HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Justice and Human Rights

JUST • NUMBER 065 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Monday, September 25, 2017

Chair

Mr. Anthony Housefather

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● (1530)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): Good afternoon, ladies and gentlemen. Welcome back to the meetings of the Standing Committee on Justice and Human Rights as we focus on our review of Bill C-46.

I would like to welcome our witnesses. Today, joining us from the Canadian Society of Forensic Science is Daryl Mayers, chair of the alcohol test committee. From Mothers Against Drunk Driving, we have Patricia Hynes-Coates, the national president, and Andrew Murie, the chief executive officer. Welcome.

We have another witness who may or may not make it here. Regardless, we will start with the testimony of Mr. Mayers.

Mr. Mayers, the floor is yours.

Dr. Daryl Mayers (Chair, Alcohol Test Committee, Canadian Society of Forensic Science): Good afternoon, everyone.

The alcohol test committee of the Canadian Society of Forensic Science has provided independent scientific advice to the Minister of Justice on the detection and quantification of blood alcohol concentrations for the past 50 years. We are a group of dedicated volunteer scientists with expertise in breath and blood alcohol testing who are committed to maintaining the consistently high standard in alcohol testing that has become the accepted norm in Canada. The ATC has created standards for, and evaluates, all equipment proposed for alcohol testing in Canada. It recommends best practices in breath alcohol testing programs and recommends the operational procedures to be followed in the use of the equipment to ensure that the results are both accurate and reliable.

My remarks say there's an appendix, and there is. I supplied it to the clerk, and I'm sure everyone will get it at some point.

My opening remarks are going to touch both on some investigative and evidentiary matters that we feel would benefit from some further scientific context.

The first thing I turn to is the investigative matters and the mandatory alcohol screening. The alcohol test committee has been on record supporting this activity in both 2008 and most recently last year when I spoke to a standing committee. What is important to realize is that impairment of an individual's driving ability can often exist when the visible symptoms that may draw the attention of a police officer are absent. Approved screening devices can detect these individuals and, moreover, these ASDs are scientifically reliable, widely deployed, and well accepted in the courts for the purposes of detecting alcohol in the human body. No alcohol testing issue exists with regard to the implementation of this initiative.

I'll turn my attention—and I've tried to do this in order—to proposed section 320.28, “Samples of breath or blood — alcohol”. I understand it's been opined that the proposed section 320.28, coupled with the proposed paragraph 320.14(1)(b), the over 80 milligram bit, would lead to officers doing tests hours or perhaps even days after the incident. This hypothetical scenario seems of little concern when I read in proposed subparagraph 320.28(1)(a)(i) that the qualified technician must take samples of breath that, in their opinion, would allow a proper analysis of the breath. In my experience, any qualified technician asked to do a test on a subject a day after the alleged incident would decline because of the training they have received to become a qualified technician.

There are some evidentiary matters that we'd like to comment on. The first thing I want to make clear for this committee is that the alcohol test committee thinks that any Canadian approved instrument is, by our very definition, accurate and reliable when operated properly according to our guidelines, and will provide accurate and reliable blood alcohol results at the time of testing. I've provided all our standards to this committee.

Proposed subsection 320.31(2) specifically deals with analysts, such as myself, and we are somewhat concerned that this section appears to open the door for the type of disclosure motions that became prevalent in breath alcohol testing in the wake of 2008 amendments. The ATC responded then with our position paper, which indicated the required data and information necessary to determine that the approved instrument was in proper working order and was, therefore, reliable and accurate. This section appears to leave accredited Canadian forensic laboratories open to what was characterized by one of my members as a full-out attack on the analytical process.

Many of us have had our files subject to full disclosure, but our fear is that the scope of the request is likely to include materials that are not relevant to the analysis. The subsequent litigation to clarify the situation will be extremely costly. All analyses done in an accredited laboratory are subject to rigorous quality assurance and are accompanied by appropriate quality control measures. The alcohol test committee feels that this should be reflected in some manner in the legislation as a mechanism to limit disclosure motions that are resource intensive and, ultimately, have no benefit to the trier of the fact.

• (1535)

Moving quickly, as I am, to the presumption of blood alcohol concentrations, this is certainly going to require some adjustment. Our courts may require a judicial calculator allowance. However, the main message the ATC wants to convey is that, given the new wording of the law, there's no real possibility with this approach—i. e. the approach where the court can then do some calculations—that a court would come to a conclusion about the blood alcohol concentration that would be prejudicial to the accused person.

The suggestion that somehow a court would be presented with a zero result and, following the formula, extrapolate it to 120 milligrams of alcohol in 100 millilitres of blood when the incident happened—and that should be 12 hours prior—seems rather extraordinary. If such a thing were to happen, I am confident that competent scientific evidence from a qualified toxicologist would be adduced to assist the court in understanding why that should not be done.

It seems clear to us that the intent of this provision is to remove the burden of requiring a toxicologist in trials every time the lowest breath alcohol is at or above the per se limit and where the statutory presumption has been lost due to the passage of time. We are somewhat interested in how the courts will grapple with the times that don't fall in perfect half-hour intervals, and that will remain to be seen, but I'm sure it won't offer too much of a problem.

I want to briefly comment on the concept that toxicology adds virtually no time to a trial for the evidence to be entered. I actually take no issue with that assertion in uncomplicated cases, but you as the committee should be aware that my quick analysis of the typical Ottawa, Ontario Court of Justice case shows that it usually takes approximately eight to 12 different steps, involving six or seven different individuals, in three different organizations, before that brief appearance happens.

Moving to the disclosure of information, the listed items in proposed subsection 320.34(1) are traceable to the ATC position paper, in which we said, "Any messages produced by the instrument during the subject breath testing procedure that indicate"—emphasis added here—"an exception or error has occurred should be provided and assessed to determine their impact, if any, on the breath test results. Messages produced at other times are not scientifically relevant and need not be reviewed."

Our concern is that proposed paragraph 320.34(1)(c) says, "any messages produced by the approved instrument at the time the samples were taken" must be disclosed. Not all messages produced are actually written down on the test record card. For example, in one of our approved instruments, "Please Blow/R" scrolls across the screen prior to the person giving the sample. That is captured nowhere, but it is a message associated with that breath testing. It appears to be suggested that this should be disclosed and it's really not necessary for that to be done.

