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Canada

Towards a Healthy Lifestyle,
2001 edition:

A reference guide on substance abuse issues for Canadian police officers

This publication can be found on the CACP website: www.cacp.ca

issued by:
the Canadian Association of Chiefs of Police
Drug Abuse Committee
and the Royal Canadian Mounted Police
Drug Awareness Service and
National Youth Strategy

This publication contains the most accurate information on drug and substance abuse issues as determined by the CACP Drug Abuse Committee and its partner agencies, including the RCMP, the Solicitor General Secretariat, Health Canada, and the Canadian Centre on Substance Abuse.

All CACP members are expected to know and understand these facts in order to disseminate them to the best of their ability in the course of their duties.

This booklet is updated annually to ensure its accuracy, the last date of publication being Dec. 1, 2000.

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1. The Role of Prevention in Policing

Crime prevention is part of the police mandate. It is a significant role for police as are enforcement-related duties. A recent public opinion survey completed by EKOS Research Associates, in September, 2000, for the National Crime Prevention Centre, shows that the Canadian public expects the police, preferably in cooperation with other government agencies and community groups, to play a primary role in crime prevention.

Prevention is about one simple question: What kind of society do we want, for ourselves, our friends and our families?
Only by asking this question of our communities, and by cooperating with other social services already working towards answers, will public education and prevention efforts yield results in the form of public responsibility.

Substance Abuse Prevention
What do we know about substance abuse?

- Substance abuse negatively affects the safety and quality of life in our communities.
- Substance abuse prevention is crime prevention.
- An integrated approach to prevention and treatment must include enforcement.
- Well informed Canadians help us in making our communities safe and healthy (a principal reason for this booklet)
- Substance abusers deserve effective treatment.
- Police can make a difference through innovative partnerships.

Police have a role to play in preventing substance abuse, as well as in communicating the reality of its causes and impacts. Substance abuse is frequently a symptom of larger social problems, and only through education can we get to the heart of the matter.

For example, if a community is turning to drugs because of poverty, it is up to us to work with that community and its other social agencies in addressing that root cause. As police officers, we have a responsibility to work in cooperation with agencies who address the social, economic, physical and political roots of substance abuse.

The causes and effects of substance abuse are as varied and complicated as the individuals it affects. It is the role of a police officer to commit to trying to understand these complex circumstances in his or her community, always in partnership with other community services.

Value $
Prevention work improves the lives of communities in many ways. Some even argue that it can be measured in dollars and cents. A short overview of the costs / benefits of crime prevention completed by John Chisholm for the Australian Institute of Criminology in February 2000 offers many insights into the real value of programs used around the world. In his conservative estimate, for every dollar spent on prevention, anywhere from as low as $0.38 to as high as $11 dollars can be saved on health, enforcement and related social and economic costs.

Most of the time, prevention costs are recovered over the long term, surfacing as savings in the most indirect areas (i.e. drug education which promoted self esteem could not only reduce demand for drugs, but also lessen the youth's chance of participating in violent activities or could help them project themselves better in a job interview). Indeed, prevention work has numerous indirect benefits and is therefore difficult to evaluate.

The improvement of people's lives is our chief concern. No matter the dollar values, proper evaluation and constant reassessment of our efforts to improve the quality of life in our communities is our focus.

As well as our commitment, this work takes patience and time. It took at least ten years for the campaign to prevent drinking and driving to begin to change people's behavior. It will likely take twice as long, with at least twice the effort, to affect our

society's choices regarding drugs, criminality and social responsibility. We believe the effort is worth it, and that prevention work makes a difference.

Levels of prevention

There are three types of prevention: universal, selective and indicated. All types of prevention recognize that many health and social problems are linked by common root factors and that prevention efforts should include better integration of strategies and resources to solve these underlying or root factors.

Universal prevention is aimed at preventing or delaying onset of one or a variety of health and social problems, with initiatives/programs being offered to youth at the school venue. Universal prevention addresses risk factors and practices that lead to adverse health and social problems (ie. substance abuse, teenage pregnancy, suicide).

Selective prevention recognizes the challenges that some youth may face in their lifetimes. (ie. poverty, disability, weak family management and/or difficulties with relationships) Selective prevention aims to reduce the influence of these risks and to have youth learn coping strategies and other life skills to then prevent and reduce substance abuse problems. In this respect, family-based approaches appear to be most effective with higher risk youth.

Indicated prevention recognizes that youth abusing drugs are at high risk of seriously harming themselves. Indicated prevention often involves an outreach component to engage and work with youth to prevent or minimize harms associated with their lifestyle. To access youth who are no longer enrolled in school, opportunities for leisure, recreation or community services, offering excitement and adventure.

(Note: these three levels of prevention may be referred to by some as primary, secondary and tertiary.)

Police generally focus on universal and selective prevention. There is a recognition that higher expertise, along with non-police personnel, may be required for optimum effectiveness resulting from indicated prevention services.

2. Dealing with Partners and the Media

Much prevention work involves dealing effectively with partners, members of the community and the media. It also consists of providing timely and factual information on issues affecting Canadians.

This does not mean you have a mandate to express your opinions on drugs. As a police officer, you must present only the most accurate information on these important issues (which are outlined in section 3). All debates on what constitutes the facts on substance abuse should be resolved internally in your municipal or provincial police service, your local police association, or the CACP.

Dealing with partners

Having the ability to deal effectively with municipal, regional and provincial partners on specific substance abuse issues is integral to a police officer's ability to be effective in his/her prevention work.

You can work with various partners (police officers, employees of social services, health services and addiction agencies) for a healthier and safer community. You should consult these experts. From coast to coast, police officers have established various partnerships, including Health and Enforcement in Partnership (HEP) and the Canadian Community Epidemiology Network for Drug Users (CCENDU). This latter initiative involves gathering data on current and projected drug trends in large urban centres.

Dealing with the media

When dealing with the media on drug abuse issues, our goal is to explain the *impact* of substance abuse on our local communities. Since substance abuse costs approximately $18.5 billion /year nationally in health, social and economic costs, there are plenty of local examples you can use. (See below for what to say.)

While the media are invariably interested in seizures and take downs, every effort should be made to explain the impact/significance of these drugs in terms of their social costs rather than their monetary value.

Explaining the impact/significance of drugs in terms of their monetary value only serves to glamorize those who traffic. However, frequently journalists will insist on knowing the monetary value of a seizure. If this is the case, give them as accurate a value as possible according to the standardized prices, and begin working to make them understand why it is important to move away from monetary values. (See section 3.9 "Social and Economic Costs of Substance Abuse" for more details.)

For example, explain the quantity of the drugs seized in terms of doses, and the potential health risks associated with those drugs, or their grave implications for their market. If you are dealing with a massive heroin seizure in a region where heroin is becoming a problem affecting a particular community, take the opportunity to explain the dangerous effects heroin is having in the area.

Most police forces have a designated Media Relations Officer. This member is, or should be, aware of the CACP's position on substance abuse issues to ensure that they have the most basic and up-to-date information. (See Section 5 for the CACP Policy and Resolutions.)

The costs of substance abuse are highlighted by the health, social and economic consequences:

- costs borne by abuser's family
- costs for substance abuse treatment
- costs of property damage due to alcohol-related traffic accidents
- fire damage
- cost of life (estimate the numbers of life-years lost because of a death)
- workers compensation
- productivity losses due to related sickness or mortality
- ambulatory care and physicians fees
- residential care
- emergency room care
- accidental falls
- alcohol or drug dependence syndrome
- drug psychosis
- motor vehicle crashes
- suicide
- drug or alcohol poisoning
- AIDS acquired through the use of illicit drugs
- assaults

Types of lines to convey to the media following a drug operation (reactively) or pro-actively:

We have assessed the degree to which our efforts in this regard will reduce the health and safety risks (or) social and economic burden to this area (or) this neighbourhood (or) this community (or) our youth (or) our society. In this case, we feel we have (or) we will ...

