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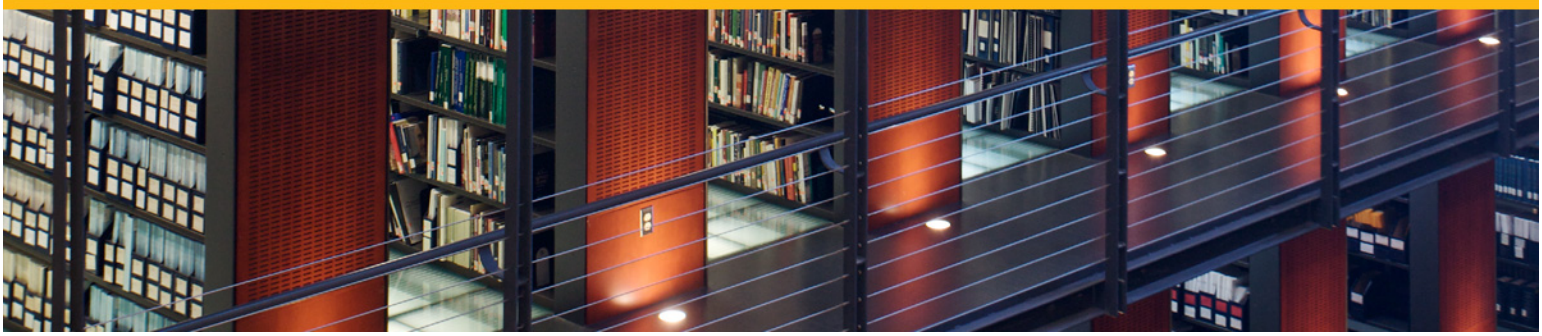

The Legal Regulation of Marijuana in Canada and Selected Other Countries

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(Background Paper)

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THE LEGAL REGULATION OF MARIJUANA IN CANADA AND SELECTED OTHER COUNTRIES

1 INTRODUCTION

This document discusses the legal regulation of marijuana in Canada and in a number of other jurisdictions. After some material on marijuana itself, it provides an overview of the international drug control regime, including current debates surrounding the possible reform of this regime and the outcomes of the 2016 United Nations General Assembly Special Session on the World Drug Problem, which took place in April 2016. The document then turns to the legal treatment of marijuana in Canada, including the prevalence of use of marijuana in this country. It then examines different regulation approaches – including legalization and decriminalization – in a number of jurisdictions.

2 MARIJUANA PRIMER

Marijuana, hashish and hash oil come from *Cannabis sativa*, a type of hemp plant. The word "cannabis" is used to refer to all three substances. Marijuana is made from the dried leaves and flowering tops of the *Cannabis sativa* plant. At one stage of the plant's growth, the flowers become coated with a sticky resin, which can be dried to make hashish. Hemp can also be used to make rope, fabric and paper.[1]

While marijuana is prescribed for medical purposes in some jurisdictions, it is also used recreationally as a mind-altering substance. The psychoactive compound in marijuana is delta-9-tetrahydrocannabinol (THC). Its effect on users varies according to dosage and the user's personality, varying from "euphoria, perceptual alterations, and relaxation at low dose to depersonalization, pressured speech, paranoia, and manic psychosis at high dose."[2]

According to the *World Drug Report 2016*, cannabis is the most widely used illicit drug at the global level, with an estimated 183 million people having used the drug in 2014.[3] It is also the most widely cultivated drug crop, grown in 129 countries between 2009 and 2014.[4] The world's largest producer of cannabis resin is Morocco, followed by Afghanistan, Lebanon, India and Pakistan. Albania, Colombia, Jamaica, the Netherlands and Paraguay are important source countries of the cannabis herb sold in international markets.[5] Cannabis is also the most trafficked drug worldwide.[6] The annual prevalence of use in North America is estimated to be 12.1% of the population.[7]

3 INTERNATIONAL DRUG CONTROL

3.1 INTERNATIONAL DRUG TREATIES

There are three main United Nations conventions concerning drugs to which Canada is a party:

- the 1961 *Single Convention on Narcotic Drugs*;[8]

- the 1971 *Convention on Psychotropic Substances*;[9] and
- the 1988 *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*.[10]

These conventions require that member states adopt specific legislative measures against the trade in illicit drugs. For example, in Canada, this has been done through the enactment of the *Controlled Drugs and Substances Act*.[11]

The cumulative effect of the three conventions is to require each party to:

- limit to medical and scientific purposes, by such measures as it considers appropriate, the manufacture, export, import, distribution of, trade in, and use and possession of drugs;
- adopt the necessary measures to establish as a criminal offence under its domestic law the intentional possession, purchase or cultivation of narcotic drugs (including marijuana) or psychotropic substances for personal consumption, subject to its constitutional principles and the basic concepts of its legal system;
- include imprisonment or other forms of deprivation of liberty, pecuniary sanctions and confiscation as punishments for drug offences; and
- adopt appropriate measures to eliminate or reduce illicit demand for narcotic drugs and psychotropic substances with a view to reducing human suffering and eliminating financial incentives for illicit traffic.