Moving forward to the later sections, proposed subsections (3), (4), and (5) of 320.34—and we approach this with full disclosure, as it were, from a non-legal sense as scientists reading these sections—it appears to undermine the previous proposed subsection, 320.34(1). Other information is not relevant, but those sections seem to give credence to the possibility that there may be something else that is relevant, and it sets up the mechanisms for counsel to get at it. That seems to us to be capable of reigniting what I sometimes call the "disclosure wars" that arose shortly after the 2008 amendments to the Criminal Code. In part due to our position paper, disclosure has become settled law in some provinces. However, as I said, these sections seem to us to invite a reopening of that debate.

I'll be meeting with my alcohol test committee members for the remainder of the week. Bill C-46 is the first substantial agenda item I propose to talk to them about, and if, following discussion about today's proceedings, they feel further items need enhancement or clarification better than I have done, which is clearly possible, we will submit any comments we have. We would undertake to do that before the end of our meeting, which ends Thursday of this week. We'll try to do that rapidly, if necessary.

• (1540)

I would like to thank the committee for the opportunity to address you.

The Chair: Thank you very much, Mr. Mayers.

We will now move to Mothers Against Drunk Driving, and I'll pass the floor to Ms. Hynes-Coates.

Ms. Patricia Hynes-Coates (National President, Mothers Against Drunk Driving): Thank you.

Good afternoon. Thank you very much for this opportunity.

My name is Patricia Hynes-Coates, and I am the national president of MADD Canada.

Like so many people who get involved with MADD, my life has been forever changed by someone else's selfish choice to drive while they were impaired by drugs or alcohol. On August 16, 2013, my stepson, Nicholas Coates, was killed by an impaired driver. Nick was riding his motorcycle on his way to work. The man who struck Nicholas was driving his pickup truck. It was 11:17 in the day. That man had been drinking the night before and the morning of the crash.

Nicholas was a son. He was my stepson. He was a brother, an uncle, and a fiancé. He was a kind-hearted, hard-working young man. He was a civil engineer. He was only 27 years old when his life was tragically ripped away from him. Like all impaired driving crashes, Nicholas's loss has devastated so many people. It has forever altered our family, his friends, and our community. His death was completely senseless.

I think that's one of the hardest things to come to grips with. Nicholas died because someone made that selfish choice that day to get into his vehicle, and because of that, Nicholas is no longer with us.

There is no way to describe the pain that Nick's whole family is going through, or how deeply it's felt every waking day. Impaired driving has lifelong effects on families, on everyone involved. To this day, my husband still wakes up at night in a sweat, in a panic as he remembers his last visual memory of his little boy as Nicholas was rushed past him on a gurney, surrounded by doctors and nurses. The only thing left in that hallway was a trail of blood.

My family's story is just one of thousands that happen within our country. I have travelled throughout Canada, and I have seen first-hand the devastation of impaired driving. I recently witnessed a nine-year-old boy stumbling up to a church to light a candle in honour of his brother. The horror of his cries echoed throughout the church. It was devastating. No one should have to feel this loss, let alone a child.

Impaired driving is not only about death. It is also devastating and debilitating in injuries, some that will never ever heal.

I recently had a conversation with a dad who told me that when his son was in a crash on Boxing Day, he had to make the decision of whether his son would live or die. He chose life and he is forever grateful for that, but that young man, who was once vibrant, can no longer dress or feed himself. That is the destruction that happens from impaired driving, all this because of somebody else's choice.

The day my husband and I put Nicholas in his final resting place we made a promise to him that he would never, ever be forgotten, and we promised him that we would not rest until we ended this fight against impaired driving. It is that fight that brought me here today.

I am here to provide a voice for those who can no longer speak for themselves, and to speak on behalf of Nicholas and other victims throughout Canada. As a mom, as a grandmother, and a wife, I know that once we lose our loved ones to impaired driving, it's too late. There is nothing else we can do, so that's why I am here to encourage the government to please move forward with the crucial laws and amendments outlined in Bill C-46 so we can reduce impaired driving, prevent crashes, and save lives.

Thank you.

I am going to turn the rest of my time over to my CEO, Andy Murie.

● (1545)

Mr. Andrew Murie (Chief Executive Officer, Mothers Against Drunk Driving): Thank you.

First, I'd like to thank our national president, Patricia, for her courage in sharing her story and being here representing thousands of victims from across Canada.

In my remarks today, I will focus specifically on what we consider the most important issue in Bill C-46 and what we think is one of the most important impaired driving countermeasures available: mandatory alcohol screening.

The other measures in the bill, which we support, are the evidentiary and procedural changes, which, if enacted, would address some of the technical concerns with the existing law, questionable court decisions, and other obstacles that make our current system ineffective in enforcing and in prosecuting impaired driving. Fewer impaired drivers would evade criminal responsibility due to factors unrelated to their criminal conduct, and those convicted would be subject to more onerous sanctions.

MADD Canada also strongly supports the measures dealing with drugs and driving, the three per se levels, the use of oral fluid screeners, and the reduced licence suspension period for alcohol interlock programs.

Canada's record on impaired driving is very poor. In 2016, the Centers for Disease Control in the United States released a report indicating that Canada had the highest percentage of alcohol-related crash deaths among the 20 wealthy nations studied.

MADD Canada strongly supports and promotes new legislation that focuses on deterrents. We need to deter people from driving when they have consumed too much alcohol. We need to deter people before they cause a crash that kills or injures someone, and that is why we need to authorize police to use mandatory alcohol screening.

Before proceeding on the merits of mandatory alcohol screening, I need to correct some misperceptions about it. Mandatory alcohol screening best practices mandate that all vehicles are checked and all drivers stopped must provide a breath sample. Mandatory alcohol screening operates the same way as mandatory screening processes at airports, on Parliament Hill, in courts, and in other government buildings.

Some witnesses have complained that mandatory alcohol screening would open the door to police harassment, discrimination, and targeting of visible minorities. We have found no such concerns about police conduct in this fashion in the mandatory alcohol screening research literature or in practice.

Canada's current system uses selective breath testing, and only drivers reasonably suspected of drinking can be tested. Studies have shown that the selective breath testing programs miss a significant portion of legally impaired drivers. They miss 90% of drivers with blood alcohol levels between .05% and .079%, and 60% of drivers with BAC over the current Criminal Code limit of .08%.

As member of Parliament, Bill Blair, Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, stated in Parliament on June 9, 2016, “The realization that they cannot avoid giving a breath sample at roadside will have a very significant deterrent effect on people who may choose to drink and drive. I would like to advise the House that this deterrent effect has been demonstrated countless times in many other countries.”

I can tell you numbers, but this slide tells it all. This is the experience in Ireland, which adopted mandatory alcohol screening in 2006. They've had a tremendous decrease in fatalities and injuries.