-OR-

We want to emphasize the degree to which these types of enforcement actions hurt criminals (or) organized criminals who prey upon the residents of this community. In this particular case, we believe we have had some (or) significant (or) sweeping success because ... was avoided.

3. Issues and Explanations

There are many heated arguments on substance abuse issues circulating in policy circles, in the media, in town halls and in school rooms. The following explanations are meant to clarify these sometimes confused debates. Having good references for all substance abuse data is important, and so references for key information are located at the end of this booklet.

3.1 Harm reduction

This term comes up constantly in prevention work and can cause much confusion. First, we need to explain what we mean by the word "harm", as it relates to substance use/abuse:

- *Physical* harm includes death, illness, addiction, the spread of diseases such as HIV/AIDS and hepatitis, and injury caused by drug-related accidents and violence.
- *Psychological* harm can include fear of crime and violence and the effects of family breakdown.
- *Societal* harm refers to breakdown of social systems.
- *Economic* harm includes the impact of the illegal drug trade and the cost of enforcement efforts as well as economic harm to individual users and society, including the costs of decreased and lost productivity, workplace accidents, and health care.

The stated goal of Canada's Drug Strategy is to "*...reduce the harm to* individuals, families and the community at large caused by the use of substances such as alcohol, pharmaceuticals, solvents and illicit drugs..." (1.)

Because harm reduction measures touch on such a broad range of impacts, the term "harm reduction" is often used vaguely, with differing definitions and intents. Generally, the term refers to any initiative aimed at preventing or reducing the impact of any of the kinds of harm listed above.

For example, harm reduction occurs through designated driver programs that prevent drinking drivers from getting behind the wheel; as a result of public education and sensitization, people are made to think about the consequences of driving drunk. As such, this public awareness initiative is a successful harm reduction measure.

One should note that harm reduction measures, like public awareness campaigns, are not a cure-all solution. For example, though most people have been made responsible for their behavior behind the wheel, habitually drunk drivers are not affected by anti-drunk driving messages. For this portion of the population, harm reduction efforts have not worked. Only when these drivers no longer drink (likely with the help of a court-appointed treatment program and abstinence from alcohol) will a harm reduction strategy achieve its ideal goal of harm cessation.

Differing interpretations

Canada's Drug Strategy states that "harm reduction" is *"a supply control/demand reduction paradigm including the prevention of use by non-users (abstinence), the management of risk of harm (for users and others), and the treatment of individuals either directly or indirectly affected by use."* (2.)

It is important to recognize that harm reduction means different things to different organizations. The CACP concurs with the Canadian Society of Addiction Medicine (CSAM) in that no treatment can be effective if it involves the addict's continued use of drugs; the effectiveness of harm reduction efforts should be considered helpful only if they encourage abstinence from substance abuse as their goal. (3.)

Methadone maintenance and needle exchange programs are two of the examples most commonly associated with harm reduction (see section 3.4 on injection drug use). These kinds of harm reduction measures, however, can affect public safety and must focus on improving the addict's quality of life. (4.)

Police fully support these measures, in principle, to save lives. We believe that once lives are saved, the quality of that life should not be forgotten. Thus, abstinence from a life of drug use/abuse should be considered the final goal of any humanitarian intervention, such as harm reduction measures.

We believe that substance abusers deserve effective treatment through coordinated efforts of health and social service agencies. If addicts are not supported socially, emotionally, and economically, they will be drawn to the illusion of the sanctuary that drugs offer again. If the addict is offered hope and is expecting to live an addiction-free life, we should follow through and ensure that abstinence-based treatment is available immediately.

Because there is no single definition of harm reduction, the term should always be defined in context, and any debate on harm reduction should be entered into carefully.

3.2 Legalization/Decriminalization

These two words get confused on a regular basis.

To *legalize* a drug is to make it legally available for consumption without a prescription, within the limits of government regulations, such as with currently legal drugs, alcohol and tobacco.

To *decriminalize* a drug is to keep it a controlled substance, while removing criminal sanctions for its consumption or possession. In other words, with decriminalization, instead of facing a criminal penalty and/or record for possession of a small quantity of a controlled substance, the accused could receive an alternative penalty, such as including a fine or community service.

Legalization:
The CACP stands in opposition to the legalization of any and all illicit drugs in Canada, including the possession of small amounts of marihuana (See section 5 for the complete CACP drug policy and resolutions).

Legalizing drugs will not save money in enforcement dollars, and certainly will not generate tax revenues adequate to cover the social and economic costs associated with drug use and abuse. (5.) We already know this based on the examples of tobacco and alcohol; the estimated annual loss to government per year due to contraband is $2.5 billion. (6.)

Moreover, legalization would do nothing to prevent under-age consumption of illicit drugs. At present, though tobacco regulations may work to prevent the majority of youth from obtaining and consuming tobacco products, half a million Canadians under the age of 18 smoke cigarettes nonetheless (7.) (See Section 5.9 on the social and economic costs of tobacco and alcohol.)

Decriminalization / the use of alternative justice measures:
According to the Government of Canada, through Canada's Drug Strategy, we have adopted a balanced approach to dealing with substance abuse issues. If the government were to create initiatives aimed at integrating the following components, including prevention, education, enforcement, counseling, treatment, rehabilitation and diversion programs, the CACP would consider endorsing initiatives to decriminalize certain offences related to the possession of small amounts of marihuana or other cannabis derivatives.

Alternative justice measures legislation could be used for summary conviction offences of possession of cannabis after a mandatory assessment of the accused. A range of options should include, but not be limited to, drug and life skills counseling, fines, community service or a combination of alternative measures. (8.)

3.3 Marihuana

The CACP position on marihuana (*cannabis sativa*) and its derivatives is that they are harmful substances, and the CACP by no means endorses their legalization. At present there is a great deal of misinformation circulating surrounding the properties of marihuana; more seriously, there is an almost complete lack of public debate based on the facts and consequences of marihuana use.

For example, with its ever-increasing potency levels — from an average of 6 per cent Tetrahydrocannabolin (THC), up to as high as 25 per cent THC, compared to 1 to 3 per cent in the late 60s and 70s — marihuana can no longer be considered a "soft" drug. (9.)

Is marihuana addictive?

All major world health organizations include marihuana on their list of addictive substances. Moreover, recently the International Olympic Committee (IOC) put the drug on its list of banned substances. (10.)

As with alcohol, daily marihuana use can cause dependence. In 1996, in six Canadian cities 31per cent of people in drug treatment named cannabis as their primary drug of abuse. (11.)

Over the past decade, studies have shown both its physically and psychologically addictive properties. Health Canada has also concluded that psychological and physical addiction is an effect of regular or heavy use of marihuana. (12.) It is estimated that half of those who use marihuana daily may become dependent on it. (13.)

Marihuana use by and addiction of, youth is of particular concern. Recent studies show that marihuana use climbed significantly between 1994 and 1998, with almost half of Grade 10 students now saying they have smoked the drug. (14.)

Even more conservative data show that Canada-wide, 14 per cent of marihuana-using youth consumed marihuana more than once a week; in Ontario, 19.7 per cent of teenaged marihuana users consumed the drug more than 40 times in the last year; in Manitoba, 25.2 per cent of marihuana users consume more than once a week. As for adults, in Ontario in 1996, 11 per cent used marihuana more than once a month, while Canada-wide the number increased to 15 per cent for users 20 to 55 years-old. (15.) (16.) (17.)

Health effects

Health Canada research affirms that marihuana can cause harmful effects in some long term users. For example, in users who have consumed regularly for a minimum of 3 years, chronic build-up of cannabinoids can produce short- and long-term impairment of brain function, so that basic skills, such as those used for safe driving, are damaged. (18.)

Furthermore, the National Institute of Health in the US has found that marihuana can produce mild to severe states of psychoses, while Health Canada claims it can cause psychotic symptoms to worsen in people with psychiatric disorders, particularly schizophrenia. (19.) (20.)

