

A Public Health Perspective on Cannabis and Other Illegal Drugs

CMA Submission to the Special Senate Committee on Illegal Drugs

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HENRY HADDAD, MD, FRCPC
PRESIDENT

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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its 52,000 members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/accident prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

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EXECUTIVE SUMMARY

Cannabis has adverse effects on the personal health of Canadians and the well-being of society. In making this submission to the Special Senate Committee on Illegal Drugs, the Canadian Medical Association (CMA) wishes to make it clear that any change to the criminal status of cannabis must be done so with the recognition that cannabis is an addictive substance and that addiction is a disease.

The CMA believes that the government must take a broad public health policy approach to address cannabis use. Focusing on the decriminalization issue alone is inadequate to deal with the complexity of the problem. Changes to the criminal law affecting cannabis must not promote normalization of its use, and must be tied to a national drug strategy that promotes awareness and prevention, and provides for comprehensive treatment. Under such a multidimensional approach the CMA would endorse decriminalization.

In this document, we primarily focus on the health effects of cannabis use. However, we also present information and recommendations on the use of other illegal drugs. While we understand that this goes beyond the intended scope of the Senate Committee's study, this information is important to the development of comprehensive policy, which we believe is required. We also recognize and welcome the fact that many of the CMA's recommendations will require a closer working relationship among health providers, justice officials and law enforcement.

The CMA's recommendations are:

Section 1: Illegal Drugs

1. **A National Drug Strategy:** The federal government develop, in cooperation with the provinces and territories and the appropriate stakeholder groups, a comprehensive national drug strategy on the non-medical use of drugs.
2. **Redistribution of Resources:** The vast majority of resources dedicated to combating illegal drugs are directed towards law enforcement activities. Government needs to re-balance this distribution and allocate a greater proportion of these resources to drug treatment, prevention, and harm reduction programs. Law enforcement activities should target the distribution and production of illegal drugs.
3. **Addiction is a Disease:** Addiction should be regarded as a disease and therefore, individuals suffering with drug dependency should be diverted, whenever possible, from the criminal justice system to treatment and rehabilitation. Additionally, the stigma associated with addiction needs to be addressed as part of a comprehensive education strategy.

4. **Increased Research:** All governments commit to more research on the cause, effects and treatment of addiction. Further research on the long- term health effects associated with chronic cannabis use is specifically required.

Section 2: Cannabis

1. **National Cannabis Cessation Program:** The federal government develop, in cooperation with the provinces and territories and the appropriate stakeholder groups, a comprehensive program to minimize cannabis use. This should include, but not be limited to:
 - Education and awareness raising of the potential harms of cannabis use including risks associated with use in pregnancy; use by those with mental illness; chronic respiratory problems; and chronic heavy use;
 - Strategies to prevent early use in adolescence; and,
 - Availability of assessment, counselling and treatment services for those experiencing adverse effects of heavy use or dependence.
2. **Driving Under the Influence Prevention Policy:** The CMA believes that comprehensive long-term efforts that incorporate both deterrent legislation and public awareness and education constitute the most effective approach to reducing the number of lives lost and injuries suffered in crashes involving impaired drivers. The CMA supports a similar multidimensional approach to the issue of the operation of a motor vehicle while under the influence of cannabis.
3. **Decriminalization:** The severity of punishment for simple possession and personal use of cannabis should be reduced with the removal of criminal sanctions. The CMA believes that resources currently devoted to combating simple marijuana possession through the criminal law could be diverted to public health strategies, particularly for youth. To the degree that having a criminal record limits employment prospects the impact on health status is profound. Poorer employment prospects lead to poorer health. Use of a civil violation, such as a fine, is a potential alternative. However, decriminalization should only be pursued as part of a comprehensive national illegal drug strategy that would include a cannabis cessation program.
4. **Monitoring and Evaluation:** Any changes need to be gradual to protect against any potential harm. In addition, changes to the criminal law in connection with cannabis, should be rigorously monitored and evaluated for their impact.

This document also contains the policies and recommendations of the CMA affiliated association that has specific expertise in the field of substance use disorders the, Canadian Society of Addiction Medicine (CSAM). In addition, for an even broader health-sector perspective, the CMA has attached information on the policy positions of other key medical organizations from Canada and the United States in regard to decriminalization of cannabis.

A PUBLIC HEALTH PERSPECTIVE ON CANNABIS AND OTHER ILLEGAL DRUGS

INTRODUCTION

The Canadian Medical Association (CMA) welcomes the opportunity to participate in the deliberations of the Special Senate Committee on Illegal Drugs. This document was developed by the CMA's new Office for Public Health in consultation with our Affiliate Societies, in particular the Canadian Society of Addiction Medicine, and our 12 provincial and territorial divisions.

