more specialized and sophisticated so as to reduce the danger of detection. Law enforcement against trafficking became more difficult.

It must be conceded, however, that it is impossible to estimate the relative effectiveness of law enforcement against trafficking with any accuracy. If we look at the increase in the illicit use of opiate narcotics in recent years we might be led to conclude that it has been relatively ineffective. But we cannot tell what the extent of use might have been had there been no such enforcement. The total number of convictions and the volume of seizures may suggest something of the level or intensity of law enforcement, but by themselves they do not tell us much. Numbers are not so important as the strategic impact of convictions—that is, the relative importance in the distribution system of the individuals who are apprehended, convicted and sentenced to imprisonment. In the face of overwhelming availability, the highest volume of seizure which police and customs officers could reasonably be expected to attain could at most cause temporary shortage and inconvenience to the distribution system.[44] Temporary shortages now fall with less severe impact on the using population because of the availability of methadone. Yet a substantial seizure from time to time may at least temporarily prevent the spread of the drug into new areas. It may reasonably be assumed that every large seizure probably prevents or postpones the introduction of some individuals to the use of heroin. Vigorous police action also makes trafficking operations more risky and less efficient.

A truly significant impact on availability could only be made by serious efforts to dry up the supply of the raw material at source. International efforts directed to this end are moving slowly with only slight prospects of success. South East Asia remains a major source of illicit opium more than capable of replacing other sources, such as Turkey, which may be reduced or cut off as a result of international cooperation. United Nation's efforts to remove the basis for illicit cultivation of opium in this and other parts of the world by economic and social measures will probably take another generation to produce appreciable results.

Whether Canadian Law Is Sufficiently Severe

Canadian law with respect to trafficking in the narcotics compares in relative severity with American law, federal and state,[45] and is more severe than that of Great Britain,[46] Australia[47] and New Zealand,[48] as well as that of several countries in Western Europe.[49]

The Canadian law with respect to trafficking in the narcotics reached its present state of severity by a series of changes over the years. The original law against opium in 1908[50] prescribed a maximum penalty of three years' imprisonment for illegal distribution. This was subsequently reduced, but later increased to seven years.[51] In 1954 the maximum sentence for trafficking offences was increased from seven to 14 years,[52] and in 1961 to the present life imprisonment.

The only ways in which the Canadian legislation could be made more severe would be the provision of a minimum mandatory sentence for trafficking and possession for the purpose of trafficking, or the provision of the death penalty. At one time in Canada all narcotic offences were punishable by a minimum mandatory sentence,[53] but this provision was abandoned. Minimum mandatory sentences, while assuring a certain minimum of severity for serious offences, limit the judicial discretion required to deal appropriately with less serious offences. This has certainly been the case with the minimum mandatory sentence of seven years for importing or exporting, particularly insofar as cannabis is concerned. The Canadian Committee on Corrections recommended the repeal of all provisions for minimum mandatory sentences, except in the case of murder.[54]

A question arises as to whether it would be appropriate to single out certain kinds of trafficking, such as distribution to minors, for a minimum mandatory sentence. American law has applied a special standard of severity to this crime. French law provides a special penalty for facilitating drug use by a minor. Formerly, there was some distinction in Canadian law with respect to distribution to minors. When there was the option to proceed by way of summary conviction or indictment in trafficking cases involving narcotics, the law was amended in 1921 to provide that it was mandatory to proceed by indictment in cases involving distribution to minors.[55] In view of the scope of discretion that is left to the courts by a maximum penalty of

life imprisonment there would appear to be no need to single out distribution to minors for special provision in the legislation.

There are a few countries which provide the death penalty for trafficking in narcotics. During the debate on the *Narcotic Control Act* of 1961 a member of the House of Commons urged that the death penalty be provided in Canadian law, but the suggestion was rejected by the Government.[56] It was argued that life imprisonment (together with the preventive detention to be provided by Part II of the Act) was a sufficiently severe penalty to convey the seriousness with which the law regarded the offence of trafficking. Particular concern was expressed about making the opiate-dependent person who trafficked to support his habit liable to the death penalty. (Since then Canada has moved in the direction of the abolition of capital punishment by reducing the cases of capital murder to those involving police officers and prison guards.)

In our opinion the Canadian legislation with respect to trafficking in the opiate narcotics would appear to be sufficiently severe to give the law enforcement authorities all the legislative basis they require for effective action. Indeed, judged by the relative severity of the law in most other jurisdictions of the western world, it might even be considered to be too severe. It would appear to be inappropriate, however, in the present climate of justified concern about the increase of opiate use and dependence to consider any reduction in the maximum penalties. There are certainly offences that merit life imprisonment, and the courts should be left with this discretion.

An aspect of the severity of the Canadian law is the offence of possession for the purpose of trafficking, with the burden of proof which it casts upon the accused. (See Appendix F.3.) There has been an increasing reliance upon this offence by the law enforcement authorities in recent years. The number of convictions for this offence, as a proportion of the total number of convictions for offences involving trafficking and possession for the purpose of trafficking, has increased from 1970 to 1972 as follows: heroin—from 19.4 per cent to 40.2 per cent; controlled drugs—from 52.7 per cent to 68.4 per cent; restricted drugs—from 44.3 per cent to 68.8 per cent. **We reaffirm the recommendation in our Cannabis Report[57] concerning the burden of proof on this offence—that when possession has been proved it should be sufficient for the accused to raise a reasonable doubt as to his intention to traffic. He should not be required to make proof which carries on a preponderance of evidence or a balance of probabilities.**

We see no reason to recommend any change in the maximum penalties for trafficking and possession for the purpose of trafficking in the controlled and the restricted drugs. The maximum penalty of ten years' imprisonment upon indictment is sufficiently severe to mark the seriousness of this offence, and the option to proceed by summary conviction, where the maximum penalty is eighteen months, gives the authorities sufficient flexibility to deal

with less serious cases in an appropriate manner. The pattern of sentences indicates that the operating maximum is between four and six years.

The Effect of Parole

The effect of severe sentences against traffickers can be undermined by the grant of parole. **We recommend that a stricter policy with respect to parole be adopted towards offenders convicted of serious trafficking offences.**

Minor Distribution Between Users

In the course of our inquiry the issue has been raised from time to time as to whether the transfer without value by one user to another of a small quantity of a prohibited drug should be punished as trafficking. **In our Cannabis Report we recommended that the giving without exchange of value by one user to another of a quantity of cannabis which could reasonably be consumed on a single occasion be excluded from the definition of trafficking. We do not believe that such an exclusion would be appropriate for trafficking in the narcotics, the controlled drugs or the restricted drugs.** Facilitating the use of these drugs is a more serious act than the transfer of a small quantity of cannabis.

Controls on the Availability of Drugs for Medical Purposes

Protection Against Loss or Theft

A major objective of the control of availability is to prevent diversion from legitimate sources of supply to illicit purposes. The system of controls on the availability of drugs for medical and scientific purposes is designed to prevent this diversion as much as possible. As indicated above, there are fairly strict controls on the narcotics, the controlled drugs, and the restricted drugs. The controls appear to be adequate in conception; their effectiveness depends, of course, on the care with which they are applied.

Despite the obligation of licensed dealers, pharmacists, practitioners, and hospitals to provide satisfactory protection against loss or theft, there is still a substantial amount of theft which feeds an illicit market. (See Appendix B *Legal and Illegal Sources and Distribution of Drugs.*) The Canadian regulations do not, like the American, go into great detail concerning the kinds of protection or safeguard which must be adopted in the various situations of distribution or custody. With few exceptions it is left to departmental discretion as to what it is reasonable to demand in each case. As a general rule licensed dealers are required to have an alarm system. The regulations specifically require that pharmacists keep all narcotics except oral prescription narcotics in a locked receptacle, drawer or safe. Most pharmacists have a safe in which they keep methadone and other narcotics. Many have only a locked cabinet. Where existing safeguards prove inad-

equate the Bureau of Dangerous Drugs will insist on greater protection. The same security measures cannot be required of small hospitals as of large institutions. In effect, the policy is a reasonably flexible one, which is adjusted in the light of actual experience. The Bureau is satisfied that it is doing what it reasonably can to assure adequate protection against loss or theft. **We do not recommend any specific changes in the existing policy, but merely emphasize again the supreme importance of everyone in the distribution system taking all reasonable care to prevent diversion by loss or theft. We also urge the Bureau to be rigorous in its application and enforcement of the security requirements.** In reconciling the convenience of licensed dealers, pharmacies and others in the distribution system with the public interest in security, the balance must be struck in favour of the public interest. Law enforcement efforts to suppress the illicit traffic can be nullified by failure of this security system.

Controls on Schedule F Drugs

An important issue is whether any or all of the prescription drugs on Schedule F of the *Food and Drug Regulations* should be subject to the same controls as the narcotics and controlled drugs. It will be recalled that the essential differences at the present time are that there is no check on the quantities of Schedule F drugs in the country for medical purposes and no regular reporting of prescriptions. Apart from conditions of quality, safety and sanitary manufacture and storage, no particular approval is required for the manufacture and distribution of Schedule F drugs, and there is no provision for record-keeping, reporting, inspection and audit which would permit the authorities to moniter inventories, sales or medical prescriptions. (Manufacturers and importers of drugs on Schedule F are required to keep certain records of their disposal of drugs to facilitate drug recall, but they are not required to make reports.)

As indicated elsewhere in this report (Appendix B *Legal and Illegal Sources and Distribution of Drugs*) there is evidence of considerable diversion of some of these drugs, such as the sedative-hypnotic methaqualone and, to a lesser extent, the hallucinogen phencyclidine (PCP),* to an illicit market. There are also indications in some areas of significant non-medical use of certain minor tranquilizers, such as diazepam (e.g., Valium®), but it would appear, given the limited data available, that at the present time these latter drugs are obtained primarily through prescription, with various patterns of subsequent distribution and use. **Because of the growing non-medical use of sedative drugs it would be prudent to carefully monitor legitimate supplies and sales of sedative-hypnotics and minor tranquilizers.** As well, with the recent tightening of administrative controls on amphetamine and phenmetrazine (as designated drugs in Schedule G), some increase in non-medical use (and pressure for diversion) of certain amphetamine-like drugs, such as methylphenidate (e.g., Ritalin®), in Schedule F may be expected. However, due

* See footnotes concerning PCP and methaqualone on pages 80 and 102.

to the absence of appropriate record-keeping and reporting provisions in the Regulations, effective detection of possible diversion of Schedule F drugs and monitoring of medical prescription abuses is not presently feasible.

Because of the significant potential for non-medical use of certain of the drugs in Schedule F, we recommend that they be brought (as a class of designated drugs) under administrative controls on availability similar to those which govern the controlled drugs. At a given moment it may not be considered desirable for a number of reasons—in particular, the more severe sanctions against trafficking—to transfer a drug from Schedule F of the Regulations to Schedule G of the Act, but it may be desirable to submit certain drugs which present a growing problem of non-medical drug use, or a significant potential for diversion to an illicit market, to stricter controls, including, in particular, those concerning record-keeping and returns, inspection and audit, and protection against loss or theft. Moreover, as indicated above, if Canada becomes a party to the *Convention on Psychotropic Substances,* 1971, it will be required to impose stricter controls on certain drugs in Schedules III and IV which are now on Schedule F of the *Food and Drug Regulations.*

Limitations on Production and Uses for Medical Purposes

There has been concern in recent years about overproduction of drugs for medical purposes, which is said to lead to pressure on physicians to increase their prescribing and also to diversion to an illicit market for purposes of non-medical use. The issue is whether an attempt should be made to impose limitations on the manufacture and importation of drugs for medical purposes. As we have indicated above, the production of narcotics is regulated by a system of annual estimates which nations are required to adhere to, and which must be approved by the International Narcotics Control Board. No such system of estimates is imposed by the *Convention on Psychotropic Substances,* 1971.

The United States does, however, provide a system of production quotas for drugs in Schedules I and II of the *Controlled Substances Act.* The Director of the United States Bureau of Narcotics and Dangerous Drugs fixes an annual quota for the production of a particular class of drug for legitimate purposes and distributes this quota among individual manufacturers. Under this system, overall production quotas and individual manufacturing quotas have been established for the amphetamines which have greatly reduced the quantity manufactured. (See Appendix B *Legal and Illegal Sources and Distribution of Drugs.*) It is now proposed that the barbiturates be transferred to Schedule II so as to be subject to the quota system.[58]

Apart from the estimate system governing the narcotics, no consideration is being given by the Bureau of Dangerous Drugs in Canada to limiting the total quantities of drugs manufactured and imported for medical purposes. The medical purposes for which amphetamines may be used have recently

been restricted,* but there has been no attempt otherwise to limit the production or importation of these drugs. There are no limits placed on the production of barbiturates, minor tranquilizers and non-barbiturate hypnotics, all of which lend themselves to abuse for non-medical purposes and to diversion to an illicit market.

While there was a decrease in the per capita consumption of licitly manufactured amphetamines of 56 per cent between 1966 and 1971, during this period nearly twice as much amphetamine was manufactured in Canada for medical use as was actually sold to hospitals and retailers. (See Appendix B *Legal and Illegal Sources and Distribution of Drugs.*) There appears to be a heavy accumulation of reserve inventories in order, apparently, to be assured of being able to meet delivery requirements. These large inventories do, however, increase the risk of diversion to an illicit market. While there was about a 25 per cent decrease in the estimated consumption of barbiturates between 1966 and 1972, there is still a very large estimated annual consumption amounting to almost one-half of a billion barbiturate pills or tablets. (See Appendix B *Legal and Illegal Sources and Distribution of Drugs.*) Although it is not possible to estimate the annual consumption of tranquilizers and non-barbiturate sedative-hypnotics, prescription surveys have suggested that there are almost twice as many prescriptions written for minor tranquilizers and almost two-thirds as many for non-barbiturate sedative-hypnotics as there are for barbiturates. (See Appendix B *Legal and Illegal Sources and Distribution of Drugs.*)

We recommend that serious consideration be given to estimating the reasonable needs for medical purposes of drugs with a potential for non-medical use and to attempting to limit manufacture and import to these amounts. Such a system would at least encourage serious annual review of legitimate requirements and, hopefully, some movement towards limitation. There are, however, real dangers in placing unrealistic restrictions on availability for medical purposes. In many cases it may merely lead to a shift to other drugs or to the encouragement of an illicit market. In the final analysis, the level of legitimate medical need is determined by medical judgment, and efforts must be concentrated on influencing the medical profession to follow sound practices in the use of drugs and to exercise restraint in prescribing. While it is highly desirable that we control, and if possible reduce, the amount of medically approved drug use for mood-modifying purposes, we must face the fact that people are going to continue to seek these drug effects to a considerable extent, and that they are going to find the necessary drugs in one place or another. In imposing excessive restrictions on the availability of these drugs through physicians we may in some cases replace medical judgment, by the virtual absence of control in an illicit market. What this simply means is that in considering any proposed policy of severe restriction or prohibition of availability we must always consider the possible cost of a virtually uncontrollable illicit market. The more we consider the system

* The medical uses of amphetamines have also been restricted in the United States.

of controls for limiting the use of psychotropic drugs to legitimate medical needs the more we see that it rests in the final analysis on the good sense and judgment of the medical profession. At the same time, overproduction leads to strong and irresistible pressures on the medical profession to make use of drugs. Thus there must be encouragement of restraint at both ends of the distribution system. **A government-sponsored mechanism of consultation, involving representatives of the pharmaceutical industry and the medical profession, to estimate reasonable requirements of drugs for medical purposes and to set up goals of restraint, would probably serve a useful purpose. The guidelines approach would probably be preferable to an attempt to set arbitrary limits.**

Controls on Prescribing Practices

Reliance on the good judgment and self-restraint of physicians, accompanied by more intensive efforts to educate the profession in the responsible use of drugs,[59] is also the only answer in the long run to the problem of control of prescribing practices. Administrative controls of prescribing can detect manifest abuses, but they cannot monitor more subtle judgments involved in good medical practice as to what is a legitimate medical requirement and what is no longer justified on sound medical grounds. It would be necessary to have a doctor to look over every other doctor's shoulder. We simply have to rely on the physician, and physicians have to be brought to a keener sense of the responsibility which such reliance involves. **At the same time we could do more to improve our techniques for detecting the more obvious abuses of misprescribing and overprescribing, as well as cases of "prescription shopping" or "double doctoring". At the present time our monitoring system is a very rudimentary one based on manual techniques. What is required is a fully automated central control system which would give the government the basis for monitoring overall consumption of prescription drugs, as well as individual prescribing and consumption patterns.** The details of such a system, which is presently under study, we leave to others more expert in these matters than ourselves. In our *Interim Report* we suggested that every medical prescription be required to bear the physician's licence number and the patient's social insurance number. (In the case of a tourist requiring a prescription, the social insurance number might be replaced by his signature, passport number or some other mark of identification.) Pharmacists should be obliged to make careful verification of the identity of the persons for whom they fill a prescription, much as a bank teller must do on presentation of a cheque.