The other thing that's really important in mandatory alcohol screening is that, because it serves as a deterrent to potential drivers getting behind the wheel when they have consumed alcohol, they will not make that choice. It is less likely to find impaired drivers, so there is a significant drop in the number of people charged. I know that witnesses have come before you and claimed that this would overburden our court system. It is totally the opposite. There is no proof anywhere, in any country that has adopted mandatory alcohol screening, that it has caused any impact in a negative way on their justice system with charges.

We are not expecting the same results that Ireland has experienced. We are expecting somewhere around a 20% reduction in deaths and injuries in Canada, and that would result in at least 200 deaths and 12,000 injuries per year prevented from happening. It also would save our system about $4.3 billion.

● (1550)

In terms of public support for mandatory alcohol screening, once it's implemented, the support in the public goes up. For example, in 2002 in Queensland, 98.2% of the population supported mandatory alcohol screening.

There's already broad support for mandatory alcohol screening in Canada. In a 2009 survey, 66% of Canadians supported legislation authorizing police to conduct mandatory alcohol screening. A 2010 Ipsos Reid survey found that 77% of Canadians either "strongly" or "somewhat" supported the introduction of mandatory alcohol screening. When informed of mandatory alcohol screening's potential to reduce impaired driving deaths, 79% of Canadians agreed that mandatory alcohol screening is a reasonable intrusion on drivers.

Earlier last week, you heard from my colleague Dr. Robert Solomon on the Canadian Charter of Rights and Freedoms. I won't repeat those types of pieces, but let us remind ourselves that in 2015 an estimated 131 million passengers got on and off airplanes in Canada. It is not uncommon for them to take off their shoes, belts, and jewellery, show carry-on items, be swabbed for explosive devices, and be scanned for weapons and subject to pat-down searches. It's not uncommon to wait 10 to 15 minutes to be subject to one of these screening and search procedures. Such procedures are accepted because they serve a public safety function.

Put bluntly, far more Canadians are killed in alcohol-related crashes each year than in attacks on airplanes. Like airport procedures, mandatory alcohol screening is consistent with the charter.

In conclusion, MADD Canada would urge this current Parliament to show leadership and enact Bill C-46. Thank you very much.

The Chair: Thank you very much for your presentation. It was very compelling and very moving.

We are joined by our other witness on this panel, Chief John Bates, Chief of Police for the Saint John Police Force.

Mr. Bates, the floor is yours.

Chief John Bates (Chief of Police, Saint John Police Force): Thank you, Mr. Chair.

Distinguished members of this committee, I am both pleased and honoured to have been afforded the opportunity to meet and speak with you today.

As was the case for our CACP president, Chief Mario Harel, who spoke with you last week, it is my first time appearing before the committee—any Commons committee, for that matter—and I consider it a privilege, if not somewhat bewildering.

The CACP has already provided the committee with its position on Bill C-46, a very technical bill, and it is not my intention to repeat what I consider its extremely thoughtful and valid insights. Undoubtedly, though, I will touch upon and reinforce some of those positions. My remarks will speak to some specifics, and I also hope to reinforce some overarching concerns and/or principles.

However, I first want to echo what my colleagues have already alluded to, that Bill C-46 contains some very positive changes that will serve to enhance the safety and security of Canadians as they relate to the scourge of impaired driving. Additionally, the recent funding announcement has, I believe, been well received by the policing community from coast to coast to coast and will go a long way as we prepare ourselves for what will flow from Bill C-45.

My comments to you will be my own, and from the perspective of the chief of a small to medium-sized police agency. Although I'm the vice-president of the organization, I am not here representing the New Brunswick Association of Chiefs of Police. Approximately three-quarters of all police agencies in Canada fall into the category of small or medium police forces and employ about 50% of the police officers across the country.

I'm going to suggest to this committee that what Parliament faces with Bill C-46 and the legalization of marijuana pursuant to Bill C-45 is what was popularized by Horst Rittel and Melvin Webber as a "wicked problem" in public policy. It is valid in this instance to define this as a wicked problem, as Brian Head, writing on "Wicked Problems in Public Policy", described it, because—and I'm going to paraphrase—there's no single root cause of the complexity, uncertainty, or disagreement, and hence no single best approach to tackling the issues.

You will undoubtedly have heard a divergence of viewpoints during your deliberations. Let me briefly touch upon just a few of the things I've considered when contemplating July of 2018.

It is my respectful submission that notwithstanding testing results from the oral fluid screening devices, the applicable science and/or application of the science is not ready. I believe the CACP has submitted concerns specific to the oral fluid screening devices that undoubtedly referenced language proposed in the act with regard to those devices.

Additionally, questions linger as to where and how the use of oral fluid screening devices will fit into the continuum or the regime of the "impaired driving by drug" investigations. Another question is, what is the correlation between saliva concentrations and blood or fatty tissue concentrations of drugs, and what level or levels will constitute actual impairment, from a scientific perspective, as compared with those we have for impairment by alcohol?

As we contemplated the science, it led us to wonder about the combination of alcohol and cannabis and/or other drugs. There's the additive effect, whereby simply the combination of, say, alcohol and cannabis—one plus one—will equal two. But there's synergism with regard to narcotics and drugs, whereby one plus one can equal five, because the influence of one compounds the influence of the other, and then there's potentiation, whereby one and one plus one, as you combine more drugs and/or alcohol, can equal something like 10. I just bring the potential and problematic issue of the cannabis cocktail to your attention during your deliberations.

It should be recognized that following the legalization of marijuana there will be an increase in impaired driving; the studies show that. I think I can say with confidence, and it will come as no surprise to you to hear it, that by and large police agencies are not currently prepared for what Bill C-45 may present us on our highways and byways. Even if all the stars align for us by July of 2018 and we are ready, it will be just barely ready.

By way of example, in New Brunswick the number of police-reported incidents of drug-impaired driving have increased 193% between the years 2008 to 2016, and there has been a 54% increase since 2013. We currently have 18 DRE officers in our province, with 100 standard field sobriety test officers. We have approximately 40% of the DRE officers that our province requires, and we are a small province.

● (1555)

With the injection of additional training dollars and hopefully the resources to deliver the training, if we were to somehow manage to even double that number over the next five years, assuming no attrition, we would still be behind in adequate numbers. If I have my facts straight, we are approaching 50% attrition with DRE officers since 2013 in this country.

I can only speak on behalf of the Saint John Police Force, but it has been my recent experience that sourcing, securing, and funding training is challenging with the travel required to disparate locations for the wide variety of training that modern-day policing necessitates.