The use of illegal drugs and relevant policies is an extremely broad, multi-disciplinary and at times, controversial subject. Considering the breadth of this subject, the limited time-lines and the areas of particular interest of the Committee, this document will focus on the following:

- What are the known health effects of cannabis and other illegal drugs?
- What experience has there been with the decriminalization of cannabis?
- What has been the impact of law enforcement on illegal drug use?
- What changes need to be considered in Canada's approach to illegal drug use including the potential decriminalization of drugs?

In addition to the above, this document will provide an overview of the relevant policy position statements and recommendations regarding cannabis and drug policy from other key medical organizations from both Canada and the United States.

PUBLIC HEALTH PERSPECTIVE ON DRUG USE

There are many different perspectives on the use of drugs including ethical and moral frameworks. This paper is prepared from a public health perspective where minimizing any harms associated with use is of primary concern.¹ This requires consideration of health issues related not only to the individual user and the drug being used, but also the key social factors associated with use.

Drug use is a complex behaviour that is influenced by many factors. It is not possible to identify a single cause for drug use, nor will the set of contributing factors be the same among different drug users and populations. Public health objectives will vary depending upon the circumstances: preventing drug use in those who have not initiated use (e.g. pre-teens); avoiding use in circumstances associated with a risk of adverse outcomes (e.g. drug use and driving motor vehicle); assisting those who wish to stop using the drug (e.g. treatment, rehabilitation); and assisting those who intend to continue to use the drug to do so in such a manner as to reduce the risk of adverse effects (e.g. needle exchange program to reduce risk of HIV).

To address this complexity, what is required is a public health strategy to combat drug use utilizing a comprehensive, multi-component approach. Public health strategies focus on the various predisposing, enabling, and re-enforcing factors that influence healthy behaviours and choices.² These sets of factors recognize the many influences upon individual behaviour including: individual and social attitudes, beliefs and values; skills; support, self-efficacy and reinforcement.

Public health actions can be grouped into the following major categories:³

- Developing Personal Skills – education and skill-building (e.g. mass media, skill development to resist peer pressure, thinking skills);
- Healthy Public Policy – policies, formal and informal that support health (e.g. school policy, substance use and driving, harm reduction initiatives);
- Creating Supportive Environments – social and physical environments (e.g. adequate housing and food, community safety, non-chemical coping mechanisms);
- Strengthen Community Action – community involvement in finding solutions (e.g. self-help, social support, community participation);
- Health Services – range of services to meet needs (e.g. prevention, assessment, early intervention, treatment, rehabilitation, harm-reduction initiatives).

This framework is useful in identifying the range of program components that need to be considered. Relative emphasis between components and the specific interventions selected will vary depending upon the target population (e.g. school students vs. injection drug users). The key is a balanced approach that will influence the factors contributing to less healthy behaviours with support for behaviour change and maintenance.

CANNABIS

Several commissions and task forces, in Canada and elsewhere, have addressed the issue of how to deal with cannabis use, although frequently their recommendations have not been implemented.^{4, 5, 6} It has been suggested that “cannabis is a political football that governments continually duck...(but that) like a football, it bounces back.”⁷ This section of the paper will review current Canadian levels of use, health effects, law enforcement issues, and experience with decriminalization in other jurisdictions.

Current Use

The Ontario Student Drug Use Survey is conducted every two years in grades 7, 9, 11, and 13, although in 1999 all grades from 7-13 were surveyed. Use of cannabis within the preceding year increased from 11.7% of students in 1991, to 29.2% in 1999.⁸ Increases were also observed for several other drugs during the same time period (tobacco, alcohol, glue, other solvents, hallucinogens, cocaine, PCP, and ecstasy). Increases in adolescent drug use have also been observed in the US, Europe and Australia through the 1990s. Compared with earlier cohorts, fewer students in 1999 reported early onset of cannabis use (before grade 7) compared with similarly aged students in 1997 and 1981. Past year drug use of cannabis, alcohol and tobacco by grade year is shown in Table 1. The proportion of students who have used one of these drugs increases with increasing grade level.

Table 1 - Past Year Drug Use (%) by Grade Level, Ontario Students, 1999

| | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
|-----------------|----------|----------|----------|-----------|-----------|-----------|-----------|
| Alcohol | 39.7 | 53.7 | 63.1 | 74.9 | 82.0 | 84.6 | 83.0 |
| Tobacco | 7.4 | 17.8 | 27.8 | 37.4 | 41.7 | 38.6 | 38.0 |
| Cannabis | 3.6 | 14.9 | 25.5 | 36.4 | 48.1 | 39.4 | 43.3 |

1999 Ontario Student Drug Use Survey⁹

The last national survey of illicit drug use in Canada was conducted in 1994.¹⁰ At that time, 23% of Canadians, aged 15 and over, reported having used cannabis more than once during their lifetime with 7% having used it within the preceding year. Current use is much more common in those under the age of 25 and diminishes significantly with age, (Table 2). Most cannabis use is sporadic with the majority of adult and adolescent users using it less than once a week.¹¹