There is some evidence that marihuana use causes "amotivational syndrome,"which has dire consequences for adolescents. (21.) According to a recent National Institute of Health-promoted study, chronic marihuana use can be associated with behavior characterized by apathy and lack of motivation along with impaired educational performance, even without obvious behavioral changes. (22.)

In general, just like tobacco, marihuana suppresses the immune system; it can contain up to 50 per cent more cancer-causing agents than cigarettes. (23.) In a recent study it was found that marihuana users who also consumed tobacco were 36.1 times more likely to develop head and neck cancer. (24.)

Medicinal marihuana

The CACP supports research into medicinal uses of any currently illicit drug. We expect that Health Canada scientists and federal legislators, through their research and regulatory approval process, will take the necessary action in the best interest of all Canadians. (25.)

Under Section 56 of the Controlled Drugs and Substances Act, people can be exempted from parts of this law with the permission of the federal Minister of Health. As such, sick people have been exempted to cultivate and possess marijuana, for use in relieving their symptoms. These people are not part of clinical trials, and Health Canada makes no claim that this drug will work in relieving any symptoms. Another group is being exempted from possession laws so that they can participate in clinical trials. (26.)

*** The Ontario Court of Appeal has recently ruled that existing legislation regarding the use of marihuana for medicinal purposes is unconstitutional. They have requested that legislation be enacted by the federal government by July 2001 to allow sick persons easier access to marijuana to treat their symptoms, over and above the current exemptions from law (ie. *Section 56* of the *Controlled Drugs and Substances Act*) offered by the Minister of Health toward selected individuals.

Other facts

An alternative form of delivery of marihuana, for medical purposes, is being developed by GW Pharmaceuticals in the U.K. in the form of a mouth spray. (27.)

The THC compound in marihuana may have medicinal utility for symptoms such as pain, vomiting, and stimulating appetite in HIV/AIDS patients. Marihuana may also be useful for controlling the intensity of epileptic seizures. (28.)

Smoking marihuana for medical reasons comes with associated risks as, for most patients, it must be consumed in large doses. (29.)

Impaired driving and testing

In most impaired driving studies, marihuana is the most commonly detected drug after alcohol, and is most often consumed in combination with alcohol. (30.) Marihuana use increases the risk of a motor vehicle accident by at least 2-4 times. An airplane pilot study shows that even a low to moderate dose of marihuana can impair driving performance for up to 24 hours. (31.) Marihuana impairs driving behavior such as braking time and reaction to red lights or other signals. (32.)

In 1998 in a study conducted by the Addiction Research Foundation estimated that 22 per cent of cannabis users, or 138,000 people total, drove under the influence of marihuana in the province of Ontario the previous year. (33.) A recent study in BC shows that almost 50 per cent of those drivers involved in motor vehicle crashes who tested positive for drugs, tested positive for marihuana use. (34.)

A 1986 Ontario study by the Traffic Injury Research Foundation found that drivers high on marihuana (also mainly coupled with some alcohol use) caused more multiple vehicle accidents than were caused by drunk drivers. (35.) Rates of impaired driving by marihuana users are highest among those aged 25 years or younger (4.3 per cent among 16-19 year olds and 5.8 per cent among 20-24 year olds) and decrease with age. (36.)

The CACP supports the use and expansion of the Drug Recognition Expert (DRE) program and corresponding legislation, which will enable them to prevent substance users from driving and further promote road safety for Canadians. (37.)

The Dutch example- tolerating marihuana

The Dutch example is usually touted by those promoting legalization, but their policy is often misinterpreted. In the

Netherlands, marihuana possession is illegal, wherein possession over 30g. is an indictable offence and under 30g. is a summary offence. (38.)

However, the Dutch tolerate the use of small quantities (5 grams) of marihuana, and ultimately the cultivation and sale of marihuana. The Dutch used to tolerate use of up to 30g., but because of the various problems encountered, they recently lowered the amount significantly. They also tolerate the use of designated spaces for drug consumption, although some towns have begun closing the "hash cafés" in which drug use was allowed. (39.)

The effects of this policy decision (tolerating use of marihuana) are still being evaluated, but a 1997 review of Dutch drug use surveys shows marihuana use among 18-20-year-olds increased consistently and sharply from 15% in 1984 to 44% in 1996. (40.) Among youth over 12 years old, cannabis use rose markedly in the 1990s. (41.)

Possession of marihuana in Canada- no criminal record

As per the new Canadian drug law, the *Controlled Drugs and Substances Act* (enacted in 1997), no person found in possession of marihuana (under 30g.) can be fingerprinted because the offence is now one of summary conviction, only. Their names cannot be entered on the Canadian Police Information Centre or CPIC (as CPIC only registers people by fingerprints). Therefore, they will NOT receive a criminal record, as entry onto CPIC has been defined by the lower courts as the criminal record registry.

However, at border crossings, such as the U.S. border, Canadians can also be asked if "they have ever been charged with a criminal offence", and will be denied entrance if they respond in the affirmative. If marihuana possession laws were enacted in the context of an Act where the offence would not be criminal in nature, such as the *Contravention Act*, then no criminal charge would be laid and there would not be an impediment to traveling.

Police do not target marihuana users

Police do not target those who possess minor quantities of marihuana for personal use. A recent study conducted in Ottawa, by the RCMP Drug Awareness Service, confirmed that over 90% of marihuana related offences were secondary charges to more serious primary charges of trafficking, possession of other drugs, weapons offences, impaired driving, court breaches and motor vehicle infractions.

For example, a police officer arrests an impaired driver and during the search finds marihuana in the car or on the person. A warrant is executed to arrest a Break and Enter suspect who when arrested, is found to have marihuana in his possession.
Both charges are laid, but there is no data base to show how they were linked, or that the possession of marihuana charge was only laid, after the person was arrested for another criminal offence. At present you can be identified only by the link of examining court records. To presume that police set out to target people for possession of small amounts of marihuana is inaccurate. (42)

Police continue to advocate enforcement to stem the importation, cultivation and distribution of marihuana which is controlled and fuelled by organized criminals, including outlaw motorcycle gangs.

The penalties for possession of small quantities of marihuana

(See section 5. for CACP policy and resolutions on this issue.)

3.4 Injection Drug Use

Injection drug use entails a host of health and substance abuse issues, everything from risks from the drugs themselves to the risks posed by diseases like HIV/AIDS and hepatitis, which are easily transmitted by shared needles.

What needs to be made clear is that injection drug use is not normal, acceptable, or healthy — it is not a lifestyle choice. It is both the cause and result of deeply alienated people who are the victims of a powerful addiction.

Police advocate for measures which result in greater access to effective treatment for injection drug users. (See section 3.1 on harm reduction.)

Symptom Control measures

Both needle exchange and methadone maintenance programs are symptom control measures. Like withdrawal or detoxification, they prepare the addict for treatment but are not treatments *per se.* Ultimately, detoxification, treatment and long-term monitored care must be considered the "gold standard" of addiction treatment; methadone and needle exchange programs are, however, transitory steps towards that goal.

Needle exchange programs (NEPs)

The CACP supports needle exchange programs (NEPs), *in principle*. Support for this type of "harm reduction" measure, which exists to reduce communicable diseases and morbidity, is dependent on the NEP having treatment programs readily available to eventually free the addict from drug abuse (see Section 5 for CACP policy on Needle Exchange Programs).

NEPs which do not have abstinence-oriented treatment programs attached to them, can only maintain the addiction of the drug abuser. They may work short-term to keep the addict alive, but do nothing to improve their quality of life for the long-term.

Although some needle exchange programs have proven beneficial, the results from others have been far less encouraging. (43.)

There are no thorough and widely-accepted ways of measuring the effectiveness of a NEP. It is argued that if the percentage of HIV-positive or infected syringes drops, then the program is doing its job. Yet, results from tracking and testing samples of returned syringes for the presence of the HIV or hepatitis, are far from conclusive in proving the effectiveness of NEPs. (44.)