The measures prescribed in the conventions are the minimum measures that the parties must adopt; there is nothing to prevent them from adopting stricter or more severe measures of control. In addition, states may provide, if desired, additional measures, such as treatment, education, after-care, rehabilitation and social reintegration, which may be substituted for sanctions in cases of a minor nature.

The conventions do not prohibit all possession or use of illicit drugs. In Canada, the regulations to the *Controlled Drugs and Substances Act* allow the prescribing of some otherwise illicit substances for treatment or therapeutic purposes.

The substances to be controlled are set out in the schedules appended to the conventions. For example, cannabis and cannabis resin are listed in Schedule I of the *Single Convention on Narcotic Drugs* among substances, like heroin, which might create dependence and present a serious risk of abuse and so are subject to all the control measures envisaged by the *Single Convention*. By virtue of its harmful characteristics, risk of abuse and extremely limited therapeutic value,[12] cannabis is also listed in Schedule IV to the *Single Convention* among drugs deemed to have "particularly dangerous properties."[13] These schedules may be amended at the request of a party. A country that has ratified the convention but that wishes to legalize or decriminalize a particular substance, such as marijuana, may seek to enter a reservation to the treaty, namely that the treaty will apply to drugs other than marijuana in that country or, if that is not successful, to withdraw from the treaty altogether.

3.2 Efforts to Reform the International Drug Control Regime

The United Nations drug control treaties were drafted and ratified in the 1960s, 1970s and 1980s based upon the belief that prohibition and law enforcement would successfully reduce the supply of illicit drugs and thereby minimize the harms that the drugs pose to the health and welfare of society.[14] While this approach has had some effect – for example, there has been a recent decline in the production of plant-based drugs, such as opium – global seizures of amphetamine-type stimulants or synthetic drugs reached a new peak of 173 tons in 2014.[15]

In addition, the prohibitive approach to dealing with illicit drugs has resulted in serious unintended consequences for the international community, including the creation of a massive criminal market for illicit drugs, estimated at over US$300 billion per year.[16] This criminal market in turn has undermined the security and stability of developing countries involved in both the production and trafficking of illicit drugs through the creation of drug cartels that use their funds to corrupt government institutions by bribing government officials and political parties.[17]

Finally, the focus on elimination of the drug supply through prohibition alone has not effectively addressed the demand side of the world drug problem, which has remained constant, with one in 20 adults worldwide aged 15–64 years – or a quarter of a billion people – using at least one drug in 2014. In addition, it is estimated that almost 12% of the total number of people who use drugs, or over 29 million people, suffer from drug use disorders.[18] Moreover, the prohibitionist approach focusing on the criminalization of drug users has undermined attempts to prevent and treat drug abuse and broader public health efforts to address the rapid spread of HIV/AIDS and other blood-borne diseases among injection drug users.[19]

These approaches have led to polarized debates within the international community regarding the need to reform the current international drug control regime. Some favour the legalization of illicit drugs, while others call instead for the strengthening of the role of governments in combatting drug abuse. Seeking to find a balance between these two positions, in 2009 the United Nations General Assembly adopted the *Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem*.[20]

The Political Declaration and Plan of Action recognizes the three international drug control conventions as the cornerstone of the international drug control system. However, it also recognizes that there is a need to pursue a broader, more integrated approach to addressing the world drug problem by:

- reducing drug abuse and dependence through a comprehensive public health approach;
- reducing the illicit supply of drugs through cooperation, coordination and law enforcement operations;
- eradicating illicit cultivation of crops by supporting alternative economic development opportunities; and
- countering money-laundering and promoting judicial cooperation to enhance international cooperation.[21]

Despite the adoption of the Political Declaration and Plan of Action, the treaty-based international drug control system continued to be challenged by some of its member states, in particular, those from Latin America.[22] In 2012, the Organization of American States (OAS), of which Canada is a member, commissioned a high-level study to explore alternatives to the current international control regime, recognizing that drugs and associated criminal activity have had a serious impact on violence and corruption in the Americas and the Caribbean countries, while efforts to combat drug trafficking have had a limited impact on the world drug problem.[23] Drawing on the work of the OAS in this area, Mexico, Colombia and Guatemala successfully put forth a motion in 2012 calling for a UN General Assembly special debate to examine alternative approaches to addressing the world drug problem, a debate which would take place in April 2016.[24]

In addition, some jurisdictions began moving away from the international control regime by legalizing or decriminalizing controlled substances, including marijuana and the coca leaf. In January 2012, Bolivia withdrew from the UN *Single Convention on Narcotic Drugs* after failing to obtain a reservation from the criminalization provisions of the treaty for the traditional use of the coca leaf.[25] However, a year later, the country was able to gain a reservation and re-acceded to the *Single Convention*. In December 2013, Uruguay became the first country to legalize the production and consumption of marijuana for non-medical use. Meanwhile, two American states, Washington and Colorado, introduced legislation legalizing the production and sale of marijuana for non-medical use in 2014, while Alaska, Oregon and the District of Columbia have also approved ballot initiatives on the non-medical use of cannabis in their respective jurisdictions.