Another issue with respect to prescription controls is the problem posed by the prescription which is transmitted by telephone. Although this practice is valued by physicians for its convenience and the rapidity with which an urgent prescription can be filled, pharmacists express concern about it. They point out that without a written prescription their record-keeping is greatly

complicated, and that telephone prescribing invites carelessness on the part of the physician. **Since it would be unwise to remove all possibility of transmitting a prescription by telephone in cases of emergency, we recommend a regulation that would limit telephone prescriptions of designated drugs with a potential for non-medical use to a quantity that is sufficient for not more than 48 hours or that would oblige the physician to furnish the pharmacist with a written prescription within 48 hours of the telephone transmission.**

Drug Classification for Control Purposes

A major concern in the control of availability is the appropriate classification or scheduling of specific drugs. In the preceding discussion we have referred to some drugs which obviously invite reconsideration at this time. The basic issues are whether a drug is to be made legally available at all, and if so, to what extent; whether, if it is to be available for medical purposes, there is to be a requirement of prescription; and the strictness of the other controls that are to be imposed on manufacture, safekeeping, distribution, record-keeping, reporting, inspection and audit.

Decisions as to proper scheduling must be based on a continuous review of the circumstances relating to each drug. **Over-the-counter drugs have to be kept under review to determine whether any of them should be made subject to the requirement of prescription. On this subject the Commission does not have anything to add to the recommendation in its Interim Report that systematic study be undertaken at regular intervals of all over-the-counter drugs and that those found to be especially hazardous be dispensed only by prescription.** There has been controversy as to whether over-the-counter drugs should be available only in pharmacies because of the information which pharmacists can furnish on request. We do not think this touches the real issue, which is the extent to which they are to be available for self-medication without the intervention of medical judgment and advice. The requirement of prescription adds to the consumer's inconvenience and expense so that it must not be imposed without good cause. The decision must be taken in each case on a very careful examination of all the pertinent facts. It would not be appropriate for the Commission to make recommendations with respect to specific drugs.

At the present time there does not appear to be a significant public health problem in Canada caused by the non-medical use of over-the-counter drugs for their psychotropic properties, although the therapeutic effectiveness of many such preparations (e.g., alleged sedatives and tranquilizers) has been seriously challenged. At the same time there are special grounds for concern about adverse effects of some of the over-the-counter drugs, as, for example, the high rate of accidental poisoning from A.S.A. (Aspirin®), particularly among children. The answer to such problems is not to subject A.S.A. to the requirement of prescription (as some have urged) since this would be impractical, nor even to restrict its distribution to pharmacies, which would also

cause great inconvenience without any compensating benefits, but to assure, through information programs, that there is adequate public understanding of the dangers of accidental poisoning (as well, for example, as the danger of such other problems as gastric bleeding in the case of A.S.A.) and that adequate measures are taken through the use of safety standards, including improved packaging and other precautions, to reduce access by children to drugs of all kinds.

The differences in the international and Canadian scheduling of drugs emphasize the fact that appropriate drug classification for control purposes depends on local conditions, and that there must be sufficient flexibility in international control instruments to permit the development of control regimes which are appropriate to the conditions in each country. Too much detail in international control instruments may require the imposition of certain domestic controls on a particular drug before they are appropriate.

The goal of international drug control policy should not be so much to dictate the specific details of the domestic policy of individual states, but to prevent the domestic policy of one state from being undermined by the policy of another. In fact, this can only be accomplished by a relatively high degree of agreement and cooperation on certain common objectives. At the same time, international control policy should allow as much flexibility as is consistent with this necessary agreement and cooperation for the development of domestic policy along lines which seem best suited to each state. International policy has not always struck this balance as happily as it might. It has sometimes developed a rather too detailed and rigid framework for national policies, but recent developments reflect an increased awareness of the need for reasonable flexibility. National policies must be permitted some scope for evolution to meet changing conditions. International agreements are entered into infrequently and usually remain relatively unchanged for years. They are not as easy to amend or replace as legislation. Meanwhile, conditions and perceptions change in each country, and there must be sufficient scope for response to these changes.

Is a New Legislative and Administrative Codification Desirable?

In recent years there has been a movement towards replacing the legislation that had developed in a rather piecemeal or *ad hoc* fashion in the drug control field by comprehensive statutes reflecting not merely a codification of the existing law but a new approach to drug classification for control purposes. A common feature of these legislative reforms has been the development of new drug schedules for the purpose of indicating the administrative controls and criminal law sanctions to be applied in each case.

Examples of these comprehensive statutes are the federal *Controlled Substances Act* in the United States, which was enacted in October 1970, and the *Misuse of Drugs Act 1971*, of Great Britain.

The American statute contains five schedules which group drugs according to the following criteria for control purposes: Schedule I—the drug has a high potential for abuse, no currently accepted medical use, and there is a lack of accepted safety for use under medical supervision; Schedule II—the drug has a high potential for abuse, it has a currently accepted medical use, and its abuse may lead to severe psychological or physical dependence; Schedule III—the drug has a potential for abuse less than the drugs in Schedules I and II, the drug has a currently accepted medical use, and its abuse may lead to moderate or low physical dependence or high psychological dependence; Schedule IV—the drug has a low potential for abuse by comparison with the drugs in Schedule III, it has a currently accepted medical use, and its abuse may lead to limited physical or psychological dependence by comparison with the drugs in Schedule III; Schedule V—the drug has a low potential for abuse by comparison with the drugs in Schedule IV, it has a currently accepted medical use, and its abuse may lead to limited physical or psychological dependence by comparison with the drugs in Schedule IV. The essential criteria, then, are accepted medical use, potential for abuse, and risk of physical or psychological dependence, or other harm. These criteria lead to groupings of pharmacologically different substances, and they do not solve some of the problems of credibility arising from the apparent assimilation of quite different drugs. Schedule I contains various synthetic and semi-synthetic opiates, including heroin, but it also contains certain hallucinogenic amphetamine derivatives (such as MDA and STP), LSD, marijuana, mescaline, peyote, psilocybin, and THC. Thus, there is an even greater mixture of pharmacological categories in Schedule I than that which is complained of in Canadian legislation in the assimilation of cannabis to the opiate narcotics. Moreover, in the stated criteria for Schedule I drugs, there is no reference (as there is in the criteria for other schedules) to dependence-producing potential, although many of the drugs listed there have such potential. This omission could give a misleading impression. It undoubtedly arises from the fact that drugs with a serious dependence-producing potential, such as heroin, have been grouped with those which do not have one, such as the hallucinogens. Schedule II includes certain natural and synthetic opiate narcotics, such as opium, morphine, pethidine and methadone, as well as cocaine, amphetamine, methamphetamine and the amphetamine-like drugs, phenmetrazine (Preludin®) and methylphenidate (Ritalin®). Distinctions are made in the criminal sanctions applicable to drugs in Schedule I and II which are defined as "narcotic drugs" (opiates and cocaine) and the other drugs in these schedules, but trafficking offences involving marijuana are subject to the same maximum penalties as those involving the strong hallucinogens and the amphetamines. It is not our purpose here to criticize the American legislation but to emphasize the difficulty of devising any theoretical basis for drug control classification that does not involve some apparent incongruities or anomalies. The attempt to formulate fairly general criteria which are not always easy to apply, but for which there must be

findings, may also introduce considerable complication into drug control administration.

In the British *Misuse of Drugs Act 1971,* there are three groupings of drugs for control purposes—Class A, Class B and Class C—with differences in the range of criminal law penalties applicable to each. No criteria are stated for the three classes, which is probably a shrewd acknowledgement that their selection is essentially pragmatic and cannot be easily summed up in any generalization. Class A contains THC, LSD, mescaline and certain other hallucinogens, as well as the major natural and synthetic opiate narcotics and cocaine. Class B contains cannabis and cannabis resin (marijuana and hashish), as well as amphetamine and certain amphetamine-like drugs, such as methylphenidate (Ritalin®) and phenmetrazine (Preludin®), and various forms of codeine. Class C includes the sedative hypnotic methaqualone (e.g., Mandrax®) and certain antidepressant and stimulant drugs such as pipradrol (Meratran®). It should be noted that the *Misuse of Drugs Act* makes no reference to barbiturates, minor tranquilizers or non-barbiturate sedatives other than methaqualone, although they require prescription. The maximum penalties are the same for Class A and Class B drugs in all cases except the offence of simple possession, where the maximum terms of imprisonment are seven and five years respectively, on indictment, and twelve and six months respectively, on summary conviction. The main differences in the range of penalties are with respect to Class C drugs.

The *Convention on Psychotropic Substances* introduces a new set of schedules which contain different groupings than those in American, British and Canadian legislation. The criteria which determine inclusion in these schedules are not spelled out in the Convention, but, according to a report of the Expert Committee on Drug Dependence of the World Health Organization,[60] they are as follows: Schedule I (hallucinogens)—"Drugs recommended for control because their liability to abuse constitutes an especially serious risk to public health and because they have very limited, if any, therapeutic usefulness"; Schedule II (amphetamine and amphetamine-like drugs)—"Drugs recommended for control because their liability to abuse constitutes a substantial risk to public health and because they have little to moderate therapeutic usefulness"; Schedule III (short-acting barbiturates)—"Drugs recommended for control because their liability to abuse constitutes a substantial risk to public health, although having moderate to great therapeutic usefulness"; Schedule IV (long-acting barbiturates, non-barbiturate sedative-hypnotics, minor tranquilizers and stimulant-anorectics) —"Drugs recommended for control whose liability to abuse constitutes a smaller but still significant risk to public health, and having a therapeutic usefulness ranging from little to great."

The short-acting barbiturates in Schedule III are subject, as we have seen, to less strict controls than the amphetamines in Schedule II. In particular, a stricter obligation of record-keeping is required of pharmacists in the case of the drugs in Schedule II than in the case of those in Schedule

III. The Canadian policy of placing the barbiturates under the same controls on availability as the amphetamines (subject to the further restrictions recently imposed on the medical use of the latter) appears to be more justified, in view of the dependence-producing potential of the barbiturates and the dangers of death from overdose. But this difference in scheduling does not present a problem, since a party is free to adopt stricter control measures for any drug than those required by the Convention. The difference in this case does, however, serve to indicate that it would not be convenient for Canada to adopt the precise system of schedules of the Convention as a new classification for control purposes. On the other hand, if Canada becomes a party to the Convention there will have to be a number of changes in the present Canadian classifications for control purposes. In particular, a number of drugs presently on Schedule F of the *Food and Drug Regulations* would have to be placed under a more strict control regime.

In considering what new grouping of drugs might be desirable in order to give effect to essential distinctions for control purposes, it is necessary to have some conception of the essential distinctions which have to be made with respect to different classes of drugs. A distinction must be drawn between administrative controls on availability and criminal prohibitions and sanctions. **All drugs which are required for medical use but which are liable to be used for non-medical purposes, and have a dependence-producing potential or carry some other risk of serious harm, should probably be subject to the same administrative controls on availability, including licensing, prescription, record-keeping, reporting, safeguards against loss or theft, inspection, and audit.** Since these requirements involve additional work and expense for the administration as well as those engaged in manufacture and distribution they should only be applied (apart from international requirements) to drugs which clearly meet the above criteria. (The reporting requirements for pharmacists are particularly onerous.) There should be another class of drugs for medical use to which the minimal prescription requirement of Schedule F of the *Food and Drug Regulations* would apply. These would be drugs which, because of some risk or another, should not be taken without medical approval, but which do not have a sufficient potential for harm or actual non-medical use to justify applying all the other administrative controls to them.

Insofar as criminal law prohibitions and sanctions are concerned, distinctions must be made between the various classes of drugs according to the relative seriousness of trafficking in them. While it may be reasonable to apply essentially the same administrative controls on availability for medical purposes to the opiate narcotics, cocaine, the amphetamines, the barbiturates and certain of the drugs presently on Schedule F of the Regulations, it would not be reasonable to apply the same maximum penalties to trafficking in any of these drugs—at least, not unless we are prepared, as they have done in some other countries, to reduce the maximum penalties for trafficking in the opiate narcotics to those which appear to be appropriate for other

controlled drugs. For reasons already indicated, this would not appear to be advisable. Thus there would have to be a distinction between classes of drugs with respect to maximum penalties for trafficking. Finally, it would not be appropriate to deal with unauthorized possession for personal use in the same way for all drugs for which essentially the same system of administrative controls on availability would be appropriate. Thus, there would have to be further distinctions between classes of drugs for such purposes. Our conclusions and recommendations concerning the application of the criminal law to unauthorized simple possession or use are contained in the next section. It is sufficient to note here that they cannot be inferred from the strictness of the administrative controls on availability which are considered to be appropriate to each class of drugs.

A legislative re-formulation of the control system to give adequate expression to these essential distinctions might show little improvement, from the point of view of clarity or economy, on the present legislative arrangements. What would be required would be a new statute and set of regulations to replace the *Narcotic Control Act* and Parts III and IV of the *Food and Drugs Act* and their respective regulations. The drugs to be subject to control under the new act could be grouped together in schedules or sub-divisions of schedules according to the following criterion: drugs would be grouped together if they were to be treated alike in respect of each of the following matters—administrative controls on availability, prohibitions and penalties with respect to unauthorized distribution, and prohibitions and penalties with respect to unauthorized simple possession or use. **We may consider one possible re-classification to reflect these essential distinctions and to give effect to the requirements of the Convention on Psychotropic Substances, 1971.**

The opiate narcotics, with cocaine, constitute a group of drugs to which it is appropriate to apply the same standards with respect to controls on availability and criminal sanctions. Cocaine is pharmacologically different from the opiate narcotics, but this would not appear to justify placing it in another classification, since circumstances require the application of the same control measures to it. In this case, the grouping with the opiate narcotics does not, as it does in the case of cannabis, convey a seriously misleading impression as to its relative potential for harm. To mark its pharmacological difference, however, cocaine could be placed in a subdivision of this first category. **Thus, with the necessary change to place cannabis in a more appropriate classification, the drugs in the Schedule of the Narcotic Control Act could constitute the first group.**

A second group could consist of the hallucinogens covered by Schedule I of the Convention on Psychotropic Substances and Schedule H of the Food and Drugs Act. If Canada became a party to the Convention certain drugs would have to be transferred to this group from other schedules. In particular, mescaline would have to be transferred from Schedule F of the *Food and Drug Regulations*. Psilocin and psilocybin, which are not listed in any of the Canadian schedules, would also have to be included in this group. DMHP

is presently covered as a cannabis derivative in the Schedule of the *Narcotic Control Act*. In effect, only four of the ten drugs in Schedule I of the Convention are presently included in Schedule H of the *Food and Drugs Act*. The other six are either included in other schedules or are in no schedule at all.

Included in these six drugs is THC, which is presently with other forms of cannabis in the Schedule of the *Narcotic Control Act*. An appropriate classification would have to be determined for cannabis, in accordance with the legislative policy which the Government decides to adopt with respect to it. The conclusions and recommendations of the Commission concerning such legislative policy are contained in our *Cannabis Report*. Certainly, cannabis has closest affinity with the hallucinogens. On the assumption, however, that it is likely to be considered appropriate to apply somewhat different provisions to it than to the strong hallucinogens, at least with respect to criminal sanctions, **it might be advisable to constitute two subdivisions in the second group: one for the strong hallucinogens, and one for cannabis, and any other hallucinogens with a relatively lower potential for harm.**

A third group could consist of the amphetamines and amphetamine-like drugs, the barbiturates, and the minor tranquilizers and sedative-hypnotics with an abuse potential which justifies the application of strict controls on availability. Once again, there could be subdivisions to permit distinctions which appear to be appropriate in respect of criminal sanctions. To conform to the requirements of the *Convention on Psychotropic Substances* certain drugs would have to be transferred to the third group from present classifications.