Table 2 - Lifetime and Current Use of Cannabis in Canada, 1994

| Age | Lifetime Use (%) | Current Use (%) (past 12 months) |
|------------|-------------------------|---------------------------------------------|
| 15-17 | 30 | 24.0 |
| 18-19 | 32.9 | 23.8 |
| 20-24 | 37.7 | 19.0 |
| 25-34 | 38.2 | 9.6 |
| 35-44 | 32.9 | 5.7 |
| 45-54 | 14.8 | 1.4 |
| 55-64 | 3.7 | - |
| 65+ | 0.8 | - |

Canada's Alcohol and Other Drugs Survey: 1994

Health Effects

Our understanding of the health effects of cannabis continues to evolve. Hall summarizes the effects into acute and chronic effects and whether these are probable or possible (Table 3).¹²

Table 3 - Summary of Probable and Possible Health Effects of Cannabis Use

| | Pattern of Use | |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| | Acute | Chronic |
| Probable | anxiety, dysphoria, panic, cognitive impairment, psychomotor impairment; | chronic bronchitis, lung cancer, dependence, mild cognitive impairment, exacerbation of psychosis; |
| Possible (possible but uncertain, confirmation required in controlled studies) | increased risk of traffic accident, psychosis, low-birth-weight babies; | cancers in offspring, impaired immunity |

From CMAJ 2000; 162: 1690-1692.

Tetrahydrocannabinol (THC) is the main psychoactive substance in cannabis. THC is inhaled in the mainstream smoke and absorbed through the lungs, rapidly entering the bloodstream. Effects are perceptible within seconds and fully apparent in a few minutes. Cannabis combines many of the properties of alcohol, tranquilizers, opiates and hallucinogens; it has anxiolytic, sedative, analgesic and psychedelic properties.¹³ Its acute toxicity is extremely low, as no deaths directly due to acute cannabis use have ever been reported. The main feature of its use is that it produces a feeling of euphoria (or ‘high’). Toxic dose-related effects include anxiety, panic, depression or psychosis.¹⁴ It should also be noted that a significant incident of co-morbid addiction occurs in those with physical and mental diseases. People with major mental illnesses such as schizophrenia are especially vulnerable in that cannabis use can provoke relapse and aggravate existing symptoms. A chronic lack of energy and drive to work in chronic users has been referred to as an “amotivational syndrome,” which is currently believed to represent an ongoing intoxication in frequent users.¹⁴

Cannabis slows reaction times, impairs motor coordination and concentration as well as the completion of complex tasks.¹³ Due to the extended presence of metabolites in the bloodstream, it is difficult to correlate blood levels with acute impairment making interpretation of crash data difficult. However, it is generally accepted that cannabis use is associated with an increased risk of motor vehicle and aircraft crashes. Impairments of attention, memory and the ability to process complex information can last for prolonged periods of time, even years, after cessation of heavy, chronic cannabis use. A cannabis withdrawal syndrome similar to alcohol, opiate and benzodiazepine withdrawal symptoms exist.¹⁴

Cannabis use increases heart rate and causes blood vessels to dilate. These present a risk for those with pre-existing cardiac disease. Smoke from cannabis preparations contains many of the same compounds as tobacco cigarettes including increased levels of tar. Chronic cannabis smoking is associated with bronchitis and emphysema. Chronic cannabis use may have risks of chronic lung disease and lung cancer comparable to cigarette smoking.

With increasing study and experience, it is clear that cannabis, like other substances such as tobacco or alcohol, can have a number of adverse physical and psychological effects.¹⁵

Law Enforcement

The 1997 data is the latest year with national drug offences' data for possession, cultivation, trafficking and importation (Figure 1).¹⁶ The proportion of drug incidents is heavily skewed towards cannabis. This is intriguing since the health concerns of cannabis are substantially less than those of heroin or cocaine.

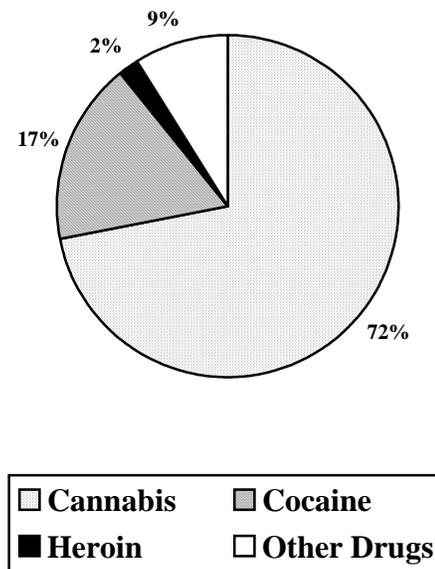


Figure 1: Proportion of All Drug Incidents by Drug Type, Canada, 1997

Of the 66,500 drug incidents in Canada in 1997, over 70% (47,908) were cannabis related. Of these, over two thirds (32,682) were for possession. The rate of cannabis offences has increased 34% since 1991 with cannabis-possession rates increasing steadily from 1991-1996 with a slight drop in 1997. Most (86%) of those charged with cannabis offences were under 25 years of age. It has been estimated that about 2,000 Canadians are sent to jail every year for cannabis possession.¹⁷