Ramping up the numbers of standard field sobriety test officers, which I wholeheartedly support, will, as I understand the investigative continuum for impaired-by-drug driving investigations, necessitate at least a proportional increase in DRE officers. The concern, and I believe it is valid, is that the demand will exceed availability for training. It will be like trying to drain an outdoor Olympic-size swimming pool with a garden hose in a rainstorm.

There are other implications: lab-testing capacity, Jordan decision implications, and rank-and-file training of members at the front lines. As I stated, my colleagues at the CACP have presented its position to this committee regarding Bill C-46, and while we're supportive of the bill, I think they have urged a delay to its becoming law in July 2018. As it stands today, I would support that delay.

Procedural fairness dictates that the law is applied reasonably and equally, and in an equal manner across Canada. Procedural fairness presumes the resources to apply the law equally across Canada. In the potential absence or application of good science and sound and timely preparation, the courts might be left to define the process, standards, and best practices. With respect, this is a job for government, for the CACP, and for the community. It is patently unfair to expect the courts to do our job with potentially undesirable or unintended results.

I know a great deal of thought has gone into potential charter implications. If the legislation or regulations are couched in terms of complexity, adaptation, and this in fact being a wicked problem, and if adequate resources, training, and time are provided, we can be ready. I'm not sanguine to the possibility that we, policing, will get there by 2018, but I'm hopeful.

In closing, I would ask the committee to consider, as I'm confident it has and will continue to do, two guiding insights when considering this wicked problem. One, we must be very thoughtful and insightful in setting the initial conditions, the legislation. Two, we must design legislation and regulation to allow for constant, collaborative, and informed adaptation. As an example, I believe there is a current list of drug categories—seven, I believe—in the pending legislation. I don't draft legislation, obviously, but I simply ask the question: do we risk boxing ourselves in? Change will occur; we know that.

It is my earnest hope that we will get this right and we'll have the necessary time to get it right. Once the final product, the legislation, becomes law, the burden of effective enforcement and public safety will fall to the front-line law enforcement community. Training, adequate human resources, equipment, and solid law will be crucial. The burden can be a heavy one, and we in policing sincerely want to get it right.

I thank the committee for the invitation to be here today.

● (1600)

The Chair: Thank you very much, Chief Bates.

We will now move on to questions, starting with Mr. Nicholson.

Hon. Rob Nicholson (Niagara Falls, CPC): Thank you very much, Mr. Chair, and thank you to our witnesses. This has been very helping in giving us greater insight into this bill and all the different issues. It's very much appreciated.

Mr. Cooper will take whatever time I have left over.

Could I start with you, Mr. Mayers? You raised one of the issues that we talked about last week, quite frankly, the evidentiary matters with respect to breath samples. I was pleased that you specifically mentioned proposed subsection 320.31(4), where it's more than two hours since the person ceased to operate the conveyance, and then the presupposition that there will be an additional five milligrams of alcohol in every 100 millilitres for every interval of 30 minutes in excess of two minutes. We heard testimony last week that this could be very problematic.

You said something interesting. You said that if somebody went to an expert to test this and it was a day or two later, they would refuse to do that. Doesn't that raise some concerns that the possibility even exists in the section? We're still trying to grapple with it. I'm still trying to grapple with it, to tell you the truth.

Dr. Daryl Mayers: It leaves little concern for me because, based on what I said about a previous action, I don't think you'll ever see a zero in front of a court. There's no breath tech that I've trained, and I've probably trained thousands, who would ever do a test on someone they knew to be 24 hours or 12 hours past the time of the occurrence. Even if you saw that come before a court, it would be an extremely unusual circumstance that a judge, in the absence of scientific guidance, would take it upon themselves to do that sort of an extrapolation for that amount of time.

Now, I do extrapolations of that type in different types of trials, for example, in cases of sexual assault, where the assault victim has zero blood alcohol but there's an allegation of consumption of alcohol at the time of the incident. A scientific approach would be if you have a zero result and a result from 12 hours before, and you want me to project it, my projection will be from zero to 240 milligrams of alcohol in 100 millilitres of blood, because I have to take into account the possibility that it is zero the whole time, but I also have to take into account something the judges are not going to do. That is, there's a higher rate of elimination available in some, so there would be a large range.

● (1605)

Hon. Rob Nicholson: Do you think it's a necessary section to have in there?

Dr. Daryl Mayers: Given the savings and resources that could be affected, I understand why that section is there. Given that it's possibly doing me out of a job, I'm not sure about that.

Hon. Rob Nicholson: Fair enough.

Dr. Daryl Mayers: Of course, that's a joke. Realistically, as I said, I don't think there is any opportunity for prejudice to the accused individual with that approach.

Hon. Rob Nicholson: Good. Thank you for that.

Mr. Murie, you heard from Chief Bates that with the legalization of marijuana we're going to see more impaired driving. Is that your conclusion as well?

Mr. Andrew Murie: That's been the experience in the U.S. states that have legalized, but we also have to take into consideration that when they legalized in the mess that they did, through a ballot, the police didn't have any tools when legalization came in.

Hon. Rob Nicholson: Or any choice....

Mr. Andrew Murie: They didn't have the ability to use oral fluids. Their per se levels were set without science and without a lot of thought.

We also have the ability in Canada to have provincial sanctions at the administrative level that support this. Our alcohol programs kick in. They can be very effective. If you look at the situation in British Columbia, where they do a three-day vehicle impoundment and three-day licence suspension for somebody in the “warn” range, it has reduced alcohol-related deaths by 50%. If we could put those types of things in place for drugs as well, simply on a failed standard field sobriety test, or a failed oral fluid test, or some combination of those, it will make us much more effective here compared with the U.S. experience.

Hon. Rob Nicholson: One of the examples you gave us from some roadside interventions was that they're not picking up the people who are around .05 to .079 I think it was. Isn't that going to be even more complicated if the person may have smoked a joint or two? Their alcohol level wouldn't go up, and the police would have to try to determine whether the person was impaired or not.

Mr. Andrew Murie: In a lot of police procedure—especially with the introduction of mandatory alcohol screening—if they can get an individual above the “warn” range, the sanctions are the same, and it's an easier procedure. They'll simply go with the alcohol at the roadside, so that makes it fairly easy.

If there's no alcohol present, they'll go on to the possibility that there might be drugs involved at the roadside. Those provincial sanctions are unique for us here.

Hon. Rob Nicholson: Are you satisfied that with provincial sanctions you can live with the legalization of marijuana? I take it that's what you're saying?