In response to these developments, the United Nations International Narcotics Control Board (INCB), the independent quasi-judicial body responsible for monitoring the implementation of the drug conventions, stated that legislative developments regarding the non-medical use of marijuana in Uruguay and the United States are clear and direct breaches of the conventions. In particular, they violate Article 4(c) of the *Single Convention*, which obliges states parties to "limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs."[26] However, the INCB has yet to take any action to sanction these jurisdictions.

It is important to note that some states had moved towards the decriminalization of marijuana and other controlled substances in previous years, with varying legal implications under the conventions. When the 1988 UN *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* required countries to criminalize the possession of marijuana, the Netherlands chose to ratify the provision with a reservation. The Dutch argued that, while the 1988 UN Convention requires criminalization, it does not prescribe the scope of the required enforcement.[27] Meanwhile, it is argued that Portugal's criminal justice approach of decriminalizing drug possession of all illicit drugs (not just marijuana) to support public health efforts in the country can fit within Article 3(2) of the 1988 UN Convention, which states that measures to combat drug use are subject to a signatory's constitutional principles and the basic concepts of its legal systems. (For a longer discussion of initiatives in these jurisdictions, please see section 5 of this paper.)

3.3 THE 2016 UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON THE WORLD DRUG PROBLEM

The Special Session of the United Nations General Assembly on the World Drug Program (UNGASS) took place from 19 to 21 April 2016 and focused on assessing progress made in implementing the Political Declaration and Plan of Action, including achievements and challenges in countering the world drug problem within the framework of the three international drug control conventions and other relevant United Nations instruments.[28] The debates and the final resolution adopted by the General Assembly focused primarily on themes outlined in the Political Declaration and Plan of Action, including these:

- prevention and treatment of drug abuse through public health approaches;
- improving medical and scientific access to controlled substances;
- reducing the supply of illicit drugs through law enforcement;
- supporting and protecting human rights in the development and implementation of drug policies; and
- addressing emerging issues including the use of new psychoactive substances.[29]

The Special Session, however, did not result in any reform of the three international drug control conventions. Rather, the resolution reaffirmed member states' commitment to the goals and objectives of the conventions. Yet the debates did reveal some differing approaches to the drug issue. In their national statements at the UNGASS, more than 30 countries explicitly declared their support for harm reduction.[30] While the INCB reiterated that the legalization of the non-medical use of marijuana by some member states was in direct violation of the conventions, it also stated that there was significant flexibility within the conventions to support a more health-oriented approach towards drug abuse, as well as proportionate criminal sanctions for offenders suffering from drug dependency.[31]

Stating that Canada's drug policy would be one informed by scientific evidence seen through the lens of public health to maximize education and minimize harm, Canada's Minister of Health indicated that the government would move towards the legalization of marijuana in 2017.[32] However, the minister did not specify what approach the government would take with respect to its obligations under the UN conventions.

Other states similarly highlighted the need for sovereign states to pursue strategies that best reflect the needs and interests of their citizens, which may differ from the current international control regime. Finally, the United States indicated that it strongly supported drug policy reform under the framework of the three UN conventions,[33] while the Russian Federation focused on the need to strengthen law enforcement efforts.[34]

4 THE SITUATION IN CANADA

4.1 HISTORY OF MARIJUANA PROHIBITION IN CANADA

The use of the criminal law, including outright prohibition, has been part of the Canadian legal landscape regarding drugs for over a century. Prohibition of the use of opium for anything other than medical purposes became part of Canadian law with the passage of the *Opium Act, 1908*.[35] The *Opium and Narcotic Drug Act, 1911*[36] provided for orders for the confiscation or restitution of seized drugs and a reverse onus for cases of simple possession of drugs.

Marijuana was first prohibited in Canada in 1923 when it was added to the *Opium and Narcotic Drug Act* by the Minister of Health, who simply stated during a sitting of the Committee of the Whole in connection with a review of that Act that, "there is a new drug in the schedule."[37] A report published by the Senate Special Committee on Illegal Drugs in 2002 stated that "it is remarkable that, over seventy-five years later, we should still not know why cannabis was placed on the list of prohibited drugs."[38]

Though recreational use of cannabis was already banned, parliamentarians grew even more intolerant of the drug in the ensuing years. As a result, Parliament introduced another law in 1938 which prohibited anyone from growing cannabis without first having obtained a permit from the Department of Health. While the new law mostly affected the medical research community and hemp production, the Minister of Health stated that it was a necessary measure to control a "new menace to youth in this country," citing Harry J. Anslinger, the first commissioner of the U.S. Treasury Department's Federal Bureau of Narcotics, who described marijuana as "the assassin of youth … one of the greatest menaces which has ever struck the country."[39]

In 1961, Canada ratified the UN *Single Convention on Narcotic Drugs* and adopted the *Narcotic Control Act* in order to implement its provisions.