Despite the current level of enforcement, cannabis use has been increasing with over 40% of grade 11, 12 and 13 students having used cannabis in the preceding year. While it is obvious that only a small percentage of users are being charged, thousands of teens and young adults are being charged every year, receiving criminal records that can impact future employment, future interactions with the justice system, and be a barrier to acquiring citizenship.¹¹ Findings from several studies indicate that perceived health risk and social disapproval were much more important disincentives to cannabis use than legal threats.¹⁸

Experience with Decriminalization in Other Jurisdictions

A number of other jurisdictions have implemented alternative enforcement approaches to the personal use of cannabis. While none of these experiences directly predict what would happen in Canada, they do provide information to address some of the issues raised when decriminalization is considered. Despite the obvious interest in the impact of these policy changes, there is a paucity of well-designed evaluations (i.e. evaluations which were designed and implemented prior to policy change, rather than post-hoc analyses on available data).

United States

In the 1970s, several US states reduced the legal sanctions for possession of small amounts of cannabis to a maximum penalty of a fine. Despite the substantial potential interest in the effects of such policy changes, evaluative studies were relatively sparse. The available data, though based upon national high school student survey data as well as evaluations in two states, indicated that there was no apparent increase in cannabis use that could be attributed to decriminalization.¹⁹ The high school student national survey data showed that while use of cannabis had increased in those states that had decriminalized possession, the rates of use had increased by a greater amount with stricter laws. California was one of the states which decriminalized possession, and similar to other states, experienced a decrease in cannabis use during the 1980s which based upon student surveys appeared to be due to changing perceptions of health risks rather than changes in the legal status of the drug.¹⁹

Netherlands

The Netherlands is the most frequently identified example of a country that altered its approach to marijuana. The Dutch impose no penalties for the possession of small amounts of cannabis and allow a number of coffee shops to openly sell the drug.²⁰ This policy therefore is not simply removing the potential for criminal records and imprisonment with possession, but actually partially legalized cannabis sales. This process began in 1976 and coffee shops were not allowed to advertise, could not sell hard drugs, no sales to minors, no public disturbances, and no sales transactions exceeding certain quantity thresholds. Initially this threshold was set at 30 gm of cannabis, a rather large amount which was reduced to 5 gm in 1995.

Attempts have been made to compare the prevalence of cannabis use in the Netherlands with other countries. Since cannabis use changes dramatically with age and over different time periods, surveys need to be of similar populations during similar time periods to be comparable. Differences in the wording of questions between surveys also make comparison difficult. A recent review by MacCouin et al makes 28 comparisons between the Netherlands and the US, Denmark, West Germany, Sweden, Finland, France and the UK.²¹ Overall, it appears that Dutch rates are lower than rates of use in the US but somewhat higher than those of some of its European neighbours. Cannabis use is higher in Amsterdam compared to other Dutch cities and is comparable to use in the US.

A limited number of surveys appear to show that from 1984 to 1992, there was a substantial increase in adolescent (aged 16 – 20) use of cannabis that did not occur in other countries. The increases observed from 1992 to 1998 however, were similar to the increases observed in other countries including Canada. Overall, it appears that while the increases in Dutch adolescent use started earlier than other countries, their prevalence of use was much lower than comparison countries so that by the late 1990s they had comparable rates of use to the US and Canada.

Australia

From 1987 to 1995, three Australian states decriminalized the possession and cultivation of cannabis for personal use by replacing penal sanctions with fines.²² The courts in other states have tended to utilize non-penal sanctions such as a fine or a suspended sentence with a criminal record. The limited number of surveys conducted in Australia has failed to find evidence of any large impact on cannabis use (some of the surveys had small sample sizes and the trend in usage has been upwards in Australian states which did not decriminalize as well as in other countries that continue to prohibit cannabis use). Interestingly, despite the decriminalization, the number of notices issued by police exceeds the number of cannabis offences prior to the change in law.

Summary

The preceding sections have suggested that cannabis use is relatively common (particularly in teens and young adults); most use is sporadic; its use is increasing; and it is not harmless. Because of these potential harms, one would not wish to encourage its use. There is however, no necessary connection between adverse health effects of any drug or human behaviour and its prohibition by law. The issue is therefore whether there are less coercive ways to discourage its use. Despite the current criminal justice approach where the bulk of all illegal drug charges are cannabis-related and the majority of these are for possession, use is increasing with thousands of teens and young adults receiving criminal records for possession each year. The available evidence from other jurisdictions suggests that decriminalization would not result in a substantial increase in use beyond baseline trends. Considering current trends, a comprehensive approach to discourage current usage is required.