In the category of the amphetamines and amphetamine-like drugs, methylphenidate (Ritalin®) would have to be transferred from its present classification in Schedule F of the *Food and Drug Regulations*. This would appear to be a wise decision and a logical sequel to the transfer of phenmetrazine (Preludin®) to the controlled drug category. Dexamphetamine (dextroamphetamine), which is included in Schedule II of the Convention, is covered under Schedule G of the *Food and Drugs Act*.

The short-acting barbiturates in Schedule III of the Convention are all regulated as controlled drugs. The only change required by this Schedule would be the transfer of glutethimide from Schedule F of the Regulations. This drug would be better included in a subdivision consisting of minor tranquilizers and sedative-hypnotics.

Three out of the eleven drugs in Schedule IV of the Convention—barbital, phenobarbital and methylphenobarbital—are presently in the controlled drug category and would be better included in the subdivision for the barbiturates. Seven of the drugs in Schedule IV—amfepramone (diethylpropion), ethchlorvynol, ethinamate, meprobamate, methaqualone, methylprylon, and pipradol—would have to be transferred from their present classification as drugs in Schedule F of the *Food and Drug Regulations*.* They would be

* Methaqualone was transferred in June 1973 from Schedule F of the *Food and Drug Regulations* to Schedule G of the *Food and Drugs Act*.

appropriate for inclusion in the sub-group consisting of the sedative-hypnotics, minor tranquilizers and the amphetamine-like drugs. The other drug in Schedule IV of the Convention—SPA—is not available in Canada and is accordingly not on any schedule in the Canadian legislation. **The third group could include drugs which are not presently in Schedule IV, such as the minor tranquilizers Valium® and Librium®, but which are considered to be appropriate for the same controls as other drugs in this grouping.**

A fourth group could consist of drugs which require prescription, but which do not require the strict controls on availability applied to drugs in the first, second and third groups. Different criminal law prohibitions and sanctions for unauthorized distribution of drugs in the fourth group would also be appropriate.

There would, of course, also have to continue to be a category of drugs corresponding to the present Schedule F of the Act, the sale of which is totally prohibited for all purposes.

Should Canada Become A Party to the Convention on Psychotropic Substances?

The foregoing discussion indicates some of the implications of Canada's becoming a party to the *Convention on Psychotropic Substances*. The question that presents itself is should Canada become a party, and if so, on what conditions. The Convention permits states to become a party with reservations, but the matters for which a reservation may be made without the agreement of other parties are limited. On becoming a party a state may make reservations without such agreement with respect to the following matters: the kinds of action which may be taken by the International Narcotics Control Board in a case of failure to comply with the provisions of the Convention; the provisions respecting territorial application of the Convention; the provisions respecting settlement of disputes; and the status of wild plants containing psychotropic substances in Schedule I which are traditionally used by "certain small, clearly determined groups in magical or religious rites".

A party may make reservations with respect to other provisions of the Convention provided they are not objected to within twelve months by one-third or more of the parties. A party that does object to a reservation need not assume towards the reserving party any obligation under the Convention which is affected by the reservation.

The right to make reservations at the time of becoming a member offers some flexibility; so also do the terms of the Convention in many places. **But with all the flexibility available, the Convention would still require important changes in Canada's system of controls on availability of drugs for medical and scientific purposes.** In particular, it would substantially increase the obligation to monitor and report on inventories. There would have to be annual reporting to the International Narcotics Control Board not only on the controlled drugs and the restricted drugs for which there are presently records

but also on a number of drugs on Schedule F of the *Food and Drug Regulations* for which there are presently no such records. There would be a great increase in the amount of record-keeping and reporting required.

The obligation with respect to penal provisions would not require any changes in Canadian law. For example, the Convention does not require the simple possession or use of the drugs in Schedules II, III and IV to be made a punishable offence. The provisions respecting the strong hallucinogens, including THC, in Schedule I of the Convention would restrict Canada's policy options in the future, since they appear to require, as indicated in the next section, that use, or at least simple possession, be made a punishable offence.

On the whole, the present Canadian control system is substantially in accordance with the essentials of the system provided by the Convention. Canadian policy has very largely anticipated the international requirements and in many cases goes beyond it. **While changes would be required in the Canadian system to bring it into full conformity with the provisions of the Convention, they would be along logical lines of development for Canadian policy.** Indeed, as we have indicated, the provisions of the Convention do not go as far as we think they should, particularly in not bringing the minor transquilizers under a stricter control regime. But as we have pointed out, the Convention does not prevent a party from imposing stricter controls on particular drugs.

There are always some inconveniences, additional burdens and losses of flexibility in international commitments, but these are counterbalanced in this case by the importance of international standards and cooperation in drug control policy. As we said earlier, the drug control policies of particular states can be seriously impeded by the lack of sufficient international cooperation with respect to control of availability. Sweden, for example, has felt that its attempt to control the non-medical use of stimulants has been seriously undermined by lack of cooperation from other nations, and this concern was one of the prime reasons for its support of the *Convention on Psychotropic Substances.* **Despite some of the inconveniences involved, we believe that Canada should continue to support these efforts to assure that domestic drug control policies are not undermined by lack of sufficient international cooperation. For these reasons we recommend that Canada become a party to the Convention on Psychotropic Substances, with such reservations (or amendments) on particular matters as are considered to be necessary and consistent with the other policy recommendations in this report.**

It must be remembered, that apart from the right to make reservations at the time of becoming a party, a state always has the right to propose amendments or to withdraw from the Convention, should that be considered necessary because of changes in policy. As in the case of the *Single Convention,* the *Convention on Psychotropic Substances,* 1971, provides that a party may withdraw as of January 1st in any year upon giving six months clear prior notice. The possibility of such recourse, if absolutely necessary, may assist a party to obtain desired amendments to the Convention.

NOTES

1. The *Single Convention on Narcotic Drugs, 1961,* was developed by the Commission on Narcotic Drugs pursuant to a direction from the Economic and Social Council in 1958. It was adopted and opened for signature in March 1961 at a United Nations plenipotentiary conference in which seventy-three states participated. Its general purpose was to replace the existing multinational treaties in the field by a single system which would limit narcotic drugs to medical and scientific use. It came into force on December 13, 1964.
2. *The Convention on Psychotropic Substances,* 1971, was approved as a basis for international agreement at a plenipotentiary conference at which more than seventy states were represented in Vienna in February 1971. Canada participated in the preparation of the Convention but, along with many other states, reserved her decision as to whether to become a party to it. States may become parties to the Convention by signing it, by ratifying it after signing it subject to ratification, or by acceding to it. The Convention was open for signature until January 1, 1972 and thereafter a state may become a party by accession.
3. These amendments, designed to strengthen the provisions of the *Single Convention* in several respects, including the functions of the International Narcotics Control Board, were adopted at a plenipotentiary conference attended by the representatives of 97 states in Geneva in March 1972. The amendments come into force after forty states have ratified or acceded to the Protocol embodying them.
4. WHO Expert Committee on Dependency Producing Drugs, *Sixteenth Report,* Wld. Hlth. Org. techn. Rep. Ser., 1969, no. 407, p. 6.
5. Article 36.
6. Article 2, paragraph 4.
7. Article 2, paragraph 5.
8. Article 7.
9. Article 5, paragraph 2.
10. R.S.C. 1970, c. N-1.
11. *Narcotic Control Regulations,* 4 to 22.
12. *Ibid.,* 23 to 37.
13. *Ibid.,* 38 to 41.
14. *Ibid.,* 42 to 44.
15. *Ibid.,* 37 and 41. The Bureau of Dangerous Drugs issues "restricted lists" of practitioners and pharmacists to whom certain drugs must not be sold or otherwise made available.
16. *Ibid.,* 47, as amended by P.C. 1972-1795, 24 August 1972, SOR/72-337, 28 August 1972.
17. *Ibid.,* 3.
18. *Ibid.,* 3(3).
19. *Ibid.,* 51.
20. *Narcotic Control Act,* s. 5.

21. *Ibid.*, s. 4.
22. *Ibid.*, s. 6.
23. *Criminal Code*, s. 646.
24. R.S.C. 1970, c. F-27.
25. *Food and Drug Regulations*, J.01.033, as amended by P.C. 1972-1794, 24 August 1972, SOR/72-336, 28 August 1972.
26. *Food and Drug Regulations*, Part J.
27. Section 42.
28. *Food and Drug Regulations*, Part G.
29. *Food and Drugs Act*, s. 34.
30. Amendments to *Food and Drug Regulations*, Part G, by Order in Council P.C. 1972-3049, December 19, 1972, SOR/73-17, December 21, 1972.
31. *Food and Drug Regulations*, G.06.001, as amended by P.C. 1972-1794, 24 August 1972, SOR/72-336, 28 August 1972.
32. *Food and Drug Regulations*, C.01.041 and following.
33. *Food and Drugs Act*, s. 26.
34. *Ibid.*, s. 2.
35. R.S.C. 1970, c. P-25.
36. Section 15.
37. In addition to enforcement of certain federal statutes the R.C.M. Police act in several provinces as provincial police.
38. G. L. Tomalty (Inspector, Officer in Charge, Drug Enforcement Branch, R.C.M. Police), Personal communication to the Commission, December 6, 1972.
39. G. L. Tomalty, Personal communication to the Commission, December 15, 1972.
40. Section 423.
41. D. Craigen (Director, Medical Services, Canadian Penitentiary Service), Personal communication to the Commission, August 30, 1972.
42. Canada, Department of the Solicitor General of Canada, Statistical Information Centre, *Study on Drug Traffickers*, May 1972.
43. For example, there was a seizure in Vancouver in 1972 of a clandestine laboratory capable of producing very large quantities of MDA.
44. It should be observed, however, that American law enforcement authorities claim to have created a marked shortage of heroin on the east coast of the United States in 1972. This was reflected in an increase in price and a decrease in the purity of street heroin. See *Federal Strategy for Drug Abuse and Drug Traffic Prevention 1973* (Report by the Strategy Council on Drug Abuse to the President), p. 112. There is also reference to this shortage in Appendix B *Legal and Illegal Sources and Distribution.*
45. This is true of the maximum penalty of life imprisonment. There are certain aspects of American federal and state law that are more severe than the Canadian, in particular, the imposition of minimum mandatory sentences in certain cases, and especially severe provisions in the federal law with respect to distribution to minors and traffickers engaged in continuing criminal enterprise.
46. Under the *Misuse of Drugs Act 1971*, trafficking offences involving the opiate narcotics are punishable, on summary conviction, by a maximum of 12 months' imprisonment or a fine of £400, or both, and on indictment, by a maximum of 14 years' imprisonment, or a fine, or both.

47. Trafficking is punishable in Australia by imprisonment for a maximum of 10 years.
48. Trafficking is punishable in New Zealand by imprisonment for a maximum of 14 years.
49. In France trafficking in the opiate narcotics is punishable by imprisonment from two to ten years, and in the case of production, manufacture, importation or exportation, by imprisonment from 10 to 20 years. In West Germany trafficking in the opiate narcotics is punishable by imprisonment from one to ten years. In Denmark, Sweden and Norway the maximum penalty for trafficking is six years. In Finland it has been increased to ten years, and it has been proposed to adopt the same increase in Norway. In Belgium trafficking offences are punishable by imprisonment from three months to two years. In the Netherlands the maximum penalty for wilful commission of trafficking offences is four years' imprisonment. In Italy trafficking offences are punishable by imprisonment from three to eight years. In Switzerland serious cases of trafficking are punishable by imprisonment for a term not exceeding five years.
50. 1908 Stat. Can., c. 50.
51. 1911 Stat. Can., c. 17, and 1921 Stat. Can., c. 42.
52. 1953–54 Stat. Can., c. 38.
53. 1923 Stat. Can., c. 22.
54. Report of the Canadian Committee on Corrections: *Toward Unity: Criminal Justice and Corrections* (Ottawa: Queen's Printer, 1969), p. 210.
55. 1921 Stat. Can., c. 42.
56. *Debates*, House of Commons, Canada, 1961, pp. 6214, 6216 and 6218.
57. *Cannabis Report*, p. 302.
58. *Barbiturate Abuse in the United States.* Report of the Sub-Committee to Investigate Juvenile Delinquency by Senator Birch Bayh, Chairman, to the Committee of the Judiciary, United States Senate, December 1972. U.S. Government Printing Office, Washington, 1972; *A Study of Current Abuse and Abuse Potential of the Sedative-Hypnotic Derivatives of Barbiturate Acid with Control Recommendations*, Department of Justice, Bureau of Narcotics and Dangerous Drugs, November 16, 1972.
59. This process might be assisted by the formulation of prescribing guidelines in certain areas by the medical profession. For example, there might be guidelines with respect to the prescribing of the barbiturates and certain other sedative-hypnotics, which are the drugs most commonly responsible for suicide and accidental poisoning deaths in North America (see Appendices A.7 and A.8). Such self-poisoning generally involves impulsive behaviour and the immediate availability of toxic drugs, typically in the house from a previous medical prescription. Consequently, it has frequently been recommended that limits be placed on the maximum quantity of drugs with significant lethal potential which can be obtained on a single prescription. Suggestions have included, for example, a limit of two weeks' normal medical doses at a time, or some quantity below that generally considered lethal. It has also been suggested that physicians be actively encouraged to prescribe the less toxic sedatives (e.g., the benzodiazepine minor tranquilizers) in place of the physically more dangerous drugs in those applications where it would be in keeping with therapeutic needs.
60. World Health Organization, *WHO Expert Committee on Dependence: Seventeenth Report* (WHO Technical Report Series, no. 437), 1970, pp. 13–18.

Section VII

Control of the User

THE REQUIREMENTS OF THE INTERNATIONAL CONVENTIONS

Reference has been made in the previous section to the provisions of the *Single Convention on Narcotic Drugs, 1961,* and the *Convention on Psychotropic Substances,* 1971, with respect to the control of availability. It is necessary here to direct attention to the provisions which contemplate control of the user.

It will be recalled that the *Single Convention* requires the parties to take such legislative and administrative measures as may be necessary "to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs". Article 36, which provides for penal provisions, does not explicitly require that use as such be made a punishable offence.[1] It refers to "possession", and it could be argued that it is possession in the context of distribution. This is a reasonable inference from the fact that all the other acts specified by Article 36 are acts of production or distribution, and such a construction is reinforced by the use of the word *détention* for possession in the French version of the article. Some have taken the position that Article 36 does not contemplate simple possession for use. The prevailing view in the international community, however, appears to be that the Convention requires parties to make simple possession a punishable offence. It is to be noted that Article 36 requires not only certain specified acts to be made punishable offences, but also "any other action which in the opinion of such Party may be contrary to the provisions of this Convention". Thus the parties are given considerable scope to determine the range of penal offences which they think is necessary to achieve the objectives of the Convention. As far as we are able to ascertain, most parties to the Convention have made simple possession or use a penal offence. Thus, by their own legislative behaviour, states have tended to give this construction to their obligations under Article 36, although on the basis of technical interpretation a good case could be made for limiting the meaning of possession to possession for the purpose of trafficking.

Article 22 of the *Convention on Psychotropic Substances,* 1971, does not, as we have seen, indicate the specific kinds of conduct which must be made punishable offences, as does Article 36 of the *Single Convention.* Instead, it refers generally to any action contrary to such laws and regulations as the parties see fit to adopt in fulfilment of their obligations under the Convention. This would appear to offer more flexibility as to the choice of conduct which must be made a punishable offence. There is, however, with respect to Schedule I drugs (hallucinogens, including THC but not marijuana or hashish) an explicit obligation to prohibit all use except for scientific and very limited medial purposes by authorized persons in approved institutions.[2] This would appear necessarily to involve making non-medical use, or at least simple possession for purposes of such use, a punishable offence. This is not the case with the drugs in Schedule II (amphetamines and certain drugs with similar action), Schedule III (short-acting barbiturates and drugs with similar action), and Schedule IV (various other sedative-hypnotics, minor tranquilizers and stimulants). A party is required to limit "by such measures as it considers appropriate", the manufacture, distribution and "use and possession" of these drugs to medical and scientific purposes.[3] Such drugs are to be made available only upon prescription, but there does not appear to be an obligation to make use or simple possession of such drugs for unauthorized purposes a punishable offence.