Mr. Andrew Murie: With one provision—that our provinces have all these things in place by July 1.

Hon. Rob Nicholson: Do you think they will?

Mr. Andrew Murie: I think a lot of provinces are working really hard and working on that deadline.

Hon. Rob Nicholson: Chief, you mentioned that you're concerned about that.

Chief John Bates: I'm concerned.

I can just speak from the hard work that's being done in New Brunswick. I know they are trying to get regulatory measures in place in time.

Hon. Rob Nicholson: Fair enough.

I hope I haven't taken up all the time of my colleague.

The Chair: You have, but we'll come back to short snappers at the end for Mr. Cooper's questions.

Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much, Mr. Chair. Thank you all very much for being here and sharing your presentations with us.

I would like to start with you, Mr. Murie and Ms. Hynes-Coates. We heard a suggestion—I think it was the last time we were in session—regarding Canada doing a pretty good job on impaired driving, and the fact that we've seen the rates of impaired driving in Canada going down over the last number of years. I think the suggestion misses the point. I note in your brief you cited in 2016 that the Centers for Disease Control in the United States released a report indicating that Canada had the highest percentage of alcohol-related crash deaths, 33.6%, amongst the 20 wealthy countries that were looked at.

I wonder if you can provide some comment, Ms. Hynes-Coates, to the suggestion that Canada is doing a good job on impaired driving because we've seen a decline over the last number of years, or Mr. Murie, if you have something to add to that.

● (1610)

Mr. Andrew Murie: Canada has seen a dramatic decrease in our alcohol-related deaths. If you go back to the 1980s, it was not uncommon that 70% of our deaths on our roads were alcohol-related. Now we're down to 33.6%, as correctly stated in the report by the Centers for Disease Control.

What you have to realize is that the other countries have done better. One of the reasons they have done better is that the majority of them have a lower BAC and mandatory alcohol screening. Those two things seem to work hand in hand on the deaths and injuries and also the number of charges going through the courts.

Canada has made great progress. That's not an incorrect statement, but when you start to compare us to other wealthy nations, internationally, we've fallen behind.

Mr. Colin Fraser: With the selective breath test versus the mandatory alcohol screening, you indicated that with the selective breath test 60% of people that have the blood alcohol concentration over .08% are missed, and between .05% and .079%, 90% are missed. What can you attribute that to?

Mr. Andrew Murie: The simple reason is people who drink and drive don't show.... You have a very quick intervention as a police officer, and if you don't have the overt signs of intoxication right there, you're not picking that up. A lot of times at .05%, you don't see those signs in that quick interaction because, in a sobriety checkpoint, you're moving people through really quickly.

It's interesting when you look at arrest rates. When you look at how people are arrested, 70% come because of random police patrols where police have observed some divergence from regular driving, 24% come from where they crashed themselves, and 6% come from sobriety checkpoints. Again, obviously observation is the key method and the ability to test them right away is very effective.

Mr. Colin Fraser: Thank you very much.

Mr. Mayers, you had talked about the presumption of blood alcohol concentration in the legislation. You talked about a judicial calculator allowance.

Could you expand on that? I wasn't sure what that meant.

Dr. Daryl Mayers: That was just a joke or a poor one, that the judges now have to add five every half hour and they may need a calculator to do it.

Mr. Colin Fraser: Okay. Fair enough.

Dr. Daryl Mayers: I'm sorry that it was a poor attempt at humour.

Mr. Colin Fraser: That's okay. The joke went over my head, but that's not always uncommon. Thanks for that.

I'll move on to Police Chief Bates. You talked about the incidence of drug-impaired driving going up in your city. I assume you see, like many police across the country, the incidence of youth usage of cannabis being quite prevalent and having gone up.

Do you see incidence of youth or young people driving impaired by cannabis happening in your city?

Chief John Bates: I can't say that I can one way or the other. The comments about the drug-impaired driving going up.... There's an old saying we used to say around the shop, “If you want to double the drug problem in your city, double your drug squad.” I think probably one of the driving factors of the higher stats is that we have, as a policing community, taken steps to train drug recognition expert and standard field sobriety officers. I think part of the driving force behind those elevated numbers will, in fact, be police officers out there and making those arrests. I think that goes without saying.

I base my comments on that we can expect to see more impaired driving by drug just simply on the stats that have flowed out of the United States: Colorado and Washington. We're sort of relying on those numbers to make the presumption that we're going to see increased numbers of people driving while impaired by drugs.

Mr. Colin Fraser: As a police force, have you seen the number of people being charged with drug-impaired driving going up? I gathered that from your previous testimony.

● (1615)

Chief John Bates: Yes. I can tell you that we in Saint John have seen the numbers increase. I gleaned provincial numbers. I didn't get the Saint John-centric numbers themselves, but I can tell you that we have a drug recognition expert who lives in another city in New Brunswick, who quite regularly helps out that city with their examinations when he's off duty.

Mr. Colin Fraser: With that going up, you would agree that the added money that has been announced for tools and training and resources for the police, coupled with per se limits, would be beneficial to your ability to deal with the incidence of drug-impaired driving?

Chief John Bates: I'm very hopeful that it would, and I'm very anxious to see how the money is going to make its way to police agencies at the local level.

The Chair: Thank you very much.

Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): Thank you.

First, I'd like to direct my questions to Mothers Against Drunk Driving, and to thank Ms. Hynes-Coates for reminding the committee about the terrible losses that Canadian families have suffered. That perspective is very valuable as we get into the statistics and the like. It's very helpful, so thank you for coming.

Mr. Murie, you spoke about your support, and MADD's support, of mandatory alcohol screening, and at one point you said that it would save our system $4.3 billion, if I've quoted you correctly. What is the source of that, and what does that include?

Mr. Andrew Murie: The source is a study that was done by Transport Canada, where they calculated the number of deaths and injuries; there was a cost value to that. Then we took that cost value and estimated if there was a 20% savings of lives and injuries, what value that would bring back. It looked at loss of life, the system, hospital care. It was a comprehensive evaluation of estimating that loss.

Mr. Murray Rankin: Including valuation of life itself.

Mr. Andrew Murie: Absolutely.

Mr. Murray Rankin: I know that Mothers Against Drunk Driving has endorsed the idea of what are called per se limits for cannabis. I think MADD has supported the idea of a five-nanogram limit for an oral swab test. We've had testimony about per se limits that would suggest there are problems with that. I wonder if you could speak a little more about that.

Then afterwards I'll ask Dr. Mayers if anything from the perspective of scientists about this would shed some light, although I realize your expertise is in the alcohol field.