OTHER ILLEGAL DRUGS

Illegal drugs other than cannabis present a different set of issues and concerns. While these drugs are not the primary focus of the Special Senate Committee's study, we have included a few key issues to better put the cannabis issue in proper context.

Current Use

The Ontario Student Drug Use Survey of students in grades 7, 9, 11 and 13 has shown that following a lengthy period of decline in drug use during the 1980s, there has been a steady increase in adolescent drug use.⁸ Past year drug use in 1999 was reported as follows: ecstasy (4.8%); PCP (3.2%); hallucinogens (13.8%), and cocaine (4.1%). By comparison, tobacco, alcohol and cannabis were 28.3%, 65.7%, and 29.2% respectively.

Canadian survey data of those aged 15 and over in 1994 found that about one in twenty reported any lifetime use of LSD, speed or heroin, or cocaine.¹⁰ Rates of use of these drugs within the preceding year were 1% and 0.7% respectively.

Health Effects

The adverse effects of drugs such as heroin and cocaine are related not just to the drugs themselves, but also increasingly to their method of intake, which is predominantly by injection. Injection drug use (IDU) is an efficient delivery mechanism of drugs, but is also an extremely effective means of transmitting bloodborne viruses such as hepatitis B, hepatitis C and HIV. The proportion of HIV infections attributable to IDU has increased from 9% prior to 1985 to over 25% by 1995.²³ IDU is also the predominant means of hepatitis C transmission responsible for 70% of cases.²⁴ The increasing use of cocaine, which tends to be injected on a more frequent basis, increases the subsequent exposure to infection. It has been estimated that up to 100,000 Canadians inject drugs (not counting steroids).²⁵ Transmission of bloodborne pathogens is not limited to injection drug users as the disease can then be further spread to sexual contacts, including the sex trade, and vertical transmission from infected mother to child. An epidemic of overdose deaths among injection drug users has been experienced in British Columbia with over 2000 such deaths in Vancouver since 1991.¹⁷

Despite the seriousness of the potential adverse effects of illegal drug use and the potential for this situation to worsen with increasing transmission of bloodborne diseases, on a population basis, legal drugs (alcohol and tobacco) are responsible for substantially more deaths, potential years of life lost and hospitalizations.²⁶

Table 4 - The Number of Deaths, Premature Mortality and Hospital Separations for Illicit Drugs, Alcohol and Tobacco, Canada, 1995.

| | Deaths | Potential Years of Life Lost | Hospital Separations |
|----------------------|---------|------------------------------|----------------------|
| Illicit Drugs | 805 | 33,662 | 6,940 |
| Alcohol | 123,734 | 172,126 | 82,014 |
| Tobacco | 34,728 | 500,350 | 193,772 |

From: Single et al. CMAJ 2000; 162: 1669-1675

Expenditures on Illegal Drugs

The direct costs associated with illicit drugs based on 1992 Canadian data are shown in the figure below:

The vast majority of expenditures related to illegal drugs are on law enforcement. Considering

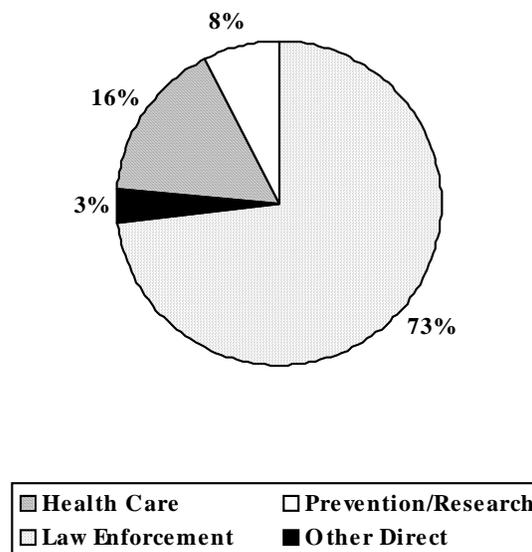


Figure 2: Direct Costs Attributable to Illegal Drugs in Canada, 1992. (from Single et al, 1998)

the distribution of drug incidents, a substantial proportion of these are related to cannabis offences although health and other costs will predominantly be associated with other drugs. A substantial proportion of drug charges are for possession as compared with trafficking or importation (cocaine 42%; heroin 42%; other drugs 56%).¹⁶ Despite illegal drug use being primarily a health and social issue, current expenditures do not reflect this and are heavily skewed towards a criminal justice approach. Unfortunately, prisons are not an ideal setting for treating addictions with the potential for continued transmission of bloodborne viruses.