Our partners in addiction medicine have told us that NEPs are only effective when offered in conjunction with full service support (housing and employment outreach programs, counseling, and community support services). The NEP must also employ needle-return measures, so that the number of addicts using the service can be registered and the prevalence of communicable diseases can be assessed. (45.)

Further research is needed to show how community injection sites (or 'safe' sites) can be beneficially applied in Canada. We cannot simply assume that what seems to work in Switzerland, for example, will work here with our own health care and legal systems.

Methadone or heroin-substitution treatment programs

Most ex-users have made it clear that they would prefer treatment rather than the substitution of one drug for another. (46.)

Methadone maintenance can provide addicts with a period of stabilization and transition while they try to put their lives back

together, if they are properly supported by counseling and social services. However, there are significant risks involved in providing easy access to methadone because it is an extremely powerful opiate similar to morphine or heroin. A single daily dose will prevent opiate withdrawal for 24-36 hours. (47.)

Some of the rationale for methadone may be out of date. Since the inception of the treatment programs over 30 years ago, 12-step and other community-based programs have largely replaced methadone as an effective form of treatment.

We fully support the use of methadone in prisons, as part of a full-service treatment option for inmates, including counseling and social services when they finish their sentence. The safety of our communities is of prime importance, an of will be enhanced if the person being released is drug-free, rather than a continued substance abuser.

Medicinal uses of heroin

Currently, heroin is available by prescription, and can be used as a painkiller. It is not frequently prescribed because other, less addictive, alternatives have proven more effective. Clinical trials using heroin would require a controlled structure, including a limited number of test subjects, urine tests, high levels of counseling and all other available social support, including housing and employment programs. (see CACP Drug Policy for support of research on the possible medicinal uses of drugs). (48.)

Other facts on this issue

Heroin prescription trials have already taken place in Switzerland; however, the decline in heroin use reported by addicts may not be a direct result of the free distribution of heroin. Researchers argue that it is more likely the result of financial aid and social services (full service treatment) provided to those who participated in that project. (49.)

3.5 Designer Drugs and Raves

Designer drugs (club drugs) are being used by young adults at all-night dance parties such as "raves," dance clubs and bars. MDMA (Ecstasy), GHB, ketamine, methamphetamine (speed) and LSD are some of the party drugs gaining in popularity. (50.)

Although they have been presented in the media as a soft alternative to hard drugs, no designer drug, such as Ecstasy, is benign.

Research supported by the National Institute of Drug Abuse demonstrates that club drugs can cause serious health problems and, in some cases, even death. In these circumstances poly-drug use is common, creating an even more dangerous situation for the drug user. Some of the effects of club drug use are: intensified sensory perception, heightened interpersonal feeling toward others, acute serotonin depletion, toxicities such as tachycardia, panic, and could induce seizures, coma or death especially if use occurs in high doses or combined with other drugs. (51.)

Moreover, these drugs are generally produced by organized criminal groups, with little care for the quality of the drugs they manufacture or distribute, or the health risks they may present. (52.)

Raves

Police strive to protect the rights of youth, who are the main audience at these venues. We are in accord with many of the recommendations of the inquest on raves held in Toronto in May 2000, including having municipal by-laws in place requiring the following safety provisions for raves:

- Both city property and private venues be made available for raves, subject to a licence or permit system.
- Public health departments work with health-care practitioners, police and school boards to educate people about the risks associated with drug use.
- A restriction on admission to those 16 and older.
- A ban on depictions of drugs and drug use on advertising material.
- Unlimited access to drinking water.
- Paramedic present at all times, with access to a proper first-aid room.
- Bonded security guards be used to ensure safety.
- Security guards having search privileges, at the entrance door, and the authority to refuse admission to those found with drugs. (53.)

By working with rave promoters and providing substance abuse training to security guards, and by working directly with youth to educate them regarding the dangers of designer drugs, police officers can work to facilitate positive, recreational events while simultaneously preventing any possible tragedies in their communities.

Note: Although there is no doubt that raves can promote a culture of drug use, there are different views on how best to police them. In some areas, raves are not legal and the police are asked to shut them down whenever they are detected. This approach may work in your area; however, in other areas the authorities have determined that this approach may serve to drive raves to underground locations. This creates a greater risk of possible harm because they are harder to police, and usually do not have any of the safety measures as outlined by the Rave Inquest in Toronto.

Lessons learned in the Vancouver area include following many of the provisions outlined by the Rave Inquest (Toronto) and especially emphasizing the fact that the use of properly trained bonded security guards (trained by police), serves to both uphold public safety and limit the resource requirements of police officers at raves.

3.6 Mental Health and Drugs

Mental illness affects the prevention and treatment of drug abuse.

We know, from our expert partners in addiction and health services, that mental illness can be a powerful factor in the decision to use drugs, and in the attempt to stop drug use from escalating into abuse. Often symptoms of mental illness mimic those of drug abuse.

In one large US study, 30 per cent of alcohol abusers and 50 per cent of drug abusers also had a serious mental illness. A smaller study in Edmonton, Alberta, yielded similar results. (54.)

The neurotransmitters affected by mental illness are the same as those affected by drug abuse and addiction. The coexistence of mental illness and substance has many different terms: concurrent disorders, dual diagnosis, co-morbidity, "double trouble," mentally ill chemical abuser, etc.

Determining factors include:

- *heredity*, which can increase the chances of developing mental illnesses (the chances of developing major depression increase from 5 per cent to 15 per cent if a close relative has been affected by depression);
- *environment*, which can also increase the chances of developing a mental illness (i.e., adult psychosis induced by abuse in childhood); and
- *use of psychoactive drugs,* which can have temporary or permanent effects, and which aggravates pre-existing mental illnesses or triggers dormant ones (i.e., chronic marihuana use can hasten the development of schizophrenia in people who are already predisposed to the illness). (55.)

The effects of drugs can directly or indirectly mimic mental illness. As such, any psychiatric diagnosis should be tentative while the user is still under the effect(s) of drug(s).

There are two philosophies about the treatment of people with concurrent disorders. The first aims to control the psychiatric disorder in the hope that the substance abuse will disappear, while the other attempts to wean the patient off drugs or alcohol in the hope that the mental problem will disappear. (56.)

Initial research suggests that integrated treatment is the best approach. This customized treatment considers a person's full range of problems, not only those important to one treatment area.

All substance abuse prevention professionals should learn to recognize and understand the most common concurrent disorders. Studies suggest that people with common mental health problems, such as anxiety and mood disorders, along with those with less common disorders such as anti-social and borderline personality and schizophrenia, may be at a higher risk of having a substance abuse problem. (57.)

3.7 Inhalants

Disturbingly, a bottle of hair spray sells for $50 in Island Lake, MB. The bottle is sufficient for at least 2 people to get high. It is the drink of choice among younger people, due to its high alcohol content, and more enhanced effects over that of liquor. (58.)

Inhalants comprise a wide variety of substances, including gases, liquids that give off fumes and aerosol sprays. Commonly used products include: typewriter correction fluid, toluene (glue), gasoline, spray paints and anaesthetic agents; they are used for their stupefying, intoxicating and sometimes slightly psychedelic effects.

The methods of inhalation include:

- *Sniffing*: breathing the inhalant directly from the container, drawing vapors into the lungs;
- *Huffing*: soaking a rag with dissolved inhalant, putting it to mouth and inhaling, which draws more vapors into the lungs;
- *Bagging*: placing the inhalant in a plastic bag and inhaling; taking in the exhaled air intensifies the effect; and
- *Spraying*: spraying the inhalant directly into nose or mouth. (59.)

Warning signs of inhalant abuse include finding any of the following items in the possession of a child or adult: tubes of glue; plastic bags; soaked rags; a chemical odor on the body and clothes or in a room; red, glassy, and/or watery eyes; slow, thick or slurred speech; and shortness of breath and/or loss of appetite. (60.)