There has been increasing concern in the international community to distinguish between trafficking and use, and to encourage the application of non-penal measures to the user. This shift in emphasis is reflected in the following provision in Article 22 of the *Convention on Psychotropic Substances,* 1971:

> . . . when abusers of psychotropic substances have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to punishment, that such abusers undergo measures of treatment, education, after-care, rehabilitation and social reintegration . . . .

This provision, which could be applied to persons convicted of trafficking offences as well as those convicted of simple possession or use, reflects the thinking that it may be more appropriate to apply non-penal measures to the drug-dependent person, regardless of his offence. Its purpose is to give states more flexibility in social policy with respect to the user. It is to be noted, however, that this alternative necessarily involves some degree of compulsion or coercion of the user.

The *Single Convention* has not contained this provision until recently, although the lack of it has not prevented the development of compulsory treatment as an alternative to imprisonment in several states. Formerly, the only reference to treatment in the *Single Convention* was Article 38, which reads:

> 1. The Parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts.

2. If a Party has a serious problem of drug addiction and its economic resources permit, it is desirable that it establish adequate facilities for the effective treatment of drug addicts.

The amendments to the *Single Convention* adopted in March 1972 incorporate the above provision of the *Convention on Psychotropic Substances*, 1971, concerning alternatives to punishment. Article 38 of the *Single Convention*, as amended, applies the language of Article 20 of the *Convention on Psychotropic Substances*, 1971 to narcotic drugs as follows:

1. The Parties shall give special attention to and take all practicable measures for the prevention of abuse of narcotic drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.
2. The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of narcotic drugs.
3. The Parties shall take all practicable measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of drugs will become widespread.

CANADIAN LAW AND LAW ENFORCEMENT WITH RESPECT TO CONTROL OF THE USER

The Prohibitions

Under Canadian federal law, the unauthorized possession for purposes other than trafficking of the drugs covered by the *Narcotic Control Act* and Part IV of the *Food and Drugs Act* is a criminal offence. These include the opiate narcotics, cocaine, cannabis, and the strong hallucinogens. The simple possession without authorization of the controlled drugs (amphetamines and barbiturates) in Schedule G of Part III of the *Food and Drugs Act* and of the prescription drugs (various sedatives, tranquilizers, stimulants, analgesics, and other substances) covered by Schedule F of the *Food and Drug Regulations* is not an offence.

Under the *Narcotic Control Regulations* "prescription shopping" or "double doctoring" is made an offence in the following terms:

> A person in whose favour a prescription or a narcotic has been issued shall not seek or receive another prescription or a narcotic from a different practitioner without disclosing to that practitioner particulars of every prescription or narcotic that he has obtained within the previous thirty days.[4]

There is no such offence for controlled drugs (amphetamines or barbiturates) under Part III of the *Food and Drugs Act*, nor for drugs covered by Schedule F of the *Food and Drug Regulations*.

PENALTIES

The offence of simple possession is punishable under the *Narcotic Control Act* as follows:

> Upon indictment, by a maximum of seven years' imprisonment; and
>
> Upon summary conviction, on first offence, by imprisonment for a term not exceeding six months or a fine not exceeding $1,000 or both, and on a subsequent offence, by imprisonment for a term not exceeding one year or by a fine not exceeding $2,000 or both.[5]

On indictment, the court may also impose a fine in any amount which it judges appropriate, in addition to imprisonment, but it may not impose a fine in lieu of imprisonment, where, as in this case, the offence is punishable by imprisonment for more than five years.[6]

The simple possession without authorization of the restricted drugs (LSD, etc.) in Schedule H of Part IV of the *Food and Drugs Act* is punishable as follows:

> Upon summary conviction, for a first offence, by a fine not exceeding $1,000 or by imprisonment for a term not exceeding six months, or by both, and for a subsequent offence, by a fine not exceeding $2,000 or by imprisonment for a term not exceeding one year, or both; and
>
> Upon conviction on indictment, by a fine not exceeding $5,000 or by imprisonment for a term not exceeding three years, or by both.[7]

Reference is made to Appendix F.3 for further details on the law respecting the offence of simple possession under the *Narcotic Control Act* and Part IV of the *Food and Drugs Act.*

For the policy governing the decision as to whether to proceed by indictment or summary conviction see Appendix F.7 *Prosecution in Drug Cases.*

CONVICTIONS

The number of convictions for the offence of simple possession of drugs other than cannabis under the *Narcotic Control Act* and of the restricted drugs under Part IV of the *Food and Drugs Act* reflect in some measure the level, or relative intensity, of law enforcement against the user.

The opiate narcotics. The vast majority of the convictions for simple possession of drugs other than cannabis under the *Narcotic Control Act* have, of course, involved heroin. Up to the end of 1970 the convictions for simple possession of heroin remained at a fairly stable level of about 200 per annum, as indicated by the following figures: 1968 – 202; 1969 –

192; 1970 – 201. The number of convictions showed a marked rise in 1971, and again in 1972, as indicated by the following figures: 1971 – 378; 1972 – 630.

The figure for 1972 is under four per cent of the estimated total of at least 15,000 heroin-dependent persons in the country, and possibly under one per cent of the total number of heroin users. (See Appendix C *Extent and Patterns of Drug Use.*)

The number of convictions for simple possession of drugs other than heroin (and cannabis) under the *Narcotic Control Act* has been relatively small, although it has been steadily increasing, as indicated by the following figures: 1970 – 57; 1971 – 73; 1972 – 106. Of these drugs, methadone and cocaine have accounted for the highest proportion of convictions.

The number of convictions for "prescription shopping" or "double doctoring" under Section 3(3) of the *Narcotic Control Regulations* has been as follows: 1970 – 12; 1971 – 46; 1972 – 38. (See Appendix E *Conviction Statistics for Drug Offences,* Tables E.1 to E.3 inclusive.) Methadone has been the drug most heavily involved.

In view of the conviction figures some general observations are in order concerning the impact of the criminal law system upon the total population of heroin-dependent persons. The policy of law enforcement against the heroin addict has traditionally been one of containment. There has been a selective policy of harrassment and arrest. Police have not wanted to drive the phenomenon underground or to disperse it too much. They have sought to keep it concentrated, visible and contained. Law enforcement against the user of opiate narcotics takes the form of careful surveillance of well-established meeting places, where distribution takes place, and observation of the subsequent movements of the user with a view to apprehending him in the act of possession. The chief concern of the police is to avoid an ill-timed encounter with the user that will enable him to swallow or otherwise dispose of the substance before it can be seized. The police usually attempt to apprehend the user when he has prepared the substance for use, and is about to use it. Thus the whole approach to apprehension of the user is one which is conditioned by the need to take hold of the substance before it is placed beyond reach. This accounts for the kind of surveillance that is practised, the need to be able to break into premises without warning, and the resort to force to recover the substance when the person in possession attempts to swallow or otherwise dispose of it. The police do not enforce the law against simple possession as intensively as they could, but do so on a selective basis. They are more concerned to know where the user is, and to keep him under surveillance, than to seize every opportunity to arrest him.

The strategy of containment requires a certain toleration of established and localized patterns of dealing in order to be able to keep the using population under observation. In recent years this strategy of containment has been undermined by the spread of opiate narcotic use beyond the traditional

areas of concentration. This has arisen in part because of the increase of such use among younger multi-drug users. The police no longer have the same sense of having the phenomenon under close observation and effective containment. As one officer in Vancouver put it to a member of the Commission's research staff:

> Three or four years ago, the heroin scene was totally under control. We knew every addict and we kept them confined to Main and Hastings (known as the corner). If we saw a new face we could really jump the guy and keep him under pressure and maybe convince him to remain "unwired". We had a list of new addicts which we kept at the station. There were 325 addicts on the street, 400 addicts in jail, 400 chipping, and 400 ex-addicts. We were able to keep the number of addicts down.[8]

It is possible that little more than ten per cent of the opiate-dependent population is under the control of the criminal justice and correctional system at any one time. In the fall of 1972 our investigations suggested that there were not more than about 1,550 known opiate dependents in the correctional system in this country. There appeared to be about 450 on probation (of whom just over 70 per cent were in British Columbia) and about 100 on parole (of whom over 90 per cent resided in British Columbia). The number of known 'addicts' believed to be in federal penitentiaries was about 330, and the number in provincial correctional institutions to be about 670. Some of those in correctional institutions were probably dependent on drugs other than the opiate narcotics.[9]

There may, of course, be many other opiate-dependent persons within the correctional system who are not known as such to the authorities. Except for cases involving an offence under the *Narcotic Control Act*, in which a presumption of heroin use is raised at the point of contact with the criminal law system, knowledge of drug use among persons convicted of criminal offences is generally obtained from admission by the offender. What may be said is that the criminal law and correctional system is apparently not aware of exercising control over much more than ten per cent of the addict population. It may be safely asserted that at any one time the vast majority of addicts are on the street.

The maximum penalties in Canada for the simple possession of the opiate narcotics fall within the general range of severity of the penalties in the United States[10] and Great Britain[11] and are, generally speaking, more severe than those in Western Europe,[12] Australia[13] and New Zealand.[14]

About forty per cent of the convictions for the simple possession of heroin are disposed of by fine, suspended sentence, probation, and absolute or conditional discharge. (See Table E.15.) Of the remaining 60 per cent of the cases, in which there is a sentence to imprisonment, about 90 per cent of the sentences are for a period under two years, and more than half of the others are for a period under three years.

A high proportion of persons convicted of the simple possession of opiate narcotics have a previous criminal record. The background of heroin addicts in federal penitentiaries shows an average of over eight convictions per person.[15] Previous offences of persons convicted of simple possession include breaking and entering, theft, false pretense, forgery, counterfeiting, possession of stolen property, vagrancy and prostitution. In most cases the previous record consists of drug offences and crimes against property, but there are also many cases of crimes of violence, mainly assault. Over one-third of the addict population in federal penitentiaries appears to have committed one or more crimes of violence. About fifty per cent of the persons imprisoned for the simple possession of heroin have a record of previous drug offences.

The restricted drugs. The total numbers of convictions for simple possession of "restricted drugs" (the strong hallucinogens) in recent years are as follows: 1970 – 1,009; 1971 – 1,253; 1972 – 1,216. The highest proportion of these convictions has been for LSD: 1970 – 956; 1971 – 1,065; 1972 – 830. The next most important drug, in terms of total number of convictions for simple possession, has been MDA, as follows: 1970 – 58; 1971 – 251; 1972 – 379. (See Tables E.66 to E.68 inclusive.) Thus, the convictions for LSD have shown a relative decline, while those for MDA have shown a steady increase. The latter have grown from slightly under six per cent of the number of convictions for simple possession of restricted drugs in 1970 to 31 per cent in 1972.

The proportion of the convictions for the simple possession of LSD which have been disposed of by imprisonment has dropped from about 23 per cent in 1970 to about 12 per cent in 1972. (See Tables E.57 to E.59 inclusive.) The remainder are disposed of by fine, suspended sentence, probation, and absolute or conditional discharge. Over 44 per cent of the convictions and about 50 per cent of the sentences of imprisonment for the simple possession of LSD involve persons under twenty-one years of age. (See Table E.59.) The majority of sentences to imprisonment are for periods under six months and all are under two years. Essentially the same observations apply to convictions for the simple possession of MDA, although the proportion of those under twenty-one years of age is somewhat lower. (See Table E.71.)

Other Legislation with Respect to the User

There are various other federal and provincial legislative provisions prohibiting drug-related conduct. For applicable provisions of the *Criminal Code* of Canada and the role of the *Juvenile Delinquents Act* the reader is referred to Appendices F.4 and F.5, respectively. Reference is made later in this section to the federal *Tobacco Restraint Act* which prohibits the possession, and use in public, of tobacco by persons under the age of 16.

From time to time the provinces have enacted penal provisions relating to non-medical drug use. Provincial legislative jurisdiction for this purpose is discussed in Appendix F.1 *The Constitutional Framework.* There are several such provisions in provincial liquor legislation, including the offence of public drunkenness and the prohibition of purchase or consumption of liquor by minors. Another example is the provision in the *Public Health Act* of Alberta prohibiting the use of a volatile solvent for purposes of intoxication.[16]

THE ISSUES WITH RESPECT TO CONTROL OF THE USER

The issues with respect to legal control of the user are whether there is to be an offence of simple possession or use for a particular category of non-medical drug use, what the maximum penalties for such an offence are to be, and whether any control or coercion is to be exercised with respect to the user for other purposes such as quarantine, treatment or indoctrination. In Section V we considered the use of law with respect to the non-medical use of drugs as a matter of general principle, the general effectiveness of the criminal law in controlling availability and use, and the costs of using the criminal law in this field. In this section we wish to look more closely at the issues with respect to control of the user in certain categories of drug use.

Despite the limitations and drawbacks of the criminal justice system in the field of non-medical drug use the majority advocate some control over the drug offender, particularly the user of heroin. The avowed purpose of such control is not merely to prevent the offender from continuing to violate the drug laws and to commit drug-related crime but also to reduce his contact with prospective users. It is felt that users spread drug use by encouraging or facilitating the use of others. In this sense it is argued that they are "contagious" or "infectious". A further reason for seeking control is to direct the user into treatment. It is said that the user often lacks motivation for treatment and needs to be encouraged to seek it.

Others dispute the assumptions underlying the case for control. They do not deny that control may reduce the offender's drug use, although they point out that drugs circulate in most institutions in which there is confinement. They also observe that while the offender's ability to influence the drug use of persons outside the institution may be severely reduced or virtually eliminated, he remains in contact with many prospective drug users within the institution. In any event, however, they dispute the contagion thesis. While they do not deny that drug users may facilitate the initial use of others, they contend that other factors must intervene as the more direct cause of harmful drug use. Finally, they take issue with the assumption that persons can be properly motivated for treatment by coercion. They contend that the person who is compelled to submit to treatment lacks the motivation which is essential for the successful treatment of drug dependence.

It is not essential to control that the offender be subjected to imprisonment or some other form of confinement. Control can be exercised over the offender in the community through a surveillance in the form of probation or parole. A system of control must, however, be backed up by an effective sanction for violation of the conditions of probation or parole, and the only effective sanction is deprivation of liberty in the form of imprisonment or some other confinement. Thus if we choose a system of control we must be prepared to use confinement whatever name we give it, and we must have the facilities and the will to make the threat of confinement real and credible. Otherwise the system will lack an effective sanction, and offenders will evade the control with impunity. If we seek to avoid the drawbacks of confinement as much as possible we must rely on individuals preferring a conditional and supervised liberty in the community to confinement and on a high proportion of them being able to comply with the conditions of such liberty in a sufficient degree to warrant leaving them in the community.

The feasibility and apparent success of such a system depend very much on the criteria of sufficient compliance and the severity or indulgence with which they are enforced. If one wishes to avoid a high rate of failure and the necessity of the repeated confinement of a large proportion of offenders one will adjust the criteria of compliance and their application to the realities of the situation. In the case of drug dependence, strict criteria strictly enforced will call for extensive use of confinement.

There have been varying systems of control and varying rates of success with them. In speaking of success we must keep clearly in mind the distinction between the various objectives of control: deterrence, isolation or quarantine, and treatment and rehabilitation. Deterrence is the principal object of punishment. Punishment is meant to persuade others that it does not pay to engage in the prohibited behaviour, and it is also meant to teach a similar lesson to the offender. Criminologists speak of general deterrence, which is the deterrence of others, and special deterrence, which is the deterrence of the offender. Short of capital punishment, deprivation of liberty is the most severe punishment we can impose. Deprivation of liberty not only serves the function of punishment but it protects others from being exposed to the offender. This is the function which we refer to as isolation or quarantine. It is often referred to as incapacitation. In the case of drug use, as we have said, it is advocated quite literally as a measure of quarantine on the ground that certain drug users are contagious or infectious. Deprivation of liberty is also seen as a means of submitting the offender to treatment with a view to rehabilitating him as a law-abiding citizen. In the case of the drug offender the emphasis is on curing his drug dependence or managing it in such a way that he is able to function reasonably effectively in a law-abiding way.