RECOMMENDATIONS

The Need for Balanced, Comprehensive Approaches

Reasons for drug use, particularly “hard drugs,” are complex. It is not clear how a predominantly law enforcement approach is going to address the determinants of drug use, treat addictions, or reduce the harms associated with drug use including overdoses and the transmission of bloodborne viruses including HIV. Costs of incarceration are substantially more than the use of effective drug treatment.²⁷ It appears that there is an over dependence on the law when other models might be more effective in achieving the desired objective of preventing or reducing harm from drug use.¹⁸ Aggressive law enforcement at the user level could exacerbate these harms by encouraging the use of the most dangerous and addictive drugs in the most concentrated forms,²⁸ because these are easier to conceal and the efficacy of injecting is greater than that of inhaling as drug costs increase in response to prohibition and enforcement.²⁹ There have been several recent sets of recommendations from expert groups regarding the need for a comprehensive set of approaches to address the public health challenges due to drug use, particularly those associated with injection drug use (IDU).^{30,31}

Recommendations include the following components:

- address prevention;
- treatment and rehabilitation;
- research;
- surveillance and knowledge dissemination;
- national leadership and coordination.

Many of the recommendations will require close working relationships with justice/enforcement officials. Drug abuse and dependency is a chronic, relapsing disease for which there are effective treatments.³² A criminal justice approach to a disease is inappropriate particularly when there is increasing consensus that it is ineffective and exacerbates harms.³³

The CMA’s recommendations have been separated into two separate sections. The first set of recommendations is focused on policies affecting illegal drugs in general. While this goes beyond the intended scope of the Senate Committee’s study, in our opinion, these recommendations are equally important for the Committee to consider. The second set of recommendations is specifically focused on cannabis. Our recommendations in this section take into consideration the health impact profile of cannabis, current levels of use, extent and impact of law enforcement activities and experience from other jurisdictions.

Section 1: Illegal Drugs

The CMA recommends:

1. **A National Drug Strategy:** The federal government develop, in cooperation with the provinces and territories and the appropriate stakeholder groups, a comprehensive national drug strategy on the non-medical use of drugs.
2. **Redistribution of Resources:** The vast majority of resources dedicated to combating illegal drugs are directed towards law enforcement activities. Government needs to re-balance this distribution and allocate a greater proportion of these resources to drug treatment, prevention, and harm reduction programs. Law enforcement activities should target the distribution and production of illegal drugs.
3. **Addiction is a Disease:** Addiction should be regarded as a disease and therefore, individuals suffering with drug dependency should be diverted, whenever possible, from the criminal justice system to treatment and rehabilitation. Additionally, the stigma associated with addiction needs to be addressed as part of a comprehensive education strategy.
4. **Increased Research:** All governments commit to more research on the cause, effects and treatment of addiction. Further research on the long- term health effects associated with chronic cannabis use is specifically required.

Section 2: Cannabis

The CMA recommends:

1. **National Cannabis Cessation Program:** The federal government develop, in cooperation with the provinces and territories and the appropriate stakeholder groups, a comprehensive program to minimize cannabis use. This should include, but not be limited to:
 - Education and awareness raising of the potential harms of cannabis use including risks associated with use in pregnancy; use by those with mental illness; chronic respiratory problems; and chronic heavy use;
 - Strategies to prevent early use in adolescence; and,
 - Availability of assessment, counselling and treatment services for those experiencing adverse effects of heavy use or dependence.
2. **Driving Under the Influence Prevention Policy:** The CMA believes that comprehensive long-term efforts that incorporate both deterrent legislation and public awareness and education constitute the most effective approach to reducing the number of lives lost and injuries suffered in crashes involving impaired drivers. The CMA supports a similar multidimensional approach to the issue of the operation of a motor vehicle while under the influence of cannabis.

3. **Decriminalization:** The severity of punishment for simple possession and personal use of cannabis should be reduced with the removal of criminal sanctions. The CMA believes that resources currently devoted to combating simple marijuana possession through the criminal law could be diverted to public health strategies, particularly for youth. To the degree that having a criminal record limits employment prospects the impact on health status is profound. Poorer employment prospects lead to poorer health. Use of a civil violation, such as a fine, is a potential alternative. However, decriminalization should only be pursued as part of a comprehensive national illegal drug strategy that would include a cannabis cessation program.
4. **Monitoring and Evaluation:** Any changes need to be gradual to protect against any potential harm. In addition, changes to the criminal law in connection with cannabis, should be rigorously monitored and evaluated for their impact.

CANADIAN SOCIETY OF ADDICTION MEDICINE

The Canadian Society of Addiction Medicine (CSAM), which was formed in 1989, is a national organization of medical professionals and other scientists interested in the field of substance use disorders.

Vision

The Society shares its overall goals with many other organizations and groups in Canada; namely, the prevention of problems arising from the use of alcohol and other psychoactive substances, and the cure; improvement or stabilization of the adverse consequences associated with the use of these drugs. This Society aims to achieve these goals through the fostering and promotion of medical sciences and clinical practice in this field in Canada, particularly by:

- fostering and promotion of the roles of physicians in the prevention and treatment of alcohol and drug related problems;
- improvement in the quality of medical practice in the drug and alcohol field through:
 - establishment and promotion of standards of clinical practice;
 - fostering and promotion of research; and
 - fostering and promotion of medical education;
- promotion of professional and public awareness of the roles that physicians can play in the prevention and treatment of alcohol and drug related problems;
- fostering and promotion of further development of programs for the prevention and treatment of problems of alcohol and drug use in physicians; and
- contributing to professional and public examination and discussion of important issues in the drug and alcohol field.