Inhalants are distinctly different from other psychoactive drugs. They are fast-acting and have intense and extremely harmful effects.

Cheap and readily available, inhalants are used more often by the young and the poor. In Canada, use of inhalants by the young in marginalized communities is alarming. Moreover, inhalants have not been dealt with adequately in any preventative measure by the majority of parents, educators, media or the police.

As for an enforcement-oriented solution, there are no laws police can enforce because most inhalants are legal substances and the administration of noxious substances is not an offence.

3.8 Alcohol and Tobacco

Many researchers consider alcohol and tobacco to be the true “gateway” drugs. (61.)

Firstly, the use of alcohol and tobacco leads to the increased potential for the use and abuse of other drugs such as marihuana, prescription medication, MDMA (ecstasy), cocaine, etc.

Secondly, exposure to the contraband environment of regulated substances like alcohol and tobacco is usually a stepping stone towards continued disrespect for social norms and laws, and can lead to participation in other serious organized types of criminal activity, such as trafficking in humans, and/or illicit drugs.

In particular, when youth resort to purchasing or “running” for black market products, they expose themselves to the criminal element and its associated dangers. The line is blurred between a legal product and its illegal distribution, and values and ethics are subverted by the pursuit of profit through illicit means. (62.)

The impact of these activities cannot be underestimated, nor can the serious health effects of the substances (legal or contraband) themselves.

Alcohol

Alcohol is a drug — it is a depressant that slows thinking and actions. (63.)

An average-sized adult person’s liver can break down about one drink per hour. Above this rate excess alcohol circulates through the body affecting behavior, judgement, perception and motor skills, such as driving. Alcohol in the bloodstream impairs motor skills at a Blood Alcohol Content as low as 0.03 per cent, while federal law states that it is a criminal offence to drive a motor vehicle with a BAC over 0.08 per cent .

In Canada, policing alcohol costs three times more than policing illicit drugs. In 1992, the cost of policing alcohol (violations of provincial liquor acts; impaired driving; violence related to alcohol) was $665 million whereas drug enforcement cost $208 million. (64.)

While the public safety campaigns to reduce impaired driving have been largely successful, 3 per cent of drivers, who have serious drinking problems, have not been affected by public education and account for 84 per cent of drunk driving trips. (65.)

Health effects of alcohol

According to a 1996/97 survey, 23 per cent of Canadians exceeded the low-risk guide-lines for alcohol consumption and 10 per cent reported having problems with alcohol (66.) Data gathered in Canada fail to account for other high-risk drinking behaviors that are equally problematic (i.e. “binge drinking”), especially among youth. (67.)

In a 1999 Ontario/Quebec prison inmate study, 46 percent of inmates interviewed said that, at a young age, they had been exposed to abuse of alcohol in their family. (68.)

Health effects of contraband alcohol

There are serious potential health consequences of purchasing contraband spirits, like the possibility of contamination or poisoning due to a lack of quality control. In 1999, a woman in Plaster Rock, NB died after mistakenly consuming windshield washer fluid. As with all contraband products, the consumer never knows if they are getting the “real thing.” (69.)

Fetal Alcohol Syndrome (FAS)/Fetal Alcohol Effects (FAE)

Alcohol use by pregnant women has significant negative effects on the fetus. It can cause physical malformations of the face and brain, as well as resulting in life-long learning disabilities or retardation. FAS is one of the major known preventable birth defects among Canadian children. **(70.)**

Tobacco

Approximately 28 per cent of Canadian men and women smoke.

That figure jumps to 35 per cent among young adult men and women. Canadians with lower incomes smoke more than those with high incomes (38 per cent versus 21 per cent). Another alarming fact is that 62 per cent of First Nations, Inuit and Métis populations smoke.

Smoking resulted in an estimated 45,000 deaths in Canada in 1999. Of those:

- 2/5 were the result of cancers
- 2/5 were the result of cardiovascular diseases
- 1/5 were the result of respiratory diseases
- 2 infants die every week due to tobacco-related reasons (i.e. second hand smoke)

More men than women die every year due to smoking-related illnesses, but deaths among women have risen dramatically by 75 percent between 1986 and 1996. A woman who smokes increases her risk of lung cancer by two to three times. Lung cancer has now become the leading cancer-caused death among women. (71.)

Tobacco taxation

The young and economically disadvantaged respond well to price elasticity, meaning that if cigarette prices are raised, they will reduce their consumption. (72.)

In the past, although sales declined when tobacco taxes were high, consumption did not because Canadian authorities were unable to control the availability of contraband tobacco. The CACP recognizes that tobacco taxes are an important part of the government's tobacco reduction efforts, and that in order to be effective, contraband must be controlled. (73.)

In general, organized crime groups are responsible for the contraband traffic of tobacco; smuggled cigarettes are one of their fastest growing "product lines." It should be made clear that these are the same smugglers who bring drugs, guns and criminal activities into communities. (74.) Recently, because of differential tax rates among provinces, interprovincial smuggling is also becoming a significant problem. (75.)

Health effects of smoking

Tobacco is an addictive drug causing illness and death. Tobacco is a factor in more deaths than all other drugs combined. (76.) Pipe smoking is as bad as cigarette smoking, and cigar smoking is worse. (77.) Using tobacco increases the risks of oral cancer, and the risk is elevated if tobacco is consumed alongside alcohol. (78.)

Secondhand smoke is equally hazardous to health. Prolonged exposure to cigarette smoke contributes to impaired lung function, lung cancer, heart disease, and other cancers. Children who are exposed to secondhand smoke have a greater risk of reduced growth, respiratory problems, middle ear infection, and asthma. A person sitting in a smoky room for one hour can inhale as much cancer-causing nitrosamines as if the person had smoked 35 cigarettes. (79.)

Quitting smoking decreases risk for disease. After quitting, former smokers notice benefits such as easier breathing and an enhanced sense of taste and smell, along with decreased risks of heart disease, stroke, emphysema and cancer.

Health effects of chewing tobacco

Long associated with professional athletes, the use of chewing tobacco has been perceived as safe to use. It is not. Chewing tobacco in the mouth for 30 minutes provides as much or more nicotine as smoking a cigarette. Nitrosamines are found in far greater quantities in smokeless tobacco than in other forms of tobacco. Chewing tobacco can cause quick, serious, and irreversible side effects. Cancer can develop where tobacco comes in contact with the mouth, beginning as white or dark red spots on the gum, cheek, or tongue. (80.)

3.9 Social and Economic Costs of Substance Abuse

In a cost estimate study completed by the Canadian Centre on Substance Abuse, it was revealed that substance abuse cost Canadians more than $18.45 billion in one single year. This represents $649 per Canadian per year, or about 2.67 per cent of Canada's total Gross Domestic Product. And by most experts' calculations, this is an underestimated cost of the problem.

While dollar figures can never wholly explain the human misery that substance abuse causes and perpetuates, they help illustrate its impact in terms of the amounts of money that could be put towards related social services.

As such, substance abuse affects more than the user (as identified in the per capita costs in the chart that follows). We all pay the cost in monetary as well as social terms; those close to the abuser also pay an emotional toll. The social and economic costs of substance abuse come in many forms, including hospitalizations, court costs, productivity losses, ambulance services, social welfare, research and training, traffic accident damage, and much more. These are the substantial costs of substance abuse to highlight to the public and the media.

In a recent study conducted in 26 communities across Canada, police reported that more than half (53%) of the people arrested for criminal offences had consumed alcohol or illicit drugs, or both, when the crimes were committed. Using a two-page questionnaire called an Arrestee Study Form (ASF), arresting officers recorded their assessment of drug and alcohol involvement in 2,765 arrests made between from May 1-30, 2000. Criminal offences include homicide, assault, property crimes, drug trafficking and impaired driving. The full results of this study, using other and expanded data sources, are expected in early 2001.