We have commented on the relative effectiveness of the criminal law as a deterrent in the field of non-medical drug use. For all of the reasons

mentioned in that discussion advocates of control will often concede that the criminal law is likely to be less effective as a deterrent against the drug user than against many other kinds of offender, but they will state that they are more concerned with isolation or quarantine. At the same time, if there is not a sufficient risk of apprehension and imprisonment to make the law an effective deterrent, then it can hardly be an effective measure of isolation and quarantine. To be an effective measure of quarantine the law must be able to assure the removal of a high proportion of offenders from contact with prospective users. It may be argued that the reason the law would appear to be a relatively ineffective deterrent in the case of drug use is not so much the small proportion liable to be detected as the very strong attraction of the prohibited behaviour, particularly in the case of dependence; and that while the threat of deprivation of liberty may be a relatively weak deterrent, the actual deprivation of liberty may be an effective measure of isolation or quarantine. Total numbers are nevertheless important where quarantine is concerned. If any substantial numbers escape the quarantine the spread of the disease will continue more or less unchecked. If the epidemic theory holds true then it is logically necessary to isolate a high proportion of the infected population if we want to check the spread of the disease and not merely to slow its rate of spread. Actually, there has not been a serious, thorough-going attempt in Western societies to check drug use by a system of quarantine. It is a policy which is still being advocated and debated.

Apart from the contagion theory, however, control is seen as an essential measure to take drug-dependent persons "off the street" and to reduce their drug-related crime, which in some large American urban centres has reached very serious proportions. Indeed, many consider this the most serious consequence of heroin dependence: the amount of property crime that heroin-dependent persons are obliged to commit to support their habit,[17] and the amount of fear and general insecurity which is generated by their drug-related criminal activity, including an increasing amount of violence. In the measure that control reduces this crime it is deemed to serve a sufficient function to justify its use.

There are various models of control. There is regular imprisonment and special treatment programs in an institutional setting such as those conducted in the American federal hospitals at Lexington and Fort Worth and at the Matsqui Institution in Canada (see Appendix I *Treatment of Opiate Dependents in Federal Penitentiaries in Canada*). There is the model offered by Part II of the *Narcotic Control Act* (which has never been put into force) of sentence to custody for treatment for an indeterminate period in a penal institution. (For discussion of these provisions see Appendix F.1 *The Constitutional Framework* and Appendix J *Probation for Heroin Dependents in Canada.*) Other models of institutional control are to be found in the civil commitment programs which exist at the federal and state levels in the United States. One of the most important of these—the California Civil Addict Program—is described in detail in Appendix L.

There are various provisions for compulsory treatment in other countries. An interesting model is that provided by the French law of December 31, 1970.[18] This law, which makes the illicit use of narcotic drugs an offence, provides further that persons who could be charged with the offence may be ordered by the law enforcement authorities to submit to detoxification and to medical surveillance for a period judged to be necessary. These treatment measures are carried out under the jurisdiction of the public health authorities who are to work in close cooperation with the law enforcement officials. In the case of a first offender the authorities will not proceed with prosecution against a person who complies with the prescribed medical treatment for its full duration. In the case of subsequent offences it is in the discretion of the authorities whether to proceed. Compulsory treatment may also be ordered after conviction of illicit drug use, as an alternative to other penalties. Finally, the French law provides for voluntary submission to detoxification and medical surveillance under conditions which will permit the patient to maintain his anonymity. This provision is designed to encourage drug users to submit to voluntary treatment rather than to wait for an order from the law enforcement authorities. Compulsory treatment may also be ordered when a drug user is reported to the public health authorities by a doctor or social worker.

The basic model for civil commitment in Canada is the provision under provincial mental health statutes for the compulsory confinement of persons suffering from mental disorder. There is legislation providing for such commitment in every province. The ground for commitment in most cases is that the person suffers from mental disorder to such a degree that hospitalization is required for his own protection or welfare or the protection of others, or, as it is expressed in some provinces, in the interests of his own safety or that of others. Commitment is usually upon a doctor's certificate, although there is also provision in most provincial legislation for commitment by court order. Commitment may be renewed for successive periods by doctor's certificate. There is generally provision for independent review of the justification for commitment. In most provinces a person with drug-related problems must fall within the general definition of mental disorder to be eligible for commitment. In some cases the definition expressly includes dependence or addiction.[19] Apart from the question of dependence, certain kinds of drug use may produce or be accompanied by a mental condition included in the definition of mental disorder.

In 1971 there was a total of 18,573 admissions to psychiatric facilities in Canada with a diagnosis of alcoholic psychosis or alcoholism, of which 2,909 involved involuntary commitment.[20] There were 2,179 admissions with a diagnosis of drug dependence (excluding alcohol) of which 420 involved involuntary commitment. The order of relative importance (along with the number of admissions) in the drug dependence categories was as follows: 1. amphetamine and related stimulants (383); 2. natural and synthetic opiate narcotics (239) ; 3. hallucinogens [excluding cannabis] (204) ; 4. barbiturates

(126); 5. other sedative-hypnotics and tranquilizers (84); 6. cannabis (28); and 7. cocaine (4). There was a large number of admissions classified as "other" (300) or for which the drugs involved were unspecified (811). (These data are discussed in more detail in Appendix A *The Drugs and Their Effects.*)

In some cases provincial legislation expressly provides for the compulsory treatment of alcoholism for periods ranging from ninety days to one year.[21] In a few cases there is special legislation for the commitment of opiate-dependent persons, although it does not appear to have been used.[22]

Other models of control are parole (see Appendix K *Parole of Heroin Dependents in Canada*), probation (see Appendix J *Probation for Heroin Dependents in Canada*), and conditional discharge (see Appendix F.8 *Sentencing*). These all involve supervision in the community rather than institutionalization.

There has been growing resort in the United States to court referral or "diversion" from the criminal justice system to treatment. A typical diversion program is the Court Referral Project of the Addiction Services Agency in the City of New York.[23] This project has developed partly out of the unwillingness of persons involved in the criminal justice system to resort to the commitment program of the Narcotic Addiction Control Commission. It has been estimated that only seven per cent of the addict population which is not incarcerated nor participating in other treatment programs is presently on civil commitment status in New York State. There are several reasons for this reluctance: the over-crowding of court facilities; and the negative attitude towards the civil commitment program of opiate dependents, legal aid lawyers (who represent more than 90 per cent of the defendants), and lawyers in the district attorneys' offices. A defendant, who may have only been charged with a misdemeanour, may request a jury trial on the issue of addiction, and the district attorney's office is often unwilling or unable to devote the necessary resources for such trials because of a backlog of felony charges and more serious cases. In such cases non-addiction is conceded and the defendant is sentenced to a correctional institution.

A common pre-trial disposition of misdemeanour cases involving opiate-dependent persons in New York City has been to adjourn the case and refer the opiate dependant to a private agency for treatment. The court discharges the defendant if he is still successful in the program after a year or so (during which time progress reports will have been received) or will have him returned to stand trial for the criminal charge if he is unsuccessful or absconds from the program.

The New York Court Project was established to formalize this diversion of opiate-dependent persons out of the criminal justice system into treatment. About two-thirds of the referrals are post-trial, where the convicted defendant goes into a treatment program on probation. If he is successful in the program (by the program's standards) he is not sent to jail. One-third

of the referrals occur before trial, and the charges are dropped against the defendant if he is successful.

The Project staff interviews the addict and tries to determine the treatment modality that will be most appropriate for him, thus eliminating the haphazard choice of a treatment program and hopefully increasing the chance of success. Between one-quarter and one-third of those interviewed are judged to be unready or ineligible for treatment and returned to the court. On very rare occasions (when an individual requests it, for example) an addict is referred to the commitment program of the Narcotic Addiction Control Commission.

The Project claims a rate of retention in treatment of between 65 and 70 per cent. As the quarterly report of the Project for the period April 1st to July 1st, 1972 notes, "It is absolutely necessary, for the success of such a venture, to obtain the cooperation of the Prosecutor and Defense Counsel, the Department of Correction, Department of Probation, the Court and, finally, the treatment programs." Opiate-dependent persons come to the attention of the Project primarily through two channels: direct referrals from defense counsel, judges, department of probation and defendants themselves; and, secondly, screening of pre-trial detainees going through detoxification in correctional institutions. The majority of the cases for referral are selected through the second of these processes. There are approximately 40,000 persons detoxified each year in the prison system in New York. It is estimated that about one-quarter of these are eligible for diversion into treatment programs.

The Court Referral Project began to place individuals in treatment in January 1972. No defendant is placed in a treatment program he does not wish to enter. Project staff visit the prisons to interview those prisoners who are awaiting trial and have indicated a wish to enter treatment. At the end of the first quarter of operation approximately 130 persons had been recommended for release from prison and placement in treatment programs. Of that number 45 had been rejected by the District Attorney or the court. Of the remaining 85 who were placed in treatment, approximately 60, or 70 per cent, were still participating at the end of this period and had "not gotten into further trouble". The court, the District Attorney and defense counsel are notified by the Project when a person leaves a treatment program. It is contemplated that a person will remain in treatment from six months to a year before final action is taken regarding the disposition of his criminal case.

A difficulty encountered by the Project has been the limited availability of treatment for the number of opiate-dependent persons in New York. There has been a particular difficulty in obtaining places in methadone programs.* By the end of the second quarter over 1,100 persons had been interviewed and approximately 300 referred to treatment. These are described

* Since the report on which this statement is based there has been a significant increase in the availability of places in treatment.

in the quarterly report of the Project as "young, hard-core addicts, who have been involved with the law on numerous occasions". Over 70 per cent of them claim to have been supporting their drug habit by crime. Approximately 50 per cent have been referred to drug-free programs, 40 per cent to methadone maintenance programs and the remainder to various other treatment programs, including in some cases the use of narcotic antagonists. At the end of the second quarter of operations, approximately 70 per cent of those released into treatment were still participating in the program.

Another model of control is the new approach adopted in recent years by several of the provinces towards the treatment of public drunkenness.[24] Where a police officer finds a person who appears to be intoxicated in a public place, he may, instead of charging him with the offence of public drunkenness, take him into custody for detoxification treatment. The police officer is given a statutory immunity from liability if he acts in good faith. The law may also provide immunity from liability to any physician or any hospital for the examination or treatment of the individual who is brought to a detoxification centre by a police officer. Generally, the law stipulates a maximum period, ranging from twenty-four to seventy-two hours, for which the individual may be detained. The law may provide for a longer period of detention upon application to a judge or magistrate for a confirming order.

Most of the provincial mental health acts which provide for civil commitment of persons suffering from mental disorder contain a similar provision giving power to police officers to take into custody and detain for medical examination any person whom they observe to be apparently suffering from mental disorder and acting in a disorderly or dangerous manner. This power exists for cases where it is not practicable to attempt to obtain the order of a judge or magistrate upon information under oath. A person apprehended and detained for examination in this manner may be committed upon the examining physician's certificate.

There has been considerable experience with deprivation of liberty as a means of facilitating treatment and rehabilitation, but on the whole the results have not been very encouraging. The experience with treatment in prison-like settings of confinement has definitely been unsatisfactory. This is borne out by the Canadian and American experience with treatment in penal institutions.[25] What they show is a very high rate of relapse and recidivism. It should be noted, however, that these treatment programs were committed to a goal of abstinence or cure. They were not experiments with the use of methadone maintenance as a means of managing opiate dependence. There is no reason to believe that their rate of failure with a drug-free goal is likely to be much higher than that of other abstinence programs. They do tend to emphasize two things, however: bringing addicts together in a long period of confinement tends to reinforce them in their commitment to drugs and a drug-using criminal subculture, and secondly, there must be long-term aftercare and follow-up to help the addict re-

structure his life, if there is to be any hope of success. According to Isbell the chief limitations of the American programs in the federal hospitals at Lexington and Fort Worth were a lack of control over voluntary patients,* a high proportion of whom left the program prematurely, and a lack of follow-up in the community.[26] The American civil commitment programs, particularly the California and federal programs, were designed to meet these requirements of control and follow-up. Their results have not been dramatically better than those in regular penal institutions, but again, at least until fairly recently, they have not permitted methadone maintenance. (See Appendix L *Civil Commitment in California.*)

In Matsqui Institution (see Appendix I *Treatment of Opiate Dependents in Federal Penitentiaries in Canada*), a hospital-like complex established as a result of the recommendations of the Fauteux Report and conceived of as a forerunner of a system of treatment facilities which would permit the introduction of compulsory treatment under Part II of the *Narcotic Control Act,* a carefully controlled experiment was conducted to determine the success of a special form of therapeutic community treatment as compared to the regular treatment program in the institution. A comparison was not made with the results of imprisonment without treatment. In the result, those who were subjected to what might be called the "advanced" or "progressive" form of treatment with a less authoritarian and more participatory group therapy atmosphere and a greater emphasis on the upgrading of skills, turned out worse than those in the regular treatment program. They appear to have become more skilful in leading the life of a criminal addict. What the Matsqui experiment tends to emphasize is the role which prison, even with well-intentioned treatment efforts, can play in strengthening the criminal inclinations and capacities of offenders. It may also suggest that more authoritarian techniques are more effective with the criminal addict than more permissive ones.

One cannot deny all efficacy to these experiments with treatment in a prison setting. A case can be made for the contention that they effected a marginal improvement, and, of course, had the merit, while the offenders were in confinement, of keeping them out of drug-related crime and out of contact with law-abiding non-users.

Vaillant has also observed that a long-term follow-up of those released from the federal hospital at Lexington showed that a certain proportion—about two per cent—had become abstinent each year.[27] Whether this can be attributed in some measure to the treatment program which they received or to the phenomenon of "maturing out", or to other factors, is not clear.

In any event, there seems to be a general acknowledgement that imprisonment or other forms of confinement, whatever we choose to call them,

* The population in these hospitals consisted partly of prisoners and partly of voluntary patients.

do not increase the chances of successful outcome with an abstinence form of treatment. As a result, there has been a very definite movement away from confinement or inpatient status to outpatient or probationary status. This reflects the general trend of thinking in penology and mental health policy in favour of more rehabilitation or treatment in the community. In the drug field this trend has been particularly marked in the California civil commitment program (see Appendix L). There has been a steady tendency in recent years to reduce the period of time required to be spent in inpatient status, and to increase the relative proportion of time spent in the community. The initial mandatory period of six months confinement in inpatient status is no longer compulsory for everyone. The program now includes a "Direct Release" experiment in which a certain number are permitted to go directly from commitment to outpatient status on methadone maintenance.

In Canada, there has been limited experience with the use of probation and parole in the management of heroin dependence. (See Appendices J and K.) In particular, the potential of these forms of control, in association with methadone maintenance, has not been fully tested. The availability of methadone justifies further experiment with these forms of supervision in the community, particularly probation. There are special problems concerning parole arising from the effect of imprisonment on the heroin dependent and the implications of forfeiture and revocation of parole.

Certain problems have arisen in connection with the relationship between the law enforcement and treatment authorities. The first involves the decision as to who is to be accepted for treatment and the second the decision as to whether a person's probation or parole should be revoked for violation of the conditions of release. The courts may be increasingly prepared to place drug-dependent offenders in a probationary status on treatment rather than sentence them to imprisonment or release them into the community again without any attempt at treatment. On the other hand, the treatment agencies point out that not all drug users are suitable for certain kinds of treatment, and that the treatment authorities must have the final word as to who is to be accepted. The law enforcement authorities are interested in effective control—in removing the drug-dependent person from the illicit market and from drug-related crime; the treatment agencies are interested in successful treatment, or at least treatment with a reasonable chance of success. There is often a tension or conflict between these two concerns—control and effective treatment. A court may wish to place a convicted offender on probation on condition that he report to a certain agency for treatment, but the agency may not wish to accept him because they do not consider him a good prospect for treatment or, for example, they consider it premature to place him on methadone maintenance.

This kind of problem can be largely resolved by proper consultation between lawyers, judge, probation officer and treatment agency *before* the decision is taken to place an offender on probation on condition that he submit to treatment. But it is well to face the fact that so long as the control

and treatment concerns are handled by essentially independent and separate agencies the perspectives which each will bring to the problem will often be in some conflict.