Policy Statement

The CSAM National Drug Policy statement requires that:

Canada must have a clear strategy for dealing with the cultivation, manufacture, importation, distribution, advertising, sale, possession and use of psychoactive substances regardless of whether they are classified as legal or illegal.

Drug possession for personal use must be decriminalized and distinguished from the trafficking or illegal sale/distribution of drugs to others that must carry appropriate criminal sanctions.

The individual and public health impact of substance use, substance abuse and substance dependence must be taken into account at all times.

An assessment to ascertain the extent of a substance use disorder and screening for addiction must be an essential part of dealing with someone identified as an illicit drug user or possessor.

Appropriate funding must be made available for supply reduction and demand reduction of various psychoactive substances that carry an abuse or addiction liability.

Recommendations

1. National policies and regulations must present a comprehensive and coordinated strategy aimed at reducing the harm done to individuals, families and society by the use of all drugs of dependence regardless of the classification of “legal” or “illegal”
2. Prevention programs need to be comprehensively designed to target the entire range of dependence-producing drugs to enhance public awareness and affect social attitudes with scientific information about the pharmacology of drugs and the effects of recreational and problem use on individuals, families, communities and society.
3. Outreach, identification, referral and treatment programs for all persons with addiction need to be increased in number and type until they are available and accessible in every part of the country to all in need of such services.
4. Law enforcement measures aimed at interrupting the distribution of illicit drugs need to be balanced with evidenced based treatment and prevention programs, as well as programs to ameliorate those social factors that exacerbate addiction and its related problems.
5. Any changes in laws that would affect access to dependence-producing drugs should be carefully thought out, implemented gradually and sequentially, and scientifically evaluated at each step of implementation, including evaluating the effects on:
 - access to young people and prevalence of use among youth;
 - prevalence of use in pregnancy and effects on offspring;
 - prevalence rates of alcoholism and other drug dependencies;
 - crime, violence and incarceration rates;
 - law enforcement and criminal justice costs;
 - industrial safety and productivity;
 - costs to the health care system;
 - family and social disruption;
 - other human, social and economic costs.
6. CSAM opposes
 - any changes in law and regulation that would lead to a sudden significant increase in the availability of any dependence-producing drug (outside of a medically-prescribed setting for therapeutic indications). All changes need to be gradual and carefully monitored.
 - any system of distribution of dependence-producing drugs that would involve physicians in the prescription of such drugs for other than therapeutic or rehabilitative purposes.

7. CSAM supports

- public policies that would offer treatment and rehabilitation in place of criminal penalties for persons with psychoactive substance dependence and whose offense is possession of a dependence-producing drug for their own use. Those who are found guilty of an offense related to Addiction, proper assessment and treatment services must be offered as part of their sentence. This goal may be attained through a variety of sentencing options, depending upon the nature of the offense.
- an increase in resources devoted to basic and applied research into the causes, extent and consequences of alcohol and other drug use, problems and dependence, and into methods of prevention and treatment.

RELEVANT POSITION STATEMENTS OF OTHER MEDICAL HEALTH ORGANIZATIONS

The purpose of this section is to provide the Special Senate Committee on Illegal Drugs with information on the policy positions of other key medical organizations from Canada and the United States in regard to decriminalization of cannabis.

Canadian Centre for Addiction and Mental Health³⁴

The Centre for Addiction and Mental Health (CAMH) does not encourage or promote cannabis use. CAMH emphasizes that the most effective way of avoiding cannabis-related harms is through not using cannabis, and encourages people to seek treatment where its use has become a problem.

Cannabis is not a benign drug. Cannabis use, and in particular frequent and long-term cannabis use, has been associated with negative health and behavioural consequences, including respiratory damage, problems with physical coordination, difficulties with memory and cognition, pre- and post-natal development problems, psychiatric effects, hormone, immune and cardio-vascular system defects, as well as poor work and school performance. The consequences of use by youth and those with a mental disorder are of particular concern. However, most cannabis use is sporadic or experimental and hence not likely to be associated with serious negative consequences.

CAMH thus holds the position that the criminal justice system in general, and the Controlled Drugs and Substances Act (CDSA) specifically, under which cannabis possession is a criminal offence, has become an inappropriate control mechanism. This conclusion is based on the available scientific knowledge on the effects of cannabis use, the individual consequences of a criminal conviction, the costs of enforcement, and the limited effectiveness of the criminal control of cannabis use.