Mr. Murie.

Mr. Andrew Murie: We think that Bill C-46 capturing the three different limits has done an excellent job of what we would consider a good beginning with per se levels for drugs. Having between the two and five nanograms as a summary offence, again there are a lot of studies out there. The problem with the studies is threefold.

One is the strength of the THC they're allowed to use in these studies. It's very low compared to street level. Two, all these studies are done on driving simulators, not real roads. It's a very different type of research compared with what we do and have historically done for alcohol. Three is the rapid dissipation as it goes through the body, very unlike alcohol, so at time of driving the per se levels were probably much higher than by the time you fail a standard field sobriety test or an oral fluid test, make the demand for the blood, and get somebody to a place that can draw the blood, and there—

Mr. Murray Rankin: Thank you.

Dr. Mayers, I know your expertise is in a different field, but have you turned your mind to per se limits for cannabis?

Dr. Daryl Mayers: I can feel the burning eyes on my back of my drugs-and-driving chairperson, who is in the audience, so I will decline to answer anything on that. I will certainly answer anything about per se limits with alcohol.

Mr. Murray Rankin: Fine. In your report, you listed several appendices of recommended standards. I wasn't clear whether you were recommending that changes are required to those standards as a consequence of Bill C-46, or are they just there for our education?

Dr. Daryl Mayers: They're for information purposes only. I've referred to them and to save the committee time looking them up I thought I'd just supply them up front.

Mr. Murray Rankin: Chief Bates, you were quite compelling in saying that police in your jurisdiction are not prepared and may be barely ready in July. Yet you were happy with the funding announcement the federal government made.

I'm not really clear. Do you have suggestions for amendments to the legislation? Remember, sir, we're here to talk about the bill before us. Do you have any suggested changes for that legislation?

● (1620)

Chief John Bates: No. The one thing in the legislation that caught my eye was simply.... It's two things. I think the legislation addresses or speaks to or contemplates standard field sobriety testing, and maybe it and the combination of oral fluid testing as moving to being able to make the blood demand. This is somewhat different from a continuum, so I'm not really clear on what the continuum is in this.

Mr. Murray Rankin: Perhaps we need greater clarification.

I want to go back, if I may, to Mr. Mayers. I thought your written presentation was great. I just had a question again about whether a recommendation is suggested here.

You talked about the famous disclosure wars after the 2008 amendments and talked about the law in some provinces having been settled, in a way. But you said, "Many of us have had our files subject to full disclosure but our fear is that the scope of the request is likely to include materials that are not relevant to the analysis. The subsequent litigation to clarify the situation will be extremely costly."

Are there specific statutory changes you're looking for here in the bill?

Dr. Daryl Mayers: I'm speaking with my laboratory hat on now. Just as we tried at the alcohol test committee to clarify what is necessary to determine that an approved instrument is in proper working order, I think the bill could benefit from the same sort of analysis—I'm now adding work onto my committee, probably—as far as the laboratory is concerned. Just as it is inappropriate and unnecessary to look at historical data for the approved instrument, it serves no purpose to ask for my previous 30-alcohol-analyses run when I can provide the quality controls of the run that had the subject's test in it.

Mr. Murray Rankin: What about putting those reports online, as some of the witnesses have suggested, the routine maintenance reports, and so forth?

Dr. Daryl Mayers: I wouldn't presume to speak about that, because that is dependent on the laboratory. The alcohol test committee is not fixed in one laboratory system. We make recommendations at a very high level, and each laboratory system —the RCMP, the Quebec lab, and the Centre of Forensic Sciences— would determine whether they wanted to follow that route.

The Chair: Thank you very much.

Ms. Khalid.

Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.): Thank you, Chair. I'd like to split some of my time with Mr. Blair, if that's okay. I just have one question, for Mr. Bates.

You indicated that the number of charges for impaired driving would increase once the cannabis legislation comes forward. Mr. Murray identified that overall, impaired driving charges would decrease or have decreased, based on the chart that is up on our screen.

Do you think that over a period of time in the long term this legislation would have a deterrent effect, that in the long term we would see impaired driving charges decrease and have safer roads in the future, once the police have the training and the process is well implemented?

Chief John Bates: There are a few things, There's a difference between charges and instances of impaired driving. I think we may see an uptick of instances of impaired driving, but unless at the end of the day we see this legislation as having a deterrent effect, what is the value in it?

Absolutely I support this legislation and as I indicated in my opening remarks, I commended the draft legislation because I think it is going to have a very positive effect on impaired driving in the future, whether it be caused by drug or alcohol or a combination of the two.

Ms. Iqra Khalid: Thank you.

The rest is for Mr. Blair.

Mr. Bill Blair (Scarborough Southwest, Lib.): Thank you very much.

I'll begin by thanking all the witnesses for appearing before us today. I offer my voice of commendation to MADD Canada for your compelling advocacy on this issue over far too many years, but we are very grateful for all your hard work. I also thank the drugs and driving committee for the sage advice they provide to the Government of Canada, which gives us confidence as we go forward, and Chief Bates.

Chief, I just want to clarify something. You express a bit of concern about the roadside screening tool. I just want to remind you that, in 2014, the Canadian Association of Chiefs of Police, by unanimous resolution, urged the Government of Canada to improve the safety of Canada's roadways by approving a drug screening tool to enhance investigation and prosecution of drug-impaired driving. They stated at the time, three years ago, that they believed advances in technology made these tools readily available for roadside detection and they also acknowledged that they were used effectively in some other jurisdictions.

Given the urgency the CACP conveyed, I'd like your sense of how important you believe it is that we make these tools available to law enforcement to keep our roadways safe.

● (1625)

Chief John Bates: Any tool we have in the box is going to make us more efficient and effective. Again, part of the concern that my colleagues at the CACP probably expressed with regard to the oral fluid testing, and one that I have, is actually defining what the investigative continuum will be and how the oral fluid testing is going to relate.

As it stands right now, I certainly stand to be corrected, but it is my belief that at the end of the day what we are looking at is, before we get to getting blood from people, we really have to have a drug recognition expert officer giving us the solid grounds for that. That might change, and I think the legislation contemplates a change, but that's where we are right now.

Mr. Bill Blair: Chief Bates, in 2008, when the government of the day passed Bill C-2 in the second session of the 39th Parliament, it introduced a legislative amendment that allowed for the testimony of drug recognition experts and gave the authority for the standardized field sobriety testing. At that time, or actually about two months after that was passed and enacted, the Canadian Association of Chiefs of Police indicated that they needed to train 27,000 officers in standardized field sobriety testing and some 2,600 officers as drug recognition experts.