Over the past 45 years, Parliament has studied the legal regulation of marijuana in Canada. The reports of three parliamentary entities – the LeDain Commission in 1972,[40] the Senate Special Committee on Illegal Drugs in 2002,[41] and the House of Commons Special Committee on the Non-Medical Use of Drugs in 2002[42] – have concluded that Canada's policy of criminalization creates harms that are disproportionate to the harms associated with marijuana use. One of the harms created by criminalization is the necessity, because there is no legal supply of marijuana, of purchasing the drug on the black market, thereby providing money for the criminal element. For marijuana users, prohibition leads to high rates of imprisonment and creates barriers to treatment. For society, prohibition leads to high costs to maintain the necessary level of policing, and to meet the demand on the court and prison systems.[43]

4.2 THE LEGAL TREATMENT OF MARIJUANA IN CANADA TODAY

4.2.1 *CONTROLLED DRUGS AND SUBSTANCES ACT*

Today, Canada's *Controlled Drugs and Substances Act* creates a scheme for the regulation of certain dangerous drugs and narcotics, now known as "controlled substances." An important part of the legislation is the schedules.

Schedule I includes the most dangerous drugs and narcotics, such as heroin and cocaine, along with the so-called "date rape drugs."

Schedule II lists cannabis and its derivatives.

Schedule III includes many of the hallucinogenic drugs, such as lysergic acid diethylamide (LSD) and psilocybin.

Schedule IV includes such drugs as the barbiturates which, while dangerous, have therapeutic uses. Simple possession of Schedule IV drugs is not an offence.

Part I of the Act sets out five main categories of offences in relation to controlled substances:

- Possession (section 4(1)): Simple possession of any of the drugs and narcotics listed in schedules I, II and III is an offence unless the person is authorized by the regulations to be in possession. The penalty for breach of this provision depends upon the schedule in which the substance is included. A special penalty scheme is included for possession of small quantities of Schedule II (cannabis) substances. Where the subject matter of the offence is a Schedule II substance in an amount that does not exceed the amount set out in Schedule VIII (30 g), then the accused is guilty only of a summary conviction offence and the maximum penalty is a $1,000 fine or six months' imprisonment or both.
- "Double-doctoring" (section 4(2)): It is an offence to seek or obtain any of the scheduled substances from a practitioner, such as a physician, without disclosing to the practitioner whether the person had acquired any of the scheduled substances within the preceding 30 days.
- Trafficking (section 5): It is an offence to traffic in any of the substances listed in schedules I to IV or to be in possession of them for the purpose of trafficking. Again, the penalty for the offence depends upon the schedule in which the substance is found. If the substance is in Schedule II (cannabis), the maximum penalty is life imprisonment, unless the amount involved is less than that set out in Schedule VII (3 kg), in which case the maximum penalty is five years' imprisonment, less one day.[44] Mandatory minimum sentences for trafficking apply in certain circumstances, such as when violence is used or drugs are sold near a school.
- Importing and exporting (section 6): It is an offence to import into Canada or export out of Canada any of the substances listed in schedules I to VI. Where the substance is listed in schedules I and II, the offence is indictable and punishable by a maximum of life imprisonment and a minimum of one year's imprisonment if
    - the offence is committed for the purposes of trafficking;

  - the person, while committing the offence, abused a position of trust or authority; or
  - the person had access to an area that is restricted to authorized persons and used that access to commit the offence.
- Production (section 7): It is an offence to produce any of the substances in schedules I to IV except as authorized by the regulations. For substances listed in schedules I and II, the maximum punishment is life imprisonment, unless the substance is marijuana, in which case the maximum punishment is 14 years' imprisonment. Various mandatory minimum punishments apply if the number of marijuana plants produced is more than five and the production is for the purpose of trafficking.

Section 10 sets out the principles of sentencing and includes a list of aggravating circumstances, including the use of a weapon in relation to the commission of the offence or the commission of a trafficking offence near a school. This section also specifies that a mandatory minimum sentence need not be applied if an offender successfully completes a drug treatment program.

Part II of the Act deals with enforcement. Sections 11 to 13 set out the powers of search and seizure for offences under the Act. Special provision is made in section 11(7) for a warrantless search in exigent circumstances. Section 13 deals with the detention and restitution of property that has been seized. Sections 14 to 23 deal with restraint orders and the forfeiture of offence-related property.

Part III of the Act (sections 24 to 29) deals with the disposal of substances seized or found by a peace officer or inspector. Part IV (sections 30 to 32) sets out the powers of inspectors under the Act, as well as the offence of obstructing or misleading an inspector. Part V (sections 33 to 43) sets out a special scheme for the enforcement of "designated regulations." Under this Part, the Minister of Health may make an emergency order where there is a substantial risk of immediate danger to the health or safety of any person due to the contravention of a designated regulation.