CAMH thus concurs with similar recent calls from many other expert stakeholders who believe that the control of cannabis possession for personal use should be removed from the realm of the CDSA and the criminal law/criminal justice system. While harmful health consequences exist with extensive cannabis use, CAMH believes that the decriminalization of cannabis possession will not lead to its increased use, based on supporting evidence from other jurisdictions that have introduced similar controls.

CAMH recommends that a more appropriate legal control framework for cannabis use be put into place that will result in a more effective and efficient control system, produce fewer negative social and individual consequences, and maintain public health and safety. An alternative legal control system for the Canadian context can be chosen from a number of options that have been tried and proven adequate in other jurisdictions.

CAMH further recommends that such an alternative framework be explored on a temporary and rigorously evaluated trial basis, and that an appropriate level of funding be provided/maintained for prevention and treatment programs to minimize the prevalence of cannabis use and its associated harms.

American Society of Addiction Medicine³⁵

The Society's 1994 policy which was updated September 2001 recommends the following:

1. National policy should present a comprehensive and coordinated strategy aimed at reducing the harm done to individuals, families and society by the use of all drugs of dependence.
2. Reliance on the distinction between "legal" and "illegal" drugs is a misleading one, since so-called "legal" drugs are illegal for persons under specified ages, or under certain circumstances.
3. Prevention programs should be comprehensively designed to target the entire range of dependence-producing drugs as well as to produce changes in social attitudes. (See ASAM Prevention Statement.)
4. Outreach, identification, referral and treatment programs for all persons suffering from drug dependencies, including alcoholism and nicotine dependence, should be increased in number and type until they are available and accessible in every part of the country to all in need of such services.
5. Persons suffering from the diseases of alcoholism and other drug dependence should be offered treatment rather than punished for their status of dependence.
6. The balance of resources devoted to combatting these problems should be shifted from a predominance of law enforcement to a greater emphasis on treatment and prevention programs, as well as programs to ameliorate those social factors that exacerbate drug dependence and its related problems.
7. Law enforcement measures aimed at interrupting the distribution of illicit drugs should be aimed with the greatest intensity at those causing the most serious acute problems to society.
8. Any changes in laws that would affect access to dependence-producing drugs should be carefully thought out, implemented gradually and sequentially, and scientifically evaluated at each step of implementation, including evaluating the effects on:
 - a. prevalence of use in pregnancy and effects on offspring;
 - b. prevalence rates of alcoholism and other drug dependencies;
 - c. crime, violence and incarceration rates;
 - d. law enforcement and criminal justice costs;

- e. industrial safety and productivity;
 - f. costs to the health care system;
 - g. family and social disruption;
 - h. other human, social and economic costs.
9. ASAM opposes any changes in law and regulation that would lead to a sudden significant increase in the availability of any dependence-producing drug (outside of a medically-prescribed setting for therapeutic indications). Any changes should be gradual and carefully monitored.
10. ASAM opposes any system of distribution of dependence-producing drugs that would involve physicians in the prescription of such drugs for other than therapeutic or rehabilitative purposes.
11. ASAM supports public policies that would offer treatment and rehabilitation in place of criminal penalties for persons who are suffering from psychoactive substance dependence and whose only offense is possession of a dependence-producing drug for their own use.
12. ASAM supports public policies which offer appropriate treatment and rehabilitation to persons suffering from psychoactive substance dependence who are found guilty of an offense related to that dependence, as part of their sentence. This goal may be attained through a variety of sentencing options, depending upon the nature of the offense.
13. ASAM supports an increase in resources devoted to basic and applied research into the causes, extent and consequences of alcohol and other drug use, problems and dependence, and into methods of prevention and treatment.
14. In addition, scientifically sound research into public policy issues should receive increased support and be given a high priority as an aid in making such decisions.
15. Physicians and medical societies should remain active in the effort to shape national drug policy and should continue to promote a public health approach to alcoholism and other drug dependencies based on scientific understanding of the causes, development and treatment of these diseases.

US Physician Leadership on National Drug Policy

The Physician Leadership on National Drug Policy (PLNDP) was started in 1997 when 37 senior physicians from virtually every medical society* met and agreed that the “current criminal justice driven approach is not reducing, let alone controlling drug abuse in America.” Their extensive review of the literature found:

- drug addiction is a chronic, relapsing disease, like diabetes or hypertension;
- treatment for drug addiction works;
- treating addiction saves money;
- treating drug addiction restores families and communities;
- prevention and education help deter youth from substance abuse, delinquency, crime and incarceration.

In follow-up to an extensive review of the literature, their key policy recommendations are:

- Reallocate resources toward drug treatment and prevention;
- Parity in access to care, treatment benefits, and clinical outcomes;
- Reduce the disabling regulation of addiction treatment programs;
- Utilize effective criminal justice procedures to reduce supply and demand (e.g. community coalitions, community policing, drug courts);
- Expand investments in research and training;
- Eliminate the stigma associated with the diagnosis and treatment of drug problems;
- Train physicians and (medical) students to be clinically competent in diagnosing and treating drug problems.

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