Another kind of problem that arises in the relations between the law enforcement and correctional authorities, on the one hand, and treatment agencies, on the other, is conflict over responsibility for enforcement of the conditions of probation or parole. In order for control to be effective—that is, to keep the offender out of the illicit market and drug-related crime as well as association with drug users and influence upon prospective users—it is necessary that the conditions of probation or parole be strictly enforced. If they are not strictly enforced and the offender knows there is really no sanction for violation, he will tend to revert to all the conduct which the control is intended to prevent. Those who are concerned primarily with control tend to emphasize strict enforcement of the conditions of probation or parole, although they themselves also develop some realism about what it is reasonable to expect in the way of substantial compliance if the system is to work at all. The role expected of the treatment agency in relation to enforcement is to establish by regular or spot urine tests whether the patient is abstaining from the use of prohibited drugs and otherwise complying with the conditions of the treatment program. The problem arises when the treatment agency is called on to furnish evidence of violation of the conditions of probation or parole. Persons engaged in treatment do not feel that this function is compatible with the relationship of trust which they must establish with the patient. Moreover, they are concerned with trying to help the patient and do not like to be involved in inflicting the harm of incarceration. Treatment agencies must, of course, establish some standards of compliance and must be prepared to drop hopeless cases from their programs. But it is one thing to drop a patient from treatment; it is another thing to send him to prison. Persons engaged in treatment find this possibility distasteful and to some extent in conflict with their commitment to heal, and those responsible for enforcement of the conditions of probation or parole sometimes complain of a lack of cooperation from treatment agencies in establishing the necessary proof of violation. Again, this problem could probably only be completely resolved by having the correctional and treatment responsibilities, or at least the control and monitoring functions, under a single authority. For a recent development giving police the power to require probationers to submit to urinalysis, see Appendix J *Probation for Heroin Dependents in Canada.*

There have been proposals from time to time for the complete isolation of heroin addicts in therapeutic colonies. Nils Bejeröt, the Swedish drug expert who has been a vigorous exponent of the contagion or epidemic theory of drug dependence, has advocated this form of isolation or quarantine.[28] Similar suggestions have been made from time to time in North America. Several of the police officers who testified before the Special Senate Committee on the Traffic in Narcotic Drugs in Canada in 1955 made a

recommendation along these lines. For example, Commissioner Nicholson of the R.C.M. Police said: "I therefore feel—and I think this view is held by many if not most other police officials—that the only hope for the possible rehabilitation of these addicts and for the eradication of the drug traffic is that they be compulsorily isolated or quarantined."[29] When introducing the *Narcotic Control Act* in 1961, the Minister of Justice of Canada referred to these suggestions but rejected the notion of life-time confinement on the ground that it would destroy all hope and motivation.[30] At the same time, Part II of the Act seemed to adopt the principle of isolation or quarantine by providing for indefinite confinement for treatment. The distinction stressed by the Minister of Justice was that under these provisions the inmate could be released on parole as soon as he had made sufficient progress in rehabilitation. But presumably most proposals for isolation or quarantine contemplate the release of the drug-dependent person when it is considered safe. The isolation or quarantine is not seen as a life-time punishment for having once become drug dependent, but as a measure of protection of others.

Opiate dependents are still imprisoned, and to this extent, subjected to a degree of isolation or quarantine for limited periods. But the use of imprisonment for the simple possession of opiates has declined somewhat in recent years, and sentences tend to be for shorter periods than in the past. The actual time spent in prison, at least initially, is also frequently shortened by parole, although in the end the high rate of revocation or forfeiture of parole and the consequence thereof may have the effect of actually increasing the total period of imprisonment. (See Appendix K *Parole of Heroin Dependents in Canada.*) Moreover, only a comparatively small proportion of the estimated opiate-dependent population is convicted and sentenced to prison each year. As indicated above, little more than 10 per cent of this population are in penal institutions in Canada at any one time. Thus the present control system does not perform an effective function of isolation or quarantine. One thing is clear, that a policy of isolation or quarantine for the present population of opiate dependents, if it were to be considered acceptable on other grounds, would require much greater resources of law enforcement personnel and custodial and treatment facilities than are currently available.

With respect to the relationship between control and treatment, the essential question is how far effective treatment is promoted or impeded by the exercise of some degree of control or coercion. There have been no satisfactory studies of the effect of control upon the treatment of drug dependence. It has been observed that there has been a high rate of premature withdrawal from voluntary treatment programs. As previously stated, this was the experience with voluntary patients at Lexington, and it has been the experience in other jurisdictions, such as New York, where voluntary programs have been tried. However, in most of these cases treatment was being carried out in an institutional setting. As we noted above, the lack of some means of keeping voluntary patients in treatment for a reasonable period of

time was felt to be a serious weakness of the Lexington program. It is no doubt to meet this objection that modern civil commitment programs quite often provide that a person who voluntarily has himself committed is obliged to remain in the program for a certain minimum period. The decision to apply for commitment is voluntary, but once the commitment is ordered it becomes compulsory. The maximum period for voluntary patients is generally shorter, however, than the maximum period for involuntary patients, and this difference is intended to encourage voluntary commitment. The control in this case is exercised not to compel the patient to accept treatment, at least initially, but to remain with it for a certain minimum period of time.

There is good reason to believe that control can have an important bearing on the ability to retain drug-dependent persons in a treatment program. This is an important issue of motivation, although it is not the only one. It is important that patients be willing to give treatment an opportunity, and it is also important that they be willing to cooperate with it while it is going on. There is the willingness to spend the required time in treatment to give it a reasonable chance of success, and there is also the determination to respond to treatment in an effort to make it as effective as possible. The two do not necessarily go together. A person may be coerced into spending the necessary time in a program, but he may not have the necessary will to respond or cooperate. Or his response may be perfunctory or feigned in order to obtain the favours that flow from compliance with the program. The effect of control or coercion on this second, and essential, aspect of motivation is not so clear. Everyone agrees that such motivation is essential if there is to be any chance of success. The question is whether control or coercion has a positive or negative effect upon it. There is no clear evidence either way, but there are divided opinions. The experience with treatment in prison settings is by no means conclusive. The high rate of failure in such cases may be attributed to the compulsory aspect, but it may also be attributed to the lack of an effective means of treatment. If we compare the rate of success claimed by certain therapeutic communities operating on a voluntary basis with the rate of success in prison settings we may be led to the conclusion that an essential difference must be one of motivation. But it may be a difference in motivation resulting from a difference in the two kinds of population. The therapeutic community attracts a type of person who is highly motivated to respond to that form of treatment. It is not acceptable to a high proportion of drug users. It has a high rate of initial drop-out. What remains is a group of people who are reasonably well adjusted to it as a form of treatment. The voluntary patients in a therapeutic community are self-selected. Prison receives a cross-section of drug-dependent persons who vary considerably in their capacity for response to a particular form of treatment. It may well be that it is not so much compelling a person to accept treatment of some kind that adversely affects motivation as poor selection of the form of treatment. The decision to accept *some* treatment

may be constructively reinforced by a degree of control or compulsion, but motivation to respond to treatment may be reinforced by allowing the patient to choose the form of treatment that seems to be most congenial to him. Those who favour some degree of control or compulsion in support of treatment express the opinion that most chronic drug users do not have much motivation to seek treatment. They need to be encouraged to do so. But once they have been helped by a little direction to make that essential decision to seek help, their motivation can be aroused and strengthened by involving them in the process of choosing and shaping their own treatment program. There is no doubt that little can be done with someone who refuses to cooperate, who sullenly refuses to be helped. But an initial use of compulsion in opening the door to treatment would not seem to rule out the subsequent possibility of arousing the necessary motivation to respond to the particular form of treatment chosen by the patient. Compulsory treatment does not mean the physical or psychological coercion of the patient on each occasion of treatment. It means making or compelling the original decision to undergo treatment.

CONCLUSIONS AND RECOMMENDATIONS WITH RESPECT TO CONTROL OF THE USER

The Offence of Simple Possession

The offence of simple possession has not prevented an increase in the various forms of non-medical drug use to which it applies. There has obviously been a very marked increase in recent years in the non-medical use of heroin, other opiate narcotics, such as illicit methadone, and cocaine. The use of LSD appears to have levelled off, and perhaps even decreased in the last year or two, but there has been an increase in the use of other hallucinogens, such as MDA. There is also every reason to believe that the use of cannabis has continued to increase, although the rate of increase may have declined in the last year or so.

What we do not know—and can never determine—is to what extent, if any, the increase in these various forms of non-medical drug use would have been greater if there had not been an offence of simple possession. Nor can we say how far the apparent levelling off, or decrease, in the use of LSD should be attributed to the offence of simple possession. There is no way of determining the effect which the absence of an offence of simple possession may have had on other forms of non-medical drug use.

There has not been an offence of simple possession for the controlled drugs (the amphetamines and barbiturates) or for the drugs on Schedule F of the *Food and Drug Regulations*, including certain amphetamine-like drugs (e.g., Ritalin®), minor tranquilizers (e.g., Librium® and Valium®), sedative-hypnotics (e.g., Mandrax®) and hallucinogens (PCP and mescaline). Notwithstanding the absence of an offence of simple possession, there has been an

apparent levelling off, and possibly even a decrease in the total numbers involved in intravenous use of methamphetamine or 'speed'. On the other hand, there has been an apparent increase in the oral non-medical use of amphetamines obtained in an illicit market, and in the non-medical use, supplied from an illicit market of phenmetrazine (Preludin®), methaqualone (e.g., Mandrax®) and PCP. There has not been an offence of simple possession or use with respect to volatile solvents, except in one province, but their use for purposes of intoxication appears to have levelled off, and perhaps even declined, in recent years.

There is no obvious general conclusion to be drawn from these facts concerning the deterrent effect of an offence of simple possession. One might be led to conclude, however, that it has relatively little influence on the extent of use. The extent of use appears to be influenced more by other factors, chiefly availability, contact with users, and their opinions and perception of the risks or possible harm involved in a particular form of drug use. There are also changing fashions in non-medical drug use, as in other forms of behaviour. As we suggested in Section V *The Use of the Criminal Law Against Non-Medical Drug Use*, there is reason to believe that the deterrent effect of the criminal law with respect to the simple possession of drugs for non-medical use is much less than it is with most other offences. The main reason is the difficulty of detection and apprehension. There are relatively large numbers involved in the prohibited behaviour in relation to the available law enforcement resources, and there are special difficulties of detection arising from the fact that the behaviour can be carried out in private and there is seldom anyone to complain. These difficulties oblige the police to resort to special methods of enforcement which are regarded as distasteful by the general public: writs of assistance, use of force to break into premises and to recover evidence, undercover agents, informers, and encouragement of offences. These methods severely limit the extent to which the law can be applied in practice to large elements of the drug-using population. It is felt by some that by its mere existence the law exerts some moral influence and exercises a deterrent effect, apart from the actual risk of detection. We may assume that many are deterred from the prohibited conduct by the mere existence of the law, but by and large they do not appear to be the individuals about whom there is most reason for concern: those who are not deterred by the risks or dangers of heavy, chronic drug use. Those who are not deterred by the harmful consequences of such drug use are not likely to be deterred by the relatively slight risk of detection and apprehension, and even less by the moral stigma of the law. Moreover, there is a significant minority of the population who appear to consider the law against certain forms of non-medical drug use as lacking the moral authority which entitles it to respect.

The adverse effects, or costs, of enforcement of the offence of simple possession far outweigh the benefits which it yields. Because of the difficulties referred to above, the offence of simple possession is necessarily enforced in a haphazard manner. Its enforcement falls with great uneveness on the

population of drug users, and this gives rise to a well-founded sense of injustice. Society could not afford the manpower, much less the methods, required to enforce the offence of simple possession in anything like a systematic and thorough-going manner.

While it may be permissible in theory to use the criminal law to prevent a person from doing harm to himself, the moral authority of the offence of simple possession, and the support which it commands, is weakened by the fact that the extent of the harm caused to the user, to third persons and to society generally by certain kinds of drug use varies considerably. The offence of simple possession does not distinguish between different levels of use, and in its effects it often appears to be grossly out of proportion to the effect of the conduct against which it is directed. The consequences of criminal conviction are clearly out of proportion to the effect of an occasional or experimental use of most drugs.

Even if imprisonment is not imposed, criminal prosecution and conviction can have serious psychological effects, causing mental suffering to the offender and members of his family, and can have an adverse effect on his prospects for employment and other opportunities. The effect of the law has been mitigated to some extent by the provision for absolute and conditional discharge and for early pardon. But in cases of absolute and conditional discharge there is still a finding or plea of guilt and the stigma of a criminal record. Early pardon may remove the official record, but it cannot remove the *fact* of a finding of guilt or a conviction and the prejudicial uses to which it can be put in the future by persons who are able to obtain knowledge of it. There is no way in which the memory of a criminal prosecution and finding of guilt or a conviction can be erased. So long as such knowledge exists it may always be a basis for action detrimental to the individual.

The main cost of the use of the criminal law against non-medical drug use is that it falls with particular severity upon the young. A high proportion of the convictions for simple possession involve persons under twenty-one years of age, and the vast majority are under twenty-five. This is particularly true of cannabis, but it is also true of the restricted drugs and to some extent of the opiate narcotics.

For all of these reasons we strongly recommend against any further extension of the offence of simple possession. We believe that we should gradually withdraw from the use of the criminal law against the non-medical user of drugs rather than extend its application. A policy to extend its application would be a policy of futility. There is virtually no limit to the number of drugs to which it would have to be applied if it were to be pursued to its logical conclusions. We would have to be prepared to apply it not only to the controlled drugs in Schedule G of the *Food and Drugs Act* but also to drugs with an abuse potential which are presently on Schedule F of the *Food and Drug Regulations*. As we have indicated above, several of these drugs have been the subject of an increasing non-medical use supplied by an

illicit market. The technical capacity exists to produce an infinite variety of drugs of abuse. This capacity is not the monopoly of a few responsible organizations but is widely accessible. Even if it were possible to suppress one drug there would be many others to take its place.

In the course of our inquiry many have urged that there be an offence of simple possession for the amphetamines, particularly for methamphetamine or 'speed'. This is a reflection of the concern for the dangerous effects of 'speed'. Law enforcement officials have urged that there be an offence of simple possession for the controlled drugs in general. They have stated that they are handicapped by the lack of such an offence in their enforcement of the laws against trafficking. While this opinion is entitled to great respect, there is no way of testing its validity. As we have indicated above, the use of 'speed' appears to have levelled off, and even decreased, in recent years despite the absence of an offence of simple possession. Convictions for trafficking offences involving 'speed' have steadily increased until they have approximated the total number of convictions for trafficking offences involving heroin. In 1971, they exceeded them, and in 1972, when there was a very marked increase in heroin convictions, they were about 85 per cent of the number. It is, of course, impossible to say whether the existence of an offence of simple possession for 'speed' would have made a significant difference to law enforcement against trafficking—at least, one which would have justified the cost of this extension of the criminal law. **Given the fact, however, that the total number using 'speed' appears to have stabilized, and possibly even declined, and given the apparent level of law enforcement against trafficking, we do not believe that there is any compelling reason for the creation of an offence of simple possession for this particular form of drug use. The total amount of 'speed' use is controlled by other factors: the poor opinion of it in the drug subculture, the perception of its potential for harm, and the self-limiting nature of the phenomenon.** (See Appendix C *Extent and Patterns of Drug Use.*) **Although the violence associated with the use of 'speed' is cited as a reason for creating an offence of simple possession, we are still of the opinion, expressed in our Interim Report, that because of the paranoia of the 'speed freak', such a step would lead to an increase in tension and violence between the police and the drug subculture.**

A decision was taken deliberately in 1961 not to create an offence of simple possession for the controlled drugs on the ground that in many cases the unauthorized possession of them would result from a member of a family obtaining access to a supply of drugs which another member had obtained on prescription.* This is still likely to be the case very often for both the controlled drugs and the drugs with stimulant or sedative-like action on Schedule F of the *Food and Drug Regulations.* The extensive use of many of these drugs by adults, the easy accessibility of others to them, and the often questionable nature of the distinction between their medical and non-

* *Debates,* House of Commons, Canada, May 30th, 1961, p. 5595; Hammond, "The Control of Barbiturates and Amphetamines," (1964) 15 U. of T.L.J. 443 at 445.

medical use would all contribute to a difficult and discriminatory application of an offence of simple possession. It is likely that the law would fall, as in the case of cannabis, on young people who happen to come into contact with the police. The likelihood of a discriminatory application of the law would be increased rather than diminished by the restrictions recently placed upon the medical use of the amphetamines and amphetamine-like drugs in Schedule G of the *Food and Drugs Act.* Because of the widespread desire of adults, including housewives, businessmen and athletes, to make use of these drugs for their stimulant effects, it is likely that there will be an illicit market in them. It is not likely, however, that enforcement of an offence of simple possession would reach large segments of the adult using population, any more than it has reached them in the case of cannabis.