The CACP, in their resolution, said they wanted to ensure there was adequate funding for that training to take place. The government of the day authorized $2 million for that training to take place, and my understanding from your testimony and from earlier testimony from the CACP is that we still do not have, at this point in time, adequate numbers of drug recognition or standardized field sobriety officers trained.

With the introduction of the government's allocation of $161 million for that training to take place now, do you believe we are in a better position to produce the desirable outcome of having adequate people trained to keep our roadways safe?

Chief John Bates: We will be in a better position particularly with regard to standard field sobriety testing.

The drug recognition experts continue to be problematic. Sourcing and getting people trained in that particular specialty continues to be a problem here in Canada.

Mr. Bill Blair: Thank you very much.

The Chair: Are there any questions for members of the panel? If not, I have one short question.

I also thank Mothers Against Drunk Driving for its advocacy and work over many years.

Last week we had another advocacy group, Families for Justice, who appeared before us and talked about the lack of minimum mandatory sentences being added to the legislation. What is MADD's position on minimum mandatory sentences?

Ms. Patricia Hynes-Coates: As a mom, as a stepmom, as a victim, I can't support it. There's no evidence to support that this will actually make a difference. We know once we bury our children or bury a loved one, it is too late. We need to focus on deterring it before it actually happens.

The Chair: Thank you very much.

I really appreciate the testimony of all the witnesses. It was very helpful.

I'm going to ask the people from the next panel to please move forward. We'll recess briefly as we change panels.

● (1625)

——— (Pause) ———

● (1630)

The Chair: It is a pleasure to be joined by our second panel of the day.

We welcome, from the John Howard Society of Canada, Ms. Catherine Latimer, who is the executive director. We also welcome from Arrive Alive Drive Sober, Ms. Anne Leonard, who is the president, and Mr. Michael Stewart, the program director. We have also, as an individual, Professor Louis Francescutti, who is from the school of public health at the University of Alberta.

We are going to start with Ms. Latimer.

The floor is yours.

Ms. Catherine Latimer (Executive Director, John Howard Society of Canada): Thank you very much for the opportunity to share with you the perception of the John Howard Society on Bill C-46. We don't bring any depth of scientific expertise, but we are an organization that's fully committed to effective, just, and humane responses to the causes and consequences of crime. We have John Howard offices throughout the country in more than 60 communities, and we're all extremely interested in community safety.

I think it is very timely to review the adequacy of the impaired driving provisions to address marijuana-impaired drivers in advance of the government's promised legalization of marijuana in July 2018.

I think this is a very timely exercise, but not only does Bill C-46 propose Criminal Code amendments in relation to drug-impaired driving. It repeals and replaces code provisions dealing with conveyances and toughens the provisions dealing with alcohol-impaired driving. It thus becomes a very far-reaching set of proposals in a highly litigated area, which will result in many legal challenges and delays in the courts.

Really, we just have three or four observations that we'd like to make about the bill.

The first is that there is a strong argument to focus on the immediate drug-impaired driving challenge with this particular bill. As I'm sure you've heard from others, it might be wise not to proceed with part 2 amendments and really focus on the drug-impaired elements.

We say this for two reasons. One is, and we heard it a little bit from the previous panel, that we've heard from police and provinces that being prepared for the July 2018 legalization of marijuana will be a challenge for them. Keeping the enforcement regime as streamlined and targeted as possible, then, would seem to assist in meeting the time frames associated with the marijuana legalization.

Secondly, we have heard from the courts and others that congestion and delays in the judicial process are leading to charges being dismissed, given the timelines set out by the Supreme Court of Canada in R. vs. Jordan. Many people feel that this is really one of the critical problems facing the justice system today.

The meaning of all new reforms is often tested before the courts, and charter compliance for some of the changes will take up further trial time. I think the brief from the Canadian Bar Association on Bill C-46 sets out a number of elements that raise charter concerns and will certainly take up a lot of time in our courts. Those reforms have unintended consequences of exacerbating serious delays, leading to a failure to hold people to account for serious crimes.

I think it's very important, therefore, to think about the breadth of this bill and what it would mean in terms of other important issues that the courts are facing.

The other issue we would like to raise is to question blood drug levels as an accurate measure of impairment. For us as an evidence-based organization it is important to look at the effectiveness of the proposed test for assessing impairment. While it simplifies enforcement to have a level of drugs in the blood that indicates impairment, the science may not support such a simple test. Relegating the level that's appropriate to regulations may avoid the immediate challenge, but embeds the presumption in legislation that a drug-blood level test of marijuana impairment is possible and desirable.

What we're hearing from experts suggests that those acclimatized to higher doses of marijuana may be less impaired than those with lower doses who are not regular users of marijuana. You could thus have the unfortunate effect that the level of marijuana in the blood does not equate to the level of impairment. Reliance on a blood-drug measurement as an indicator of impairment could have really unjust results and lead to convictions of those who are not impaired. Rather than focusing on the level of drug in the blood, a better test of impairment should perhaps be considered.

The standard field sobriety test could be used, which would indicate impairment, and this would avoid the problems of an intrusive procedure to obtain blood, which raises some charter issues in and of itself. Such a test would be available without the need for legislative amendments.

I also think that in this age of higher technology it might well be possible to have a different type of test for impairment that looks at the speed of reflexes and the variety of things you would worry about to which marijuana consumers, in terms of their impairment, might be subject. If you got a good program for a computer or something, you could also have some quantifiable results, which I think puts the mind of law enforcement a little more at ease. That's the second issue that we would raise for consideration.

● (1635)

The third is the mandatory minimum penalties. The John Howard Society opposes mandatory minimum penalties, believing that judicial discretion is needed to promote fit sentences that are proportionate to the seriousness of the offence and the degree of responsibility of the offender. We are disappointed to see that mandatory minimum penalties are included in this bill and would recommend that they be dropped.

In conclusion, while we share an interest in ensuring that our streets and communities are safe from drug-impaired drivers, this bill may not achieve our shared goals. It risks an inaccurate test for assessing impairment based on drug-blood levels that would have unjust results. It risks clogging the already overburdened courts with trials and charter challenges to the changes, and many of these are in part 2 of the bill. It risks disproportionate sentences by maintaining mandatory minimum penalties.

We would urge the committee to sever part 2 from the bill and deal with that when we've addressed the delays in the court and the important challenges that are there. We would urge the committee to adopt a more accurate tool for assessing actual impairment by marijuana that would be better than a faulty blood-drug level test, and we would urge you to drop the mandatory minimum penalties or to allow judges to impose something other than a preferred mandatory minimum penalty if needed for a proportionate and fair sentence.