Part VI (sections 44 to 60) contains a number of important miscellaneous provisions. Under section 48, the evidentiary burden is initially upon the accused to show that any certificate, licence, permit or other qualification operates in the accused's favour. Section 55 gives the Governor in Council wide regulation-making powers, while section 60 permits the Governor in Council to add or delete items from any of the schedules, where it deems the amendment to be in the public interest.

4.2.2 EXEMPTION FROM THE *CONTROLLED DRUGS AND SUBSTANCES ACT*

Section 56 of the Act grants the Minister of Health the power to exempt any person or class of persons or any substance from any or all of the provisions of the Act, if, in the opinion of the minister, access to the substance is necessary for medical or scientific purposes, or is otherwise in the public interest. Furthermore, section 55(1) of the Act allows for the development of regulations concerning the medical, scientific and industrial applications and distribution of controlled substances.

Since 2001, Health Canada has granted access to dried marijuana for medical purposes to Canadians who have had the authorization of their health care practitioner.[45] In 2013, the *Marihuana for Medical Purposes Regulations*[46] created conditions for a commercial industry that was responsible for the production and distribution of marijuana for medical purposes. The regulations were intended to ensure that Canadians with a medical need could access quality-controlled marijuana grown under secure and sanitary conditions.

On 24 August 2016, the *Marihuana for Medical Purposes Regulations* were replaced by the *Access to Cannabis for Medical Purposes Regulations*.[47] The new regulations respond to two court cases. In *R. v. Smith*,[48] the Supreme Court of Canada held that the prohibition on possession of non-dried forms of medical marijuana infringed the right to security of the person set out in section 7 of the *Canadian Charter of Rights and Freedoms*. The Court held that the prohibition achieved this by forcing a person to choose between a legal but inadequate treatment and an illegal but more effective one, and that there was also no connection between the prohibition on non-dried forms of medical marijuana and the health and safety of the patients who qualify for legal access to medical marijuana.

In the case of *Allard v. Canada*,[49] the Federal Court of Canada held that requiring individuals to obtain their marijuana only from licensed producers meant that there was no guarantee that the necessary quality, strain and quantity of marijuana would be available when needed. The Court concluded that this lack of reasonable access to marijuana violated the section 7 Charter right to security of the person.

Under the *Access to Cannabis for Medical Purposes Regulations*, individuals requiring marijuana for medical purposes still must obtain a medical document from their health care provider that indicates support for the patient's use of medical marijuana. Now, however, medical marijuana can come in the form of fresh marijuana and cannabis oil in addition to dried marijuana. The other major change is that medical marijuana users can now register with Health Canada to produce marijuana for their own medical purposes or they can designate someone else to produce it for them. These means of access are in addition to continuing to obtain marijuana by registering with a licensed producer. As of August 2016, there were 34 licensed producers. No matter how individuals obtain their marijuana, their possession limit is the lesser of a 30-day supply or 150 g of dried marijuana or the equivalent amount if in another form.

Access to marijuana for medical purposes is only permitted under the terms and conditions set out in the regulations. This means that storefronts selling marijuana, commonly known as "dispensaries" and "compassion clubs," are not legally permitted to sell marijuana for any purpose. Any individual registered to produce a limited amount of marijuana for him or herself may not sell, provide or give cannabis to another person. A designated person may not sell, provide or give cannabis to any person, except for the individual for whom he or she is authorized to produce. It also remains illegal for a company or an individual to advertise marijuana to the general public.[50]

The new regulations provide an immediate response to the critiques presented by the courts, but the Canadian government has stated they should not be interpreted as being the longer-term plan for the regulation of access to marijuana for medical purposes. The form of that access will be determined as part of the Government of Canada's plan to legalize, strictly regulate and restrict access to marijuana. Health Canada has committed itself to studying other models, including pharmacy distribution, to provide access to marijuana for medical purposes.[51]

4.3 Marijuana Use in Canada

The Canadian Tobacco, Alcohol and Drugs Survey is a biennial survey of tobacco, alcohol and illicit drug use by Canadians aged 15 years and older. The most recent survey results are taken from data collected between February and December 2013.[52]

Among its findings, the survey indicated that the prevalence of past-year cannabis use among Canadians aged 15 years and older was 11% (3.1 million) in 2013, a slight increase from 10% (2.8 million) in 2012. The prevalence rate in 2013 among youth aged 15 to 19 (22% or 469,000) and among young adults aged 20 to 24 (26% or 635,000) was higher than that among adults 25 years and older (8% or 1.9 million). As shown in Table 1, the average age of people who began using cannabis as youths was 15.1 years; for first-time users as young adults, 16.6 years; and for first-time users as adults, 18.3 years.