Perspectives: Alcohol
Nationally, alcohol alone accounts for more than $7.5 billion per year in terms of financial costs, or $265 per Canadian. This represents 40.8 per cent of the total cost of substance abuse. The largest economic costs of alcohol are $4.1 billion for lost productivity due to illness and premature death, $1.36 billion for law enforcement and $1.3 billion in direct health care costs. Provincially, the report shows that the per-capita costs of alcohol abuse are highest in Alberta ($285 per capita). The lowest per-capita costs of alcohol are in Newfoundland ($199). Among the other provinces, per-capita alcohol costs range from $243 in Quebec to $283 in Prince Edward Island.

Perspectives: Tobacco
Across Canada, tobacco accounts for $9.56 billion in costs, or $336 per capita. This is more than half (51.8 per cent) of the total substance abuse cost. Lost productivity due to illness and premature death accounts for more than $6.8 billion of these costs and direct health care costs due to smoking account for $2.67 billion. By province, Nova Scotia has the highest per-capita costs related to tobacco ($398), followed by Prince Edward Island ($361), New Brunswick ($354) and Ontario ($346). The lowest per-capita costs attributed to tobacco are in Alberta ($277), Saskatchewan ($281) and Newfoundland ($294).

Perspectives: Illicit Drugs
Nationally, the economic costs of illicit drugs are estimated at $1.37 billion, or $48 per capita. Approximately $823 million of that is due to lost productivity due to illness and premature death, while another $400 million goes toward law enforcement. Direct health care costs due to illicit drugs are estimated at $88 million. Provincially. the per-capita costs of illicit drugs range from $31 in Newfoundland to $60 in British Columbia. It is estimated that illicit drugs cost the British Columbia economy $207 million in 1992. Relatively high economic costs are also attributed to illicit drugs in Alberta ($135 million or $51 per capita), Ontario ($507 million or $48 per capita), Quebec ($333 million or $47 per capita) and Prince Edward Island ($4.7 million or $36 per capita).

The total costs of substance abuse in Canadian provinces, 1992

The costs of substance abuse vary **considerably** from province to province in Canada.

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NF
population total	3,451.3	2,632.4	1,004.5	1,113.1	10,609.8	7,150.7	749.1	920.8	130.3	581.1
GDP (in millions)	86.3	73.7	21.0	23.6	280.5	156.7	14.0	17.8	2.2	9.1
Alcohol										
Alcohol total costs	938,863	749,330	265,977	283,542	2,861,926	1,728,517	178,645	240,092	36,928	115,333
Total per capita	272	285	265	255	270	243	239	261	283	199
Tobacco										
Tobacco total costs	1,110,665	728,589	281,842	354,008	3,673,860	2,366,748	265,551	367,016	47,058	170,976
Total per capita	322	277	281	318	346	331	354	398	361	294
Illicit Drugs										
Illicit drug total costs	207,534	135,258	36,128	45,132	507,518	334,299	25,256	36,156	4,686	18,239
Total per capita	60	51	36	40	48	47	34	39	36	31
Substance Abuse Total										
Total substance abuse total	2,257,062	1,613,176	583,946	682,682	7,027,101	4,429,546	469,451	643,265	88,672	304,548
Total per capita	654	613	581	613	662	619	627	698	681	524

source: The Canadian Centre on Substance Abuse, "*The Social and Economic Costs of Substance Abuse in Canada*", 1996

4. People, Publications, and Websites

There is a network of police, social service, health and addiction partners in your city/region you can work with to improve the health and safety of your local community. You should refer questions to these experts. Across Canada, police are involved in many partnerships, two of which are Health and Enforcement in Partnership (HEP), and Canadian Community Epidemiology Network on Drug Use (CCENDU), which gathers data on current and expected future drug trends in your local large urban areas.

People

CACP Drug Abuse Committee Members and Technical Advisors, 2000-2001	
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Publications

Books and Articles

- *Costs of Substance Abuse in Canada* - CCSA (available at www.ccsa.ca)
- *Straight Facts about Drugs and Drug Abuse* - Health Canada (available at www.hc-sc.gc.ca)
- *Uppers, Downers and All-Arounders,* Darryl S. Inaba, Pharm.d
- *Toward a Healthy Future: Second Report on the Health of Canadians*- F/P/T Deputy Ministers Advisory Committee on Population Health, 1999.
- *Designer Drugs and Raves* - B.C. Drug Awareness Service, by Cpl. Scott Rintoul (available at www.rcmp-fairmont.org/da)
- *The Health Effects of Cannabis* - ed. Harold Kalant
- *Canada's Drug Strategy*- Government of Canada
- *Drug Policy: Striking the Right Balance* - Avram Goldstein, M.D. and Harold Kalant, M.D.
- *Canadian Profile: Alcohol, Tobacco and Other Drugs* - Canadian Centre on Substance Abuse and Addiction Research Foundation, 1999.
- *Clinical And Societal Implications of Drug Legalization* - Herbert D. Kleber, Joseph A. Califano, and John C. Derners
- *Drugs and Sports* - C Div. Drug Awareness Service, by Natacha Llorens

- *Substance Abuse and conjugal violence: literature and the situation in Quebec*.- T. G. Brown, T. Caplan, A. Werk, P. Seraganian, and M.K. Singh, Comité permanente de lutte à la toxicomanie., 1999.
- *Jeunes et prévention de la toxicomanie: quand les parents s'impliquent*, Comité permanente de lutte à la toxicomanie, 1999. (available in French, only)
- *La famille: un tresor à preserver*, Comité permanente de lutte à la toxicomanie, 1999. (available in French, only)

Videos

- *Through a Blue Lens* - Vancouver Municipal Police Department and the National Film Board of Canada

Substance Abuse Web Sites

- Canadian Centre on Substance Abuse: www.ccsa.ca
- Health Canada: www.hc-sc.gc.ca
- Centre for Addiction and Mental Health: www.camh.net
- Alberta Alcohol and Drug Abuse Commission: www.gov.ab.ca/aadac
- Addictions Foundation of Manitoba: www.afm.mb.ca
- Virtual Clearinghouse on Alcohol, Tobacco and Other Drugs: www.atod.org
- Canadian Health Network: www.canadian-health-network.ca
- Club Drugs information from NIDA: www.clubdrugs.org
- B.C. Ministry Tobacco Facts: www.tobaccofacts.org
- National Crime Prevention Centre: www.ncpc.ca
- Canadian Council on Social Development: www.ccsd.ca
- Center for Substance Abuse Prevention (U.S.) Decision Support System for local communities: www.preventiondss.org
- Canadian Association of Chiefs of Police: www.cacp.ca
- RCMP Drug Awareness Service: www.rcmp-grc.gc.ca/html/dr-awar.htm
- Delivering Education and Awareness for Life: www.deal.org / www.choix.org

Police websites

There are so many municipal and provincial websites related to police in Canada that not all can be mentioned them here. Instead, if you are looking for a certain police service, go to a search engine such as www.yahoo.ca or www.altavista.ca and enter in the full name of the police service.

5. CACP Drug Policy and Resolutions

The Canadian Association of Chiefs of Police has established positions on a number of important substance abuse issues. The following outlines are provided to give you an idea of where the majority of Canada's police chiefs stand.

In order of their approval by the CACP, you will find policy relating to 4 contentious drug issues - needle exchange, legalization, decriminalization and medical use. The drug policy resolutions, found on the next few pages, are a roadmap for dialogue on substance abuse issues with other Canadian stakeholders and the government. The CACP seeks action and support from the government for their early implementation.

CACP Policy on Needle Exchange Programs - 1995

The CACP supports the National AIDS Strategy in advocating a community-based needle exchange program model including [all of the following integral components]: outreach, education, counseling, testing of needles and drug users, the provision of condoms and the exchange of needles.

CACP Drug Policy- 1999

The Canadian Association of Chiefs of Police (CACP) stands firm in opposing any type of **legalization** of any and all current illicit drugs in Canada, including the possession of small amounts of marihuana or other cannabis derivatives in accordance with international covenants to which Canada is a signatory.