While we are opposed to any *extension* of the offence of simple possession, we recognize that it may be necessary to take a somewhat different view of a proposed *elimination* of this offence in particular cases. This arises from the effect which such a proposed change in the law may have on attitudes and behaviour with respect to a particular form of non-medical drug use. There is clearly a difference in this respect between a proposal to extend the application of the criminal law and a proposal to reduce its application. The existing situation is not adversely affected by a refusal to extend its application, but it may be adversely affected by a change in the law which reduces its application. While the offence of simple possession may have relatively little effect as a deterrent of use, it undoubtedly has some, and what is more important, its elimination is likely to have some effect on the perception of harm. It is inevitable that many will infer from such a change that the potential for harm must not be as serious as was originally contended.

In each case, the issue must be decided, as we stated in our *Cannabis Report,* on an estimate of the balance of benefit and cost. We conceded at that time that the elimination of the offence of simple possession of cannabis would probably result in some increase in use and some effect on perception of harm, but having regard to the relative potential for harm of cannabis, the degree to which the law regarding it was at variance with the facts, and the costs of applying the criminal law to thousands of young people, we concluded on balance in favour of the elimination of the offence of simple possession of cannabis.

Despite our general misgivings about the offence of simple possession we do not believe that it would be prudent to remove it at this time with respect to the strong hallucinogens classified as "restricted drugs" in Schedule H of the Food and Drugs Act. While the use of these drugs is generally experimental or occasional, rather than regular, any use of them is potentially dangerous or hazardous. The effects of the strong hallucinogens are unpredictable, and adverse psychological reactions can arise from occasional as well as chronic use. There is impressive clinical evidence to suggest that

they can be a factor in precipitating mental illness or adverse personality change. The strong hallucinogens present an even greater danger of adverse effect on adolescent maturation than that about which we expressed concern in the *Cannabis Report*. There are also the hazards involved in the "echo effect" or "flashback", in which the effects of an hallucinogenic experience may recur under conditions which present a danger to the user or to others.

While the total number using LSD appears to have levelled off, and possibly even decreased somewhat, there is still a large population of youthful users, and there has been a marked increase in recent years in the use of MDA, a particularly dangerous hallucinogen with amphetamine-like properties. This drug appears to have resulted in several deaths from overdose. The potential for harm of the strong hallucinogens is much greater than that of cannabis.

The perception of this potential for harm is a factor which limits use. It would be unwise to make a change in the law that might seriously undermine this perception. Because of the perceived potential for harm of the restricted drugs, the present law with respect to them is not seen as being at variance with the facts to the same extent as the law regarding cannabis. The classification of cannabis with the opiate narcotics and the extreme nature of the maximum penalties involving cannabis have clearly called for some change in the law. For this reason we expressed the opinion in the *Cannabis Report* that substantial changes could be made in the law regarding cannabis in order to make it more rational without a seriously adverse effect on the caution with which cannabis should be treated. The same is not as true of the strong hallucinogens or "restricted drugs". The offence of simple possession for these drugs has only existed in Canada since August 1969, but, unlike the case of cannabis, it was deliberately introduced into the law after careful consideration of the apparent harm being caused by the strong hallucinogens and of the penalty structure that was appropriate for them. The penalty structure that was introduced for the restricted drugs was much less severe than that for cannabis, which was left with the same legal status as heroin. The maximum penalties for trafficking offences and for simple possession were much lower, there was not the mandatory minimum sentence of seven years' imprisonment for importing or exporting, and there was the option to proceed by way of indictment or summary conviction in cases of trafficking as well as simple possession. Thus any change in the law would likely be perceived as more closely related to a change in the perception of harm than to a grossly mistaken classification in the first instance, as in the case of cannabis.

At the same time, some reasonable balance must be struck between the need to retain the law in order to maintain the perception of harm, and the adverse effects inflicted by the law. For this reason we adhere to the opinion expressed in our Interim Report that there should not be liability to imprisonment for the simple possession of the restricted drugs. Having regard to the potential for harm of the restricted drugs, the age distribution of the majority

of users involved, and the serious effects of imprisonment on persons in this age group, we do not believe that the courts should have the power to impose imprisonment in such cases. We are strengthened in this opinion by the very wide disparity in the approach to sentencing that has been disclosed by our studies. (See Appendix F.8 *Sentencing.*) Liability to imprisonment increases the possibility of injustice arising from this disparity. We do not believe that imprisonment is justified for the simple possession of restricted drugs, even in cases in which there is a previous criminal record. This offence should be judged on its own merits and should not be invested with the seriousness which may carry over from other cases.

In the case of the drugs other than cannabis which are presently governed by the Narcotic Control Act, we believe that the offence of simple possession must be retained for reasons similar to those which apply to the restricted drugs — the effect of its removal on the perception of harm. We believe, moreover, that it is necessary to retain liability to imprisonment for the simple possession of this class of drug. This represents a change in the view we expressed in our *Interim Report* — that there should be no imprisonment for the simple possession of *any* psychotropic drug. We are led to this conclusion for a number of reasons. There has been a very marked increase in the extent of opiate dependence and experimental or occasional use of opiate narcotics since our *Interim Report*, and the whole perspective of the relative seriousness of this form of non-medical drug use has altered significantly in Canada. The removal of liability to imprisonment for the simple possession of these drugs would be completely at variance with the impression of the problem which their use presents at this time. Apart from its effect on the perception of harm, liability to fine is likely to be relatively ineffective as a measure of control for the opiate-dependent person whose compelling need of the drug already involves him in the necessity of finding large amounts of cash on a regular basis through drug-related crime. Finally, **we see the continuing use of the criminal law against the user of opiate narcotics as a necessary device of catchment and referral for treatment or management.**

As we have indicated in the preceding discussion, there is no doubt about the adverse effect of imprisonment on drug offenders in reinforcing their preoccupation with drug use and their attachment to a drug-using and criminal subculture. Prison may interrupt drug use, but it does not cure drug dependence in the vast majority of cases. At the same time, an effective control system for the management of drug dependence must be backed up by the threat of confinement of some kind for failure to comply with the program. **We believe that the courts should avoid the use of imprisonment as much as possible for opiate dependents, but that it must remain as a sanction for refusal to comply with the conditions of supervised release into the community. We recommend, however, that the maximum sentence to imprisonment for the simple possession of the opiate narcotics and cocaine be two years.** As we have indicated above, about 90% of the sentences to imprisonment presently fall within this range.

The Use of Control for the Management of Opiate Dependence

There should be greater use of probation (or conditional discharge) on condition of compliance with an approved treatment program. The existence of methadone maintenance makes it more reasonable to impose treatment as a condition of probation. The opiate-dependent person may pursue a goal of abstinence in a therapeutic community or other treatment program, if he wishes, but he has a viable alternative in methadone maintenance. The range of options is likely to be enlarged in the near future by the availability of a satisfactory opiate antagonist.

There is no doubt that if there is a serious attempt to use the criminal law process for purposes of diversion to treatment or management of opiate dependence, instead of incarceration or other relatively ineffective sanction, there will have to be not only an increase in treatment facilities of all kinds, including specialized methadone units and therapeutic communities, but a considerable increase in the number of probation officers and others capable of assisting with the task of social rehabilitation.

The form of treatment which is to be followed by the probationer should be determined by the court after consultation involving the probationer, the probation officer, treatment personnel, and any others, such as police or social workers, who may have useful advice to offer. The probationer should be made fully aware of the nature and implications of the proposed course of treatment. It is important that expectations be clearly defined. Much dissatisfaction is created in practice by a vague transfer of responsibility from the judicial authorities to treatment institutions, accompanied by unrealistic expectations. At the same time, there should be sufficient flexibility to permit changes in the treatment program when these are considered to be desirable by the treatment staff and the patient. In other words, an agreed program should be defined in advance, based on adequate determination of the probationer's preferences, as well as relevant expert advice, but it should be capable of being modified by the treatment institution with the patient's consent. Probably the probation officer should be given discretion to approve such changes.

The question arises as to whether there should be provision for a program of compulsory management of opiate dependence outside of the criminal law process. For reasons indicated in Appendix F.1 *The Constitutional Framework*, it is doubtful if the Parliament of Canada has legislative jurisdiction for such purposes. (There is further discussion of this issue in Appendix J *Probation for Heroin Dependents in Canada.*) The general assumption is that compulsory treatment not related to the criminal law process falls within provincial jurisdiction. If the criminal law system is to be used to direct or encourage opiate dependents to submit to treatment, then it seems reasonable that we should make the catchment system as effective as possible by providing for a non-criminal form of compulsory treatment or management. Opponents of compulsory treatment tend to exaggerate the extent to which the

opiate-dependent person is actually free from compulsion towards treatment. The difficulty of supporting his habit in the illicit market, and the danger of arrest and imprisonment are factors which, after a time, exert a compulsion to seek treatment. The heroin-dependent person who seeks methadone maintenance because he is tired of "hustling" in the illicit market is in effect being compelled to do so, whether he likes it or not. It is not the wholly free decision which some suggest is essential to a proper motivation for treatment.

While we do not see how, as a practical matter, we can withdraw at this time from the use of the criminal law against the user of opiate narcotics, we are not in favour of introducing long periods of civil commitment. We do not believe that the results obtained elsewhere with this approach justify the extended deprivation of liberty in cases in which there has not been a criminal conviction. We do believe, however, that there is a strong case to be made for the use of compulsory confinement for a short time to oblige the opiate dependent to confront his situation and to consider, in an atmosphere in which he is free from the pressures of "hustling" in the illicit market and has access to good diagnosis and advice, whether he desires to pursue one of the treatment or management options open to him.

We recommend that provincial legislation confer power on police officers to bring any person whom they have reasonable and probable grounds for believing to be dependent on opiate narcotics before a magistrate, in order that it may be determined, upon *prima facie* evidence, whether the person should be committed to custody for medical examination for a period up to seventy-two hours. If the person is found to be drug-dependent, the examining physician and another physician who confirms the diagnosis should have power to commit the person to a residential treatment facility for a period of not less than one month and not more than three months. The purpose of such confinement would be to permit further examination and observation of the drug-dependent person, to permit him to confront his situation and to consider the various treatment or management options open to him, and to afford an opportunity for a commencement of treatment including extended detoxification, the technique of the therapeutic community or stabilization on methadone maintenance. The chief purpose would be to acquaint the patient with the possibilities of treatment, to encourage him to decide in favour of some course of treatment, and to begin the treatment process. If, at the end of the stipulated period, the patient refuses to follow a course of treatment he should be discharged. The period of residential confinement would also afford an opportunity for advice and assistance with other problems having a bearing on the patient's drug use. The residential facility should have access to the necessary counselling personnel to assist with problems of social rehabilitation.

Such a policy would require sufficient residential capacity in close association with general hospital and methadone facilities. There should also be

provision during the stipulated period of residential confinement for temporary release into the community under specified conditions and supervision. Police officers should have power, upon order of the head of the residential facility, to return the patient to confinement for violation of the conditions of release. In no case, however, should the total period of confinement be longer than that originally stipulated by the committing physicians. Moreover, where the confinement fails to produce constructive results on a first attempt, in the form of a decision to pursue treatment, the authorities would be well advised not to attempt it again, although this possibility should remain open. If a drug-dependent person fails to respond to this non-criminal law attempt to force him to confront his situation and elect treatment, then it would be better to leave further attempts at control to the criminal law system.

For the present, we would confine this experiment to cases of opiate dependence.* Since methadone maintenance offers the opiate-dependent person a viable option if he cannot accept treatment with a drug-free goal, there is some justification in a limited use of compulsion to encourage acceptance of treatment. In certain other forms of drug dependence, such as dependence on the intravenous use of amphetamines, there are no such viable options at the present time. Where there is no clearly effective treatment, there is no justification for the use of compulsion to direct persons into treatment. Moreover, the restless and obstreperous nature of the average 'speed freak' would make him much less amenable to the short compulsory period of residential confinement to permit him to consider his position and the options available to him. The difficulties involved in attempting to apply such compulsion to the 'speed freak' would far outweigh any likely benefits.

The period of residential confinement should be presented to the opiate-dependent person as an opportunity for him to obtain good diagnosis of his drug-related problem, as well as advice and various forms of assistance, and to experiment with a serious attempt at treatment. Its purpose would be to precipitate the decision to withdraw for a period from involvement in the illicit market, to take stock, and to take a step in the direction of treatment and rehabilitation. **The goal would be to replace the initial compulsion as soon as possible by voluntary acceptance of and response to treatment.** The effectiveness of such an experiment would depend to a great extent on the manner in which it is administered by police officers acting in a public health role, and by the personnel involved in treatment and social rehabilitation. **While being obliged to confront his situation with the assistance of expert advice, the opiate-dependent person should be encouraged to involve himself in the decision process. Ultimately the choice of whether to pursue the particular course of treatment must be his. We would not be in favour of compelling acceptance of a particular course of treatment or management, such**

* It could, however, also be applied to cases of alcoholism, although as indicated earlier there is presently provision in some of the provinces for the exercise of a non-criminal law form of control in such cases.

as methadone maintenance or the administration of an opiate antagonist,* although we recognize that once compulsion is used the options available to the opiate-dependent person may necessarily have this tendency in some cases. It must be noted, however, that this proposal contemplates a definite limit of three months to the use of compulsion. It thus could not have the effect of an indefinite compulsion to accept a certain course of treatment.

If the experiment proved useful it could be applied to other forms of drug dependence, if, and when, viable treatment or management options are developed for them.

We recognize that this proposal for a limited period of compulsory residential confinement raises a serious question as to how and where the necessary facilities are to be provided. It would undoubtedly have to begin on a pilot project basis. The minimum security requirements would probably make it difficult or impracticable to establish these residential facilities under the supervision of specialized treatment units or general hospitals. At the same time, they would have to be sited in close proximity to the necessary services for treatment and social rehabilitation. The residential centres would require some permanent staff for diagnosis, counselling, and custody, with others associated on a non-resident basis. The power of original commitment should be restricted to physicians associated with diagnostic and treatment facilities properly equipped to confirm opiate dependence and to make an adequate evaluation of the patient's general condition and suitability for treatment. The residential facility would be a place where the opiate-dependent person would be accommodated and would receive counselling and various forms of vocational and recreational therapy, but he would also have access to nearby treatment facilities, such as a general hospital for acute problems of medical management, and to methadone maintenance if he elects to pursue that course of treatment. The decision to enter a therapeutic community would have to be a wholly voluntary one, after the patient had had an opportunity to consider its implications, and it would involve a transfer from one residential facility to another. Such transfer, prior to the expiry of the period of compulsory confinement, would have to be approved by the physicians who ordered the commitment.

We do not recommend the use of compulsion in non-criminal cases for purposes of education or indoctrination of persons engaged in the occasional use of drugs for non-medical purposes, particularly where the drugs do not have a significant dependence-producing potential. We would see no point, for example, in the use of a non-criminal form of compulsion for such purposes in the case of the occasional use of hallucinogens or the volatile solvents. We would very much doubt the efficacy of any such efforts. For such cases, informational and educational efforts are better left on a voluntary basis.

* The chief reason in the case of methadone maintenance is the seriousness of the decision to continue and confirm a form of opiate dependence, and in the case of an antagonist, the risk that such treatment may interfere, in an emergency, with the use of an opiate narcotic for the relief of pain.

Whether There Should Be an Offence of Use

Because of the seriousness of the heroin problem in Canada the question is raised as to how law enforcement against the use of opiate narcotics can be made more effective. There is particular concern about how the police can be more effective in the apprehension and conviction of the experimental or occasional user of opiate narcotics who is considered by many to be more "contagious" than the person who has become dependent, because of his belief that he can experiment with opiate narcotics with impunity. It has been suggested that the police are seriously handicapped by the present offence of simple possession, and that they could be much more effective if there was an offence of use, backed up by the power to compel urinalysis as the means of proof.