The prevalence of past-year cannabis use in 2013 was higher among males (14% or 2.1 million) than females (7% or 1.0 million). Provincial prevalence of past-year cannabis use ranged from 8.1% in Saskatchewan to 13.3% in British Columbia. The prevalence of past-year cannabis use for most of the other provinces clustered around the overall Canadian past-year prevalence of use rate of 10.6%.

Table 1 – Illicit Drug Use (Past 12 Months and Lifetime) by Sex and Age Group, Canada, 2013

Drug Category	Overall	Males	Females	Age: 15–19	Age: 20–24	Age: 25+
Sample size	14,565	6,659	7,906	3,509	2,575	8,481
Cannabis – Average number of times used in lifetime	33.7	40.5	27.1	25.8	41.7	33.6
Cannabis – Average number of times used in the past 12 months	10.6	13.9	7.4	22.4	26.2	8.0
Average age of initiation (years)	17.9	17.8	18.1	15.1	16.6	18.3

Source: Government of Canada, *Canadian Tobacco, Alcohol and Drugs Survey*, 2013.

5 THE REGULATION OF MARIJUANA IN SELECTED JURISDICTIONS OUTSIDE CANADA

As mentioned in section 3.2 of this paper, jurisdictions around the world have implemented means other than prohibition to deal with the use of marijuana or they are considering doing so. Examples of the alternatives of legalization, decriminalization and de facto decriminalization of marijuana are discussed below.

5.1 LEGALIZATION

Legalization of drugs has been defined in the following terms by the Organization of American States:

> The process of eliminating legal prohibitions on the production, distribution, and use of a controlled substance for other than medical or scientific purposes, generally through replacement with a regulated market. The term has often been associated with "liberalization" or regimes in which the prohibition for certain drugs is ended without necessarily imposing strict state controls. It also sometimes refers to regimes of regulation to control commercialized production and distribution. The term "legalization" is therefore usefully qualified for the sake of clarity – for example, "legalization and regulation" or "free-market legalization."[53]

5.1.1 URUGUAY

On 20 December 2013, the president of Uruguay signed Act No. 19.172, establishing a nationalized market for the cultivation, sale and use of cannabis and its derivatives.[54] In May 2014, the regulatory provisions for the application of the law were adopted. Uruguay became the first state party to the 1961 *Single Convention on Narcotic Drugs* to legalize the production, distribution, sale and consumption of cannabis and its derivatives for purposes other than medical and scientific uses.[55]

Under the new law, the cannabis market is regulated by an agency of the Uruguayan government, known as the Institute for the Regulation and Control of Cannabis.[56] There are three legal means of acquiring non-medicinal marijuana:

- individuals may grow as many as six plants at home;
- individuals may purchase marijuana from a registered "cannabis club," which can grow up to 99 plants; or
- individuals may buy as much as 40 g of marijuana per month at state-licensed pharmacies.

Those who purchase or grow cannabis are registered and fingerprinted to prevent anyone from buying more than 480 g per year. The value of the gram of marijuana sold at pharmacies on the regulated market is set by the president's office through the control agency.[57]

Uruguay has banned cannabis-impaired driving and set a cut-off for driving after using marijuana at a specific level of THC in the blood.

Uruguay has also banned all promotion of cannabis products.

The revenues generated by the tax on marijuana will fund the Institute for the Regulation and Control of Cannabis as well as a public health campaign.[58]

The law does not give non-citizens the right to smoke or buy marijuana in Uruguay.[59]

5.1.2 United States

At the sub-national level, two American states, Washington and Colorado, introduced legislation regulating the sale of marijuana for non-medical purposes in November 2012, Amendment 64 and Initiative I-502 respectively. Table 2 summarizes the regulatory frameworks governing the sale of marijuana in these two states. In November 2014, voters in the states of Alaska and Oregon and in the District of Columbia also approved ballot initiatives on the non-medical use of cannabis in their respective jurisdictions. While sales of recreational marijuana are underway in Colorado and the state of Washington, retail sales are anticipated to begin in Alaska and Oregon in late 2016. Under U.S. federal legislation, however, cannabis remains a controlled substance.[60] There may, therefore, be prosecutions for marijuana possession by federal authorities under the dual sovereignty doctrine.[61]

Table 2 – Overview of Regulatory Frameworks Governing the Sale of Marijuana in the States of Colorado and Washington, United States

Area of Regulation	Colorado	Washington
Age restrictions	• 21 or older	• 21 or older
Personal possession and/or sales limits	• 1 oz. or its equivalent	• A combined maximum of: ▪ 1 oz. dried product ▪ 16 oz. infused solid product ▪ 72 oz. infused liquid product ▪ 7 g concentrates
Personal production	• Up to 6 plants (maximum 3 mature) that must be in an enclosed, locked space	• Not permitted
Commercial production	• Yes, licensed	• Yes, licensed and capped
Retail distribution	• Yes, independent	• Yes, licensed and capped
Licensing body	• Colorado Department of Revenue	• Washington State Liquor and Cannabis Board
Taxation	• 15% excise; 10% sales + municipal taxes (approx. 30% of total price)	• Before 1 July 2015: 25% excise tax at each of production, processing and retail sale stages + state and local sales taxes (approx. 50% of total price) • As of 1 July 2015: 37% excise tax + state and local sales tax
Forms of sale	• Dried marijuana, extracts and infusions	• Dried marijuana and infusions