The CACP, in the interest of assisting the partnership of Health, communities and the police in meeting a common goal of providing a safe and healthier environment for all Canadians to enjoy, would entertain endorsing sound Government initiatives to **decriminalize** (conviction does not give rise to a criminal record) certain offences related to the possession of small amounts of marihuana or other cannabis derivatives. However, such endorsement would be subject to the **proviso that there be corresponding initiatives** instituted by the Government including a balance of prevention, education, enforcement, counseling, treatment, rehabilitation and diversion programs.

Pertaining to the issue of the **medicinal use** of marihuana and any and all other current illicit drugs, the CACP, as with all Canadians, are concerned with the potential hazards, the health care costs, safe storage, misuse and a host of other issues. However, we feel confident that Health Canada scientists and our federal legislators will take the necessary action in the best interest of all Canadians to assess, through their research and regulatory approval process, if marihuana or other current illicit drugs and their derivatives should be approved for medicinal use, in a similar vein that currently enables tranquillizers, morphine and other drugs to be legally prescribed, despite their potential for addiction.

The CACP Drug Policy *Resolutions*- 1999

As police, we have a social role in improving the health and safety of our communities, through our enforcement and demand reduction activities, and alongside our partners, we definitely have a role to play in the drug issue.

As police, we stand totally opposed to legalizing any illicit drug.

As police, we need more tools and greater flexibility in our interactions with drug users. This would include: a highly reliable system of drug recognition (DRE), which should be used to determine levels of drug-impairment, alternative justice measures and longer sentences for organized criminals who feed the drug supply.

We have called on the federal government to provide:

1. Additional police and health resources for demand reduction initiatives, prevention programs, public education and research into cost-effective interventions;

To improve the health and safety of all Canadians we need to dedicate more resources to preventing the harm resulting from drugs. *Prevention through the education of youth, prior to their initiation into drug use, is our major focus in successfully reducing the demand for drugs.* To achieve success, demand reduction must be integrated with reduced availability of drugs, accomplished through enforcement of our drug laws.

2. Adequate police resources for supply reduction and anti-organized crime initiatives;

Enforcement-related activities maintain a level of control over the availability of drugs and provide a concrete expression of our society's disapproval of them. They also ensure that simple availability does not contribute to drug use-related problems. To successfully prevent drug problems a reduction in the demand for drugs must be accompanied by initiatives which lead to a reduction in the supply of drugs.

3. A champion to be identified to lead Canada's Drug Strategy, and ensure that Canada has an effective and coordinated national strategy on drug issues;

A champion would put Canada's drug strategy into action, ensuring consistent and accurate information is provided to the media, to parents and children, and to other public groups. The drug issue is important enough to Canadians to demand the priority and coordination accorded to drug-prevention programs in similar countries.

4. Priority be given to the research and development of effective drug testing technology and Drug Recognition Expert Training, which should be followed up by enabling legislation. It is our belief that police, customs and correction officers, through the use of approved screening devices, should be able to determine levels of drug-impairment;

If the police were able to better detect levels of drug-impairment, it would only serve to increase the safety of our communities. Right now, blood or urine specimens can only be taken by police officers in special circumstances, allowing drug-impaired drivers to go undetected, unconvicted and unpunished. *A recent study shows that if police could test for marihuana, 1/3 of impaired drivers who are currently set free could be taken off the roads.* The police community has developed a highly reliable system of drug recognition (DRE), which should be used to determine levels of drug-impairment.

5. Alternative justice measures be established, as set out in Bill C-41, for summary conviction offences of possession of cannabis, after a mandatory assessment of the accused. A range of options should include, but not be limited to: drug and life skills counseling, fines, community service or a combination of alternative measures. Alternative justice measures should not be available to those whose offence(s) occurred in or near a place frequented by children under the age of 18, within 500 meters of a school or public park, or in a vehicle or vessel with occupants under 18 years of age;

The CACP has heeded calls by experts to alter our approach to the first-time cannabis/marihuana user, and modify the consequences they face. We also want to improve the tools and processes to maximize your effectiveness as police officers. Because

cannabis/marihuana is not a benign drug and our goal is to reduce drug use, we are asking that offenders be assessed to determine an appropriate response. To this end, our objectives include:

Better serving the public interest
- to reduce the demand for marihuana through prevention and education, and reduce the supply
- to reduce both the direct and indirect social and economic costs to all Canadians resulting from marihuana possession
- to have Canadians realize that marihuana is not a benign drug

More tools and alternatives
- to incorporate alternatives into the justice system to prevent or deter people from using marihuana, and help those who have become drug-dependent through counseling, life skills and rehabilitation programs to promote drug-free, safe lifestyles.
- increased flexibility to have pre-trial options exist both before and after the first-time offender is assessed
- if it is a repeat offence, police have further options

6. Mandatory minimum sentencing be established for enterprise criminals, including organized criminals, convicted of importing, trafficking, producing or cultivating illicit drugs in Canada.

We must send a strong message to organized crime, who are driving the drug trade, that their business is not welcome in Canada. It is out of proportion with the seriousness of their crime for a person who created, supplied and profited from thousands of drug addicts to receive only a light sentence.

Marihuana policy

In regards to cannabis (marihuana) and penalties for possession, support exists for the CACP position from our expert partners on substance abuse issues, such as the Canadian Centre on Substance Abuse (CCSA), Council on Drug Abuse (CODA), and from the Centre for Addiciton and Mental Health (CAMH), whose most recent policy statement is found below.

The Centre for Addiction and Mental Health (CAMH) position on cannabis (spring 2000)

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 behavioral 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 offense, 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.

6. Endnotes

1. Government of Canada, “Canada’s Drug Strategy”, 1998.

2. Ibid (same as above).

3. Canadian Society of Addiction Medicine, Policy Statement, 1999.

4. Dr. Douglas Coleman, Speech to International Conference on Injection Drug Use, Montréal, Canada, March 1999.

5. Avram Goldstein, M.D. and Harold Kalant, M.D.. “Drug Policy: Striking the Right Balance”, 1990.

6. Customs and Excise Branch, Federal Services Directorate, RCMP, 2000.

7. Canadian Cancer Society, et al. “Surveying the Damage: Cut-rate Tobacco Products and Public Health in the 1990s”, 1999.

8. Canadian Association of Chiefs of Police (CACP), “Drug Policy, and Drug Policy Resolutions”, 1999.

9. Criminal Intelligence Directorate, RCMP. “Project Serre II.”, 1999.

10. International Olympic Committee. “Olympic Movement Anti-Doping Code: Appendix A: Prohibited Classes of Prohibited Methods.”, January 1, 2000. (www.nodoping.org)

11. Canadian Community Epidemiology Network on Drug Use (CCENDU), “First Annual Report”, 1998.

12. Health Canada. “Straight Facts on Drugs and Drug Abuse”, currently in print.

13. Harold Kalant, M.D., et al. (ed.) “The Health Effects of Cannabis.”, An Addiction Research Foundation (ARF) Publication., 1999.

14. Mary Johnston, Health Canada spokesperson, noting a 1999 study.

15. Canadian Centre on Substance Abuse (CCSA) /Addiction Research Foundation (ARF) “Canadian Profile”, 1999.

16. Addiction Research Foundation, “Ontario Student Drug Use Survey”, 1997.

17. The Addiction Foundation of Manitoba, “Student Drug Use Survey”, 1997.

18. Solowij et al., 1995.

19. National Institutes of Health, U.S. Report on the “Ad-Hoc Experts Workshop on the Medicinal Utility of Marijuana.”, 1997.