Most countries rely on the offence of simple possession although there are several in which there is also an offence of use. American federal law uses the offence of simple possession as does the Canadian, but use is an offence under the laws of several of the states. Despite the decision of the Supreme Court of the United States in *Robinson v. California*,[31] holding it to be unconstitutional to make addiction a crime, several states have retained this offence and apparently convictions will be upheld if they are sought only for "use" or "being under the influence" of a drug. The *Uniform Controlled Substances Act* drafted by the United States National Conference of Commissioners on Uniform State Laws relies, however, on an offence of simple possession, punishable as a misdemeanour. In most cases the maximum penalties for the offence of use under state legislation are lower than those for possession. In many cases, however, a distinction is not made, in respect of maximum penalties, between simple possession for use and possession for purposes of sale, which would account for a difference in the maximum penalties for use and possession. The maximum penalties for the offence of addiction or use range from 30 days to six years, but in most cases they are one year or less. We are informed that in practice the offence of use plays a relatively minor role, being resorted to mostly in cases where small quantities of the prohibited drug are involved. In Europe most countries appear to rely on the offence of possession to reach the user, but several countries punish use as well.[32] In New Zealand use is an offence as well as possession.[33]

In Canadian legislative history the only offence of use with respect to narcotics was the offence of smoking opium which was introduced by the *Opium and Drug Act* in 1911.[34] The act created an offence of simple possession, which was punishable by imprisonment for not more than one year or a fine of not more than $500, or both, as well as an offence of smoking opium, which was punishable by imprisonment for not more than three months or a fine of not more than $50, or both. There is an offence to smoke or otherwise use prepared opium in the *Misuse of Drugs Act 1971* of the United Kingdom which is subject to the same penalties as simple possession.

A current example of an offence of use in federal legislation is the prohibition, in the *Tobacco Restraint Act*,[35] against smoking in public by persons under the age of sixteen years. There is also an offence of possession under this statute. Reference has also been made earlier to the prohibition under Alberta law of the use of volatile solvents for purposes of intoxication.

The reason for reliance on an offence of simple possession is that the prosecution must prove the nature of the drug involved, and generally it is necessary to have possession of a specimen of the drug for such purpose. The police have occasionally complained that they are handicapped by the need to obtain a specimen of the prohibited drug. They must surprise heroin addicts in the act of possession and sometimes must use force to prevent them from swallowing the evidence or otherwise disposing of it. What they have generally suggested as an alternative, however, is really an offence of addiction, for which the courts could impose confinement for an indeterminate period. There was testimony to this effect before the Special Senate Committee of 1955.[36] To some extent this suggestion was reflected in Part II of the *Narcotic Control Act* (which has never been put into force), although the provisions of Part II would require a conviction for an offence under the *Narcotic Control Act* before addiction could be made the basis of a "sentence" to custody for treatment for an indeterminate period. There are serious doubts as to whether the Parliament of Canada has the legislative jurisdiction to make addiction an offence. (See the discussion in Appendix F.1 *The Constitutional Framework*.) In making addiction an offence, Parliament would be basing itself on a medical condition without any necessary reference to criminal conduct. If Parliament acted purely on the basis of a medical condition, such as addiction, without specific reference to prior or prospective criminality, it would probably be held to be acting unconstitutionally. In effect, it would have to be considered to be punishing the offender, not for the medical condition as such, for which it would be wholly inappropriate to hold him criminally responsible, but for the previous acts of use which gave rise to it. While technically there appear to be few limits to the kinds of conduct which Parliament can validly declare to be criminal, so long as it is clearly not making a "colourable" or disguised use of the criminal law power to usurp an area of provincial jurisdiction, legislative propriety would argue strongly against making addiction a crime.[37] Whether or not our courts would apply the prohibition against cruel and unusual punishment in the Canadian Bill of Rights in the same manner as the Supreme Court of the United States did in *Robinson v. California*, the logic of such a challenge would remain to rebuke the propriety of the legislation as a matter of policy.

There would not appear to be any objection in principle to adding an offence of use as an *alternative*[38] to the offence of simple possession. But with an offence of use it would still be necessary to prove the nature of the drug that had been used, and as a general rule this would require possession and analysis of a sample of the drug. This problem could only be overcome by the compulsory administration of a satisfactory test for the presence of

the drug in the body. Urinalysis, as a test for determining the use of heroin by the presence of morphine in the human body, is by no means foolproof. Thin layer chromatography, the method most commonly used, is subject to error, including false positives as well as failure to detect. Further, it is typically only able to detect the presence of morphine in the body if the use of heroin has occurred within the previous 24 hours or so. Recently developed immunoassay techniques are apparently less subject to the possibility of false positives and can detect the drug in the urine for a significantly longer period after use. At the present time, however, they are not able to efficiently distinguish between the use of codeine, morphine and heroin, although it is believed that the simple identification of codeine by immunoassy will be possible in the near future. So long as there is a significant possibility of false positives, compulsory urinalysis must be ruled out as a sufficient basis for determining criminal liability.*

But even if we developed a foolproof method for identifying heroin in the body which could be made operational in a sufficiently practical form for law enforcement purposes, there would remain the problem of detecting the experimental or occasional user. The existence of compulsory urinalysis would not by itself make this task any easier. And detection would have to take place within a certain limited period after use. The occasional user of heroin is not exposed to police surveillance and detection in the same manner as the impaired driver. It would require much more intensive law enforcement, involving many more police and a greater use of informers and other distasteful methods to increase the chances of detecting occasional use, which is not only infrequent and unpredictable, but as a general rule private. **We do not believe that the likely return in law enforcement effectiveness from an offence of use backed up by compulsory urinalysis would justify the creation of this additional means of interference with personal liberty and this additional risk of injustice. We are, therefore, opposed to the creation of an offence of use if it were made dependent on compulsory urinalysis. As we have indicated above, we are not in favour of extending the application of the criminal law against the user but rather of making an orderly withdrawal from it.**

* The use of urinalysis to monitor compliance with the conditions of probation or parole (see Appendix J *Probation for Heroin Dependents in Canada*) does not in our opinion present the same risks since there is opportunity for further tests to confirm a pattern of behaviour, and there is discretion to consider what action should be taken on the basis of positive urinalyses, in the light of all the other circumstances of the case. (As may be seen from the above appendix, it is not practicable for probation or parole officers, in the case of opiate dependence, to act on a single positive urinalysis.) There is an important difference in an initial finding of criminal responsibility and the question of whether a convicted offender should be permitted to remain in the community under supervision.

NOTES

1. Article 36, paragraph 1, reads as follows:
   1. Subject to its constitutional limitations, each Party shall adopt such measure as will ensure that the cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention, and any other action which in the opinion of such Party may be contrary to the provisions of this Convention, shall be punishable offences when committed intentionally, and that serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.
2. Article 7.
3. Article 5.
4. *Narcotic Control Regulations*, section 3(3).
5. Section 3(2).
6. *Criminal Code*, section 646(2).
7. Section 41(1).
8. R. Solomon, "The Enforcement of Drug Laws in Vancouver," Unpublished Commission Research Paper, 1971.
9. The figure of 450 opiate dependents on probation is based on information provided by Senior Probation Officers (following consultation with probation officers under their direction) in Canadian cities with a high concentration of opiate narcotic use. (This information is discussed in more detail in Appendix J *Probation for Heroin Dependents in Canada.*) Similarly, the figure of 100 opiate dependents on parole is based on information provided by National Parole Service District Representatives in those cities with a high concentration of narcotics use. (Appendix K *Parole of Heroin Dependents in Canada* contains a more detailed discussion of this information.) The Director of Medical Services in the Canadian Penitentiary Service maintains a file on "drug addicts" in federal penitentiaries which is kept current on a weekly basis. Information on the drug history of these inmates is obtained from members of the R.C.M. Police and from classification officers in the Penitentiary Service. The figure of 330 "drug addicts" in federal penitentiaries is based on an analysis of this file by a member of the Commission's staff on August 30, 1972. The figure of 670 opiate dependents in provincial correctional institutions is based on information provided by the Directors of provincial adult correctional services.
10. Under United States federal law the maximum penalty is one year imprisonment or a fine of $5,000 or both, and on subsequent offences two years' imprisonment or a fine of $10,000 or both. Conditional discharge may be granted on first offence, and if the offender is not over twenty-one years of age the record of the case may be expunged. (*Comprehensive Drug Abuse Prevention and Control Act of 1970*, sec. 404.) The maximum penalties under state laws for simple possession of opiate narcotics vary considerably.

The majority are within the range of five years or less but there are some states with maximum penalties of ten years (Alaska, Arizona, California, Indiana, Kansas, Oklahoma, Oregon, Virginia), fifteen years (Alabama, Colorado, Ohio, Rhode Island), and twenty years (Maine, Missouri), and in one case there is a maximum penalty of life (Texas). (Illinois also appears to have a maximum of life for simple possession of 30 gm or more of heroin.) Several states have mandatory minimum sentences of one year (Nebraska, Nevada, New Mexico, Vermont, Virginia, Kansas, Kentucky) or two years (Alabama, Alaska, Arizona, California, Colorado, Georgia, Indiana, Ohio, Oklahoma, Texas).

11. In the United Kingdom, under the *Misuse of Drugs Act 1971*, simple possession of an opiate narcotic is punishable as follows: on summary conviction by a maximum of 12 months' imprisonment or a fine of £400, or both, and on indictment, by a maximum of seven years' imprisonment or a fine in the discretion of the court, or both. Under the *Dangerous Drugs Acts 1965 and 1967*, which are to be replaced by the *Misuse of Drugs Act 1971*, no distinction is made in respect of maximum penalties between possession with intent to supply or traffic and simple possession for use. The maximum penalties for all offences, including possession, under the *Dangerous Drugs Acts 1965 and 1967*, are as follows: on indictment, a maximum of ten years' imprisonment or a fine of £1,000, or both, and on summary conviction, a maximum of twelve months' imprisonment or a fine of £250, or both.

12. In France, where the offence is illicit use rather than simple possession, the penalties are imprisonment from two months to one year or a fine of 500 to 5,000 francs, or both. In Belgium the maximum penalties for simple possession of opiate narcotics are three months to two years' imprisonment or a fine of 1,000 to 10,000 francs, or both. In the Netherlands the maximum penalties for all offences, including possession, are four years for wilful offences, and otherwise six months or a fine of 3,000 guilders. In Denmark, Norway, Sweden and Finland the maximum penalty for possession is imprisonment for two years. In West Germany possession is punishable by a maximum of three years.

13. In Australia governments have agreed to make simple possession of opiate narcotics punishable by a maximum of two years' imprisonment.

14. In New Zealand simple possession is punishable by a maximum of three months' imprisonment.

15. See note 9 above.

16. *The Public Health Act*, R.S.A. 1970, c. 294, s. 40.

17. The person who is obliged to engage in theft to support his habit must steal goods to the value of about three times the price of the drug since he is only able to realize about a third of their value on the illicit market. It is conservatively estimated that the opiate dependent in the United States steals an average of $10,000 worth of goods per year. William H. McGlothlin et al., "Alternative Approaches to Opiate Addiction Control: Costs, Benefits and Potential," paper prepared for the U.S. Department of Justice, Bureau of Narcotics and Dangerous Drugs, mimeographed, February 1972. It may be reasonably assumed that a comparable amount is stolen by opiate dependents in Canada each year. In 1964 a parole officer in Vancouver estimated that the average daily consumption of drugs by an addict would cost about $20,000 a year, and that the estimated addict population at that

time was probaby involved in theft of goods of an order of $120 million a year. (J. F. D. Selkirk [Parole Service Officer, Vancouver, British Columbia], "National Parole Board Experimental Release of Drug Addicts," *The Canadian Journal of Corrections*, January 1964, 6(1): 31.) A study in British Columbia a few years ago estimated that twenty-six per cent of an opiate dependent's time must be spent in illegal pursuits, resulting in an illegal income of $2,693 per month. (B. C. Murphy, "Response Measures for Assessing the Effectiveness of Training Programs for Delinquent Addicts: A Preliminary Report on Validation," Matsqui, B.C., Canadian Penitentiary Service [mimeographed, n.d.].)

18. Loi n° 70-1320 du 31 décembre 1970 relative aux mesures sanitaires de lutte contre la toxicomanie et à la répression du trafic et de l'usage illicite des substances vénéneuses.

19. For example, the *Mental Health Act* of Manitoba, R.S.M. 1970, c. M110, s. 2(o).

20. Canada, Mental Health Section, Health and Welfare Division, Statistics Canada, May 1973.

21. See, for example, *The Liquor Control Act* of Ontario, R.S.O. 1970, c. 249, s. 90(4) and section 64A of the *Summary Convictions Act* of British Columbia, as enacted by 1968 Stat. B.C., c. 12 and amended by 1970 Stat. B.C., c. 46.

22. For example, *The Narcotic Drug Addicts Act* of Manitoba, R.S.M. 1970, c. N10.

23. The description of this project is based on reports by its director, Mr. Martin J. Mayer.

24. See, for example, *The Liquor Control Act* of Ontario, R.S.O. 1970, c. 249, s. 106a, as enacted by 1971 Stat. Ont., c. 88.

25. B. C. Murphy, *A Quantitative Test of the Effectiveness of an Experimental Treatment Program for Delinquent Opiate Addicts*, Department of the Solicitor General of Canada, Research Centre Report 4 (Ottawa: Information Canada, 1972); C. E. Beech & A. I. Gregersen, "Three Year Follow-Up Study—Drug Addiction Clinic, Mimico," *Canadian Journal of Corrections*, 1964, 6(2): 211–224; The Senate of Canada: Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada, 1955, p. 382; J. C. Kramer, "The State Versus the Addict: Uncivil Commitment," *Boston University Law Review*, 1970, 50(1): 1–22; R. W. Wood, "Major Federal and State Narcotics Programs and Legislation," *Crime and Delinquency*, January 1970, 16: 36–56; G. E. Vaillant, "The Natural History of Narcotic Drug Addiction," *Seminars in Psychiatry*, November 1970, 2(4): 486–498; J. A. O'Donnell, "The Relapse Rate in Narcotic Addiction: A Critique of Follow-Up Studies," in *Narcotics*, D. Wilner & G. Kassebaum, eds., (New York: McGraw-Hill, 1965), pp. 226–246; B. J. Langenauer & C. L. Bowden, "A Follow-Up Study of Narcotics Addicts in the NARA Program," *American Journal of Psychiatry*, July 1971, 128(1): 73–78. See also Appendix I *Treatment of Opiate Dependents in Federal Penitentiaries in Canada* and Appendix L *Civil Commitment in California.*

26. The Senate of Canada: Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada, 1955, p. 381.

27. G. E. Vaillant, "The Natural History of Narcotic Drug Addiction." *Seminars in Psychiatry*, 1970, 2(4): 486–489.

28. Nils Bejerot, Addiction and Society (Springfield, Illinois: C. C. Thomas, 1970), pp. 271 ff.
29. The Senate of Canada: Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada, 1955, p. 31.
30. *Debates,* House of Commons, Canada, June 7th, 1961, p. 5984.
31. 370 U.S. 660 (1962).
32. As indicated earlier, French law prohibits illicit use. Use is also an offence under Norweigian law. In Belgium, use is an offence if carried out in the company of others.
33. *Narcotics Act 1965,* s. 6 provides: "Except pursuant to a licence under this Act, or as otherwise permitted by regulations made under this Act, no person shall procure, receive, store, or have in his possession, or consume, smoke, or otherwise use, any narcotic."
34. 1911 Stat. Can., c. 17.
35. R.S.C. 1970, c. T-9.
36. The Senate of Canada: Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada, 1955, pp. 412–414.
37. For discussion of this possibility see testimony of the Honourable Paul Martin, then Minister of National Health and Welfare, and F. P. Varcoe, then Deputy Minister of Justice of Canada, in The Senate of Canada: Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada, 1955, pp. 9–10 and 433–434.
38. When the smoking of opium was an offence under Canadian law it was held that an accused who was found smoking opium, as well as in possession of opium for his personal use, could be convicted and sentenced for both offences. *R. v. Yuen,* [1932] 3 D.L.R. 234, 57 C.C.C. 372. Such liability virtually amounts to double jeopardy. If there were an offence of use in addition to one of simple possession there should be legislative provision that an accused may be convicted of one, but not both offences, arising out of a single set of circumstances.