Area of Regulation	Colorado	Washington
Residency restrictions	• Purchase limit of ¼ oz. for non-residents • Retailers and producers must have lived in the state for 2 years	• Retailers and producers must have lived in the state for 3 months
Driving restrictions	• 5 ng/mL THC in whole blood	• 5 ng/mL THC in whole blood
Public use	• Not permitted	• Not permitted

Source: Canadian Centre on Substance Abuse, *Cannabis Regulation: Lessons Learned in Colorado and Washington State*, November 2015, p. 4.

5.2 DECRIMINALIZATION

Decriminalization has been defined in the following terms by the Organization of American States:

> Eliminating criminal penalties for the unauthorized consumption and possession (typically of amounts small enough to be for personal use only) of a controlled substance. In a decriminalized system, the act no longer results in criminal sanctions like incarceration, but administrative sanctions may still apply in some jurisdictions – for example, fines or community service, or merely a summons or citation. In some places use and possession for personal use cease to be a punishable offence or infraction altogether, so no sanction, criminal or administrative, is applied at all.[62]

5.2.1 PORTUGAL

As early as 1983, there was growing agreement among political parties in Portugal that it was necessary to address drug use as a health issue and not as a criminal matter. That year, a new law (Decree-law 430/83) recognized the drug user as a patient in need of medical care, stating that the priority was to treat and not to punish. In 1993, Portugal adopted its main drug control law, Decree-law 15/93. The preamble to the law stated:

> [T]he main sense of the changes introduced consists in adapting the legal instruments to serve the purpose of contributing to the utmost of its capacities to liberate the drug addicts and the habitual consumers from slavery, provide appropriate incentives for medical treatment and rehabilitation, and bring him back to real life, preferably happy, within the community.[63]

In 1998, the Portuguese government appointed the Commission for the National Strategy to Fight Against Drugs, with a mandate to produce a report on topics such as prevention, treatment, social reintegration, training, research, risk reduction and supply control. The Commission's report that same year recommended the decriminalization of personal drug use. The Parliamentary Committee on Drugs unanimously approved the report one year later and it became the 1999 National Strategy for the Fight Against Drugs. This strategy remains the foundation of today's drug policy in Portugal. It specifies eight principles, which include "Humanism," or the recognition of the human dignity of citizens, including drug users. This is translated into a commitment to offer a wide range of services to those in need and to adopt a legal framework that causes no harm to them.

The principles were first implemented through the National Action Plan for the Fight Against Drugs and Drug Addiction – Horizon 2004, which was adopted in 2001.[64] One important proposal of the new drug strategy was the decriminalization of all personal drug use that was implemented with Law 30/2000, which entered into force on 1 July 2001. This law maintains the illegality of using or possessing any drug for personal use without authorization. However, the offence changed from a criminal one, with prison a possible punishment, to an administrative one. The legislation provides that in the case of possession of a small quantity of drugs for personal consumption (not exceeding the quantity required for average individual consumption during a period of 10 days) and in circumstances where drug trafficking is not an issue, the drug will be seized by the police and the case put before a local administrative body called the Dissuasion of Drug Addiction Commission.

This commission is the body responsible for adjudicating drug offences and imposing sanctions or an oral warning, if it chooses. The main objective is to explore treatment needs and promote recovery. Treatment is provided free of charge and is accessible to all drug users.[65]

Drug trafficking remains an offence in Portugal, with punishment based upon six lists of controlled substances. The punishment for trafficking in cannabis and derivatives is a prison sentence of four to 12 years, unless users sell drugs to finance their own consumption, in which case the maximum penalty is reduced to up to three years.[66]

5.2.2 Spain

Spanish law does not criminalize the possession of marijuana, but it does criminalize its sale. This has resulted in the formation of cannabis “social clubs,” which are non-commercial entities with the goal of providing their members with enough cannabis to meet their personal needs. The social clubs were first established in 2002 and can provide quality marijuana to members. Members are not allowed to sell cannabis or distribute it to minors. In Spain, possession of large quantities of cannabis does not constitute an offence unless this is done for the purpose of trafficking.[67] Consumption of marijuana in public is not permitted.