20. Health Canada, “Straight Facts on Drugs and Drug Abuse”., currently in print.

21. Ibid.

22. Pope and Yurgelin-Todd, 1996.

23. National Institute on Drug Abuse, 2000

24. Zhang et al, 1999.

25. Canadian Association of Chiefs of Police (CACP)., “Drug Policy”, 1999.

26. Carole Bouchard, Manager, Office of Controlled Substances, Health Canada. "Presentation to Health and Enforcement in Partnership (HEP) members", May 4, 2000.

27. Brad Buxton, Research and Evaluation, Office of Controlled Substances, Health Canada. "Presentation to Health Canada's Consultation Workshop on the Medicinal Uses of Marihuana", February 28, 2000.

28. Dr. Harold Kalant, M.D. "Presentation to Health Canada's Consultation Workshop on the Medicinal Uses of Marihuana", February 28, 2000.

29. Ibid.

30. Holly Richter, M.A. , RCMP Drug Awareness Service. "Marijuana's effect on Traffic Safety in Canada: A literature review and educator's guide." 1999.

31. Yesavage et al., 1985.

32. World Health Organization (WHO), "Cannabis: A Health and Research Perspective", 1997.

33. Gordon W. Walsh and Robert E. Mann, 'On the High Road: Driving under the Influence of Cannabis in Ontario." Addiction Research Foundation, 1998.

34. Wayne Jeffery, M.Sc., et al. "The Involvement of Drugs in Driving in Canada: An update to 1994"., 1996.

35. Donelson et al., Traffic Injury Research Foundation (TIRF), 1986.

36. B.A. Jonah, "Age Differences in Risky Driving"., 1990.

37. Canadian Association of Chiefs of Police (CACP), "Drug Policy Resolutions", 1999.

38. Ministry of Justice, and Ministry of Health, Welfare and Sport, of the Government of the Netherlands. "Drug Policy", 1997.

39. Ibid.

40. Robert McCoun et al. "Interpreting Dutch Cannabis Policy: Reasoning by Analogy in the Legalization Debate.", Science, vol. 278, Oct., 1997. ...see also Larry Collins. "How Holland Made a Hash out of Drugs", 1998.

41. Ministry of Health, Welfare and Sport, of the Government of the Netherlands. "Drug Policy", 1999.

42. Selina Olson, B.A. (Gen.) with Donald Loree, Ph. D., RCMP Headquarters. "Drug Crimes Case Study Data Anlaysis for the Region of Ottawa-Carleton, 1996-1998: a Preliminary Report on Cannabis". August 1999. (300 random case files were examined)

43. Jacobs, Philip; et al. Cost effectiveness of street works' needle exchange program of Edmonton Canadian Journal of Public Health, 90(3): 168-171, 1999; Bruneau, Julie; et al. High rates of HIV infection among injection drug users participating in needle exchange programs in Montréal: results of a cohort study. American Journal of Epidemiology, 146(12): 994-1002, 1997; Hurley, Susan F.; Jolley, Damien J.; Kaldor, John M. Effectiveness of needle-exchange programmes for prevention of HIV infection. The Lancet, 349(June 21): 1797-1800, 1997; Strathdee, Steffanie; et al. Needle exchange is not enough: lessons from the Vancouver injecting drug use study. AIDS, 11(8): F59-F65, 1997; Poulin, Céline; et al. World AIDS Conference (12th : 1998, June 28-July 1 : Geneva, Switzerland) HIV-1 infection and risk factors among injecting drug users (IDU) attending a needle exchange program in Quebec City [Québec, QC : The authors, 1998].

44. Addictive Drug Information Council., 2000. (A council in Vancouver, comprised of doctors who are experts in addiction medicine and of police officers.)

45. Ibid.

46. Ibid.

47. Dr. Douglas Coleman, Speech to International Conference on Injection Drug Use, Montréal, Canada, March 1999.

48. Canadian Association of Chiefs of Police (CACP), “Drug Policy”, 1999.

49. Director General of the World Health Organization (WHO), “Letter from the Director General of the W.H.O. to the President of the International Narcotics Control Board (INCB)”, April,12, 1999.

50. Cpl. Scott Rintoul et al., RCMP “E” Div. Drug Awareness Service, “Designer Drugs and Raves”, 2000. See also National Institute on Drug Abuse (NIDA) at 2000

51. National Institute on Drug Abuse (NIDA) at 2000

52. Cpl. Scott Rintoul et al., RCMP “E” Div. Drug Awareness Service, “Designer Drugs and Raves”, 2000.

53. City of Toronto Coroner’s Inquest into Raves. “Recommendations”, May 2000.

54. Darryl S. Inaba, Pharm.D., et al. “Uppers, Downers and All-Arounders”, 1997.

55. Ibid.

56. Health Canada, “Exploring the Links Between Substance Use and Mental Health”, 1996.

57. Centre for Addiction and Mental Health (CAMH), “Concurrent Disorders: Innovations in Treatment, Screening and Integrated Programs”, in The Journal magazine, Sept./Oct. 1998.

58. Cst. Gerry Thomas, “email to Drug Awareness HQ regarding reality of inhalant abuse in Island Lake, Manitoba”, June 2000.

59. Darryl S. Inaba, Pharm.D., et al. “Uppers, Downers and All-Arounders”, 1997.

60. RCMP “E” Div. Drug Awareness Service, in collaboration with the Addictive Drug Information Council (ADIC) “Help-Guide to Detect Substance Abuse” as part of “Drug Facts” pamphlet., 2000.

61. Darryl S. Inaba, Pharm.D., et al. “Uppers, Downers and All-Arounders”, 1997.

62. The Alliance Against Contraband, “Strategic Intelligence Bulletin(s)”, Summer and Fall, 1999, and the RCMP’s Customs and Excise Branch of the Federal Services Directorate, HQ, 2000.

63. Darryl S. Inaba, Pharm.D., et al. “Uppers, Downers and All-Arounders”, 1997.

64. Canadian Centre on Substance Abuse (CCSA). “The Costs of Substance Abuse in Canada”, 1996.

65. Grant Smith, Transport Canada (seconded to Community, Contract and Aboriginal Policing Services, HQ) ‘via e-mail with author”. July, 2000.

66. Health Canada, ‘National Population Health Survey”, 1997, and Health Canada “General Health Survey”, 1993.

67. Canadian Centre on Substance Abuse (CCSA) and the Addiction Research Foundation (ARF), “Canadian Profile: Alcohol, Tobacco and Other Drugs:, 1999.

68. Serge Brochu, Ph.D. “Pathways Study of Quebec and Ontario Federal Inmates”., 1999.

69. RCMP’s Customs and Excise Branch of the Federal Services Directorate, HQ, June, 2000.

70. Health Canada's Child and Youth Division website "Fetal Alcohol Syndrome, Fetal Alcohol Effects (FAS/FAE)", 2000.

71. Health Canada "Deaths in Canada Due to Smoking" Fact sheet, January 1999.

72. Canadian Cancer Society et al. "Surveying the Damage: Cut-rate Tobacco Products and Public Health in the 1990s." October, 1999.

73. RCMP's Customs and Excise Branch of the Federal Services Directorate, HQ, June, 2000.

74. The Alliance Against Contraband, "Strategic Intelligence Bulletin(s)", Summer and Fall, 1999.

75. RCMP's Customs and Excise Branch of the Federal Services Directorate, HQ, June, 2000.

76. Canadian Centre on Substance Abuse (CCSA) and the Addiction Research Foundation (ARF), "Canadian Profile: Alcohol, Tobacco and Other Drugs:, 1999.

77. Health Canada's Tobacco Reduction Division's website, July 2000 (see www.hc-sc.gc.ca/hppb/tobaccoreduction)

78. Canadian Dental Association, "CDA Facts on Oral Cancer", July 2000, as found on website (see www.cda-adc.ca).

79. Health Canada's Tobacco Reduction Division's website , July 2000

80. Canadian Dental Association, "CDA Facts on Smokeless Tobacco", July 2000, as found on website (see www.cda-adc.ca)

81. Canadian Centre on Substance Abuse (CCSA). "The Costs of Substance Abuse in Canada", 1996.