5.3 De Facto Decriminalization

De facto decriminalization has been defined in the following way by the Organization of American States:

> Not applying statutes that penalize the production, distribution, or consumption of a substance to the fullest extent. … [T]he criminal justice system fails to operate or take action without formally having lost the power to do so. It is usually a result of the evolution of customs in a society when a practice begins to be socially accepted despite still being formally prohibited, or of the criminal justice system being overburdened and therefore failing to intervene in minor offenses, focusing attention on more serious criminal behaviour. In jurisdictions with discretionary legal powers based on the expediency principle (applying a public interest test when deciding about priorities for criminal prosecution), the practice of non-enforcement of certain offences can be formalized in directives to the police, prosecution, or judiciary.[68]

5.3.1 NETHERLANDS

The most well-known example of de facto decriminalization of marijuana is the Dutch coffee-shop model, introduced in 1976. In that year, the *Opium Act* was changed to distinguish between drugs presenting unacceptable risks and commonly referred to as "hard drugs" (Schedule I) and drugs like cannabis, referred to as "soft drugs" (Schedule II). The Act prohibits the possession, commercial distribution, production, import and export of all illicit drugs,[69] but penalties were removed for the possession of small quantities of marijuana. Currently, possession of a maximum of 5 g of marijuana or five plants will not lead to prosecution. Possession is not legal, but it is tolerated.

With the understanding that "soft drugs are less damaging to health than hard drugs,"[70] the Netherlands permits coffee shops to sell small amounts of marijuana, with certain restrictions. Proprietors:

- must not cause any nuisance;
- are not permitted to sell hard drugs;
- are not permitted to sell cannabis to minors;
- are not permitted to advertise drugs; and
- are not permitted to sell large quantities (over 5 g) in a single transaction.

In addition, the municipalities in which coffee shops are located decide the conditions and parameters they operate under and may impose additional rules.[71]

Under the *Opium Act*, a distinction is made between trafficking in hard drugs and in soft drugs. The importing and exporting of any classified drug is considered a serious offence, and the penalty for hard drug trafficking can run to 12 to 16 years. In contrast, the maximum penalty for importing or exporting any quantity of cannabis is four years' imprisonment or a €67,000 fine or both.

6 CONCLUSION

According to the Canadian Centre on Substance Abuse, cannabis is not a benign drug, as there are risks and harms associated with its use, including negative effects on mental and physical health, brain function (memory, attention and thinking), and driving performance. Marijuana can also negatively affect the development and behaviour of children born to women who used the drug during pregnancy.[72]

However, there is significant debate about how to proportionately mitigate marijuana's risks to public health and safety through different legal frameworks, including prohibition, decriminalization and legalization.

Whichever regulatory model is instituted, the mechanisms chosen to apply that model can vary widely. For example, both Uruguay and the state of Colorado in the United States follow a legalization model. In Uruguay, this model entails strict

government controls on the amount of consumption and the price of marijuana. In Colorado, however, a much more laissez-faire free market approach prevails. Thus, a regime of legalization can put its emphasis on harm reduction or upon revenue generation, depending upon the policy choices of the jurisdiction in question.

Information about the effects of the various models varies widely, often depending upon the source of that information. Whatever their bias, most studies look at some or all of the following factors to gauge whether a particular legal model for the treatment of marijuana can be judged a success:

- Has the rate of marijuana consumption increased or decreased since the particular model was adopted?
- Have drug users changed their drug habits based upon the model chosen?
- Have the harms associated with marijuana use increased or decreased? For example, has the rate of drug-impaired driving changed?
- What are the financial repercussions of any change in the legal model? For example, if marijuana has been legalized, how much revenue has been generated? Conversely, have law enforcement costs decreased?
- If the model has changed, what has been the effect upon law enforcement?
- If the model has changed, has there been any effect on neighbouring jurisdictions?
- If marijuana is now regulated as opposed to prohibited, has that had an influence on its quality and safety?
- What effect, if any, does the model chosen have on the number of people seeking treatment for marijuana dependency?
- If marijuana has been legalized, what, if any, has been the effect on organized crime organizations which sold marijuana under a prohibitionist policy?

If marijuana is no longer prohibited outright, and its use is regulated, a number of goals can be promoted through the way the regulation is structured. Many commentators on this issue agree that the primary goals of any regulatory scheme should be public health promotion and protection. Such goals could include:

- delayed onset of use by youth;
- reduced demand;
- reduced risky use (e.g., drug-impaired driving);
- decreased addiction;
- increased public safety (through reduced drug-related crime); and
- reduced consumption of drugs with unknown contaminants and potency.[73]

While there is little precedent for regulating legalized marijuana, the regulation of a formerly illegal substance – alcohol – could provide a model. Since the prohibition of alcohol has been lifted, a number of different approaches to its sale have been

followed, including government monopoly and a free market. In addition, various regulations have been adopted, ranging from restrictions on advertising and public consumption to laws concerning public drunkenness and impaired driving. These regulations, and the manner in which alcohol is sold, may provide guidance on how marijuana should be regulated.

NOTES

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    - has no currently accepted medical use in treatment in the United States; and
    - lacks accepted safety measures for use under medical supervision.

61. Under the dual sovereignty doctrine, the government of the United States and of each of the states may enact their own laws and prosecute crimes under them, provided there is no prohibition by the Constitution of the United States or of the state in question.

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