That's the position of the John Howard Society.

Thank you very much.

• (1640)

The Chair: Thank you very much, Ms. Latimer, for your testimony.

We will now move to Mr. Stewart and Ms. Leonard.

Mr. Michael Stewart (Program Director, Arrive Alive DRIVE SOBER): Good afternoon, Mr. Chair and members of the committee. Thank you for inviting Arrive Alive Drive Sober to provide our comments on Bill C-46. My name is Michael Stewart, and I am the program director with Arrive Alive. I am joined here today by the president of our board of directors, Ms. Anne Leonard.

For almost 30 years, our charity has provided leadership and programs to eliminate impaired driving, such as choose your ride and operation lookout. We enable people and communities to share resources and information intended to prevent injuries and save lives on our roads. We are recognized as a leader in the fight against impaired driving. In a recent government survey, our slogan and messaging was recognized by four out of five Ontarians, making it the most recognized campaign.

We have 85 members and stakeholders comprised of dedicated professionals and volunteers. We frequently partner with community groups, police services, public health units, schools, businesses, and government entities. Each year, we distribute for free over $100,000 in printed materials across Canada and receive over $12 million in donated television and radio airtime. In March of this year, one of our countermeasure campaigns, our wrecked car coasters received national and international media coverage, with interviews from coast to coast and as far away as Australia. Since the inception of our organization, impaired driving fatalities in Ontario have declined by almost 75%, demonstrating that comprehensive legislation and enforcement requires a third partner—effective public awareness—to save lives on our roads.

Arrive Alive commends the work of the federal government and its commitment to creating new and stronger laws to combat impaired driving. Introducing three new offences for drivers having specified levels of drugs in their system, making changes to the “over 80” offence, as well as increased penalties are improvements that will help us all arrive alive.

Drug-impaired driving has been included in our messaging for over a decade, but it has recently become of greater concern for Canadians due to the pending legalization of cannabis. In a recent nationwide survey conducted by State Farm, 80% of respondent’s voiced concern about people driving under the influence of marijuana, and 83% felt that there is not enough information about the risks that come with driving while high.

Bill C-46 is an important step forward, but it's critical that it be accompanied by a comprehensive plan of education and public awareness. We have heard a common misconception from both youth and adults that driving while high on cannabis is not only safe, but makes them better drivers. This dangerous myth underscores the critical need to ensure that all drivers know that driving while impaired by drugs is just as dangerous as driving while impaired by alcohol. The Canadian Centre on Substance Use and Addiction reports that in 2011, 21% of high school students who were surveyed in Canada said that they had driven at least once within an hour of using drugs, and 50% had been a passenger in a vehicle where the driver had used drugs. This data, in combination with these dangerous myths, creates a road safety hazard in and of itself that must be addressed not only by enforcement but by fulsome education.

According to Statistics Canada, police reported that drug impaired driving incidents have doubled since 2009. As well, our colleagues in states where cannabis has been legalized, such as Colorado and Washington state, have seen marked increases in drug-impaired driving. We have no reason to believe that this experience will not be replicated in Canada, but education and awareness are key to reducing the numbers of people who combine drug use and driving. We have seen sustained and consistent reductions in alcohol-impaired driving incidents. It clearly appears that the population of drivers who combine drugs and driving is distinct or different from the population that is well aware of the dangers of drinking in combination with driving.

Health Canada has stated that the government is committed to investing in a robust education campaign to inform youth of the risks and harms of cannabis use. We urge the members of this committee to accelerate the government’s pace and economic support when it comes to public awareness efforts. It is crucial to the safety of Canadians to be educated not only about the dangers of driving in combination with drugs, but also about the new consequences and blood drug concentration levels set out in Bill C-46. An absence of awareness and education will limit the impact and deterrent effect these increased penalties are intended to have. Given the brief time between now and July 1st, 2018, we encourage you to explore strategic opportunities for partnership on education campaigns.

Arrive Alive has been at the forefront in raising awareness about the dangers of driving while impaired by drugs. Our drug-impaired driving efforts to date include *The Sober Truth About Driving High*, a video PSA filmed in partnership with the CACP and the RCMP in 2012; our award-winning *iDRIVE* educational video that was shared, in partnership with Transport Canada, with every high school in Canada in 2011; a radio PSA entitled *Potchecks* in 2015; and our ongoing Eggs on Weed campaign that began in 2014.

We are going to continue to do our part, but we will need help, especially with the legalization of cannabis and Bill C-46.

● (1645)

Training officers and ensuring that they have the necessary tools in place to detect and remove impaired drivers from the road has been a key concern of our membership for many years. We know that training these officers to detect impairment and supplying them with devices takes time and money. While the federal government has announced $161 million to be divided up amongst the provinces, our police partners have warned us that there is neither enough time nor funding to have sufficient officers and approved screening devices ready for legalization. We encourage the government to continue to work with police services to determine what amount is needed to fulfill their training and research requirements. As the bill provides necessary tools to help law enforcement in this fight, it is paramount to ensure that they can be fully utilized across Canada.

While Bill C-46 is an important step in the right direction, it is unfortunate that the bill itself perpetuates a myth or misunderstanding amongst the public that accidents are the result of drug- or alcohol-impaired driving. Referring to drug- or alcohol-impaired driving that causes bodily harm or death as an “accident” implies that the criminal conduct and consequence happened for no apparent reason when, in reality, it was a person’s decision to drive impaired. We ask that the committee consider changing the terminology to “collision” to recognize this fact.

In conclusion, Arrive Alive Drive Sober supports the government’s efforts to create stronger legislation. It is with the help of tough legislation that we have continued to see alcohol-impaired driving incidents and fatalities decrease in Canada. However, effective public education and awareness was also instrumental in reducing those numbers. To combat drug-impaired driving like we have with alcohol, the government must provide ample funding and resources. Additionally, with the legalization of cannabis fast approaching, the government must look to strategic partnerships to create public awareness initiatives, both to educate Canadians about driving high, as well as to educate them on the new consequences outlined in Bill C-46. We would be happy to bring forward our track record in this area to assist you in this endeavour.

Thank you for your time and for the invitation to appear.

The Chair: Thank you very much, Mr. Stewart.

We will now move to Mr. Francescutti.

Dr. Louis Hugo Francescutti (Professor, School of Public Health, University of Alberta, As an Individual): First of all, I'd like say that it's nice to come to Ottawa to see our tax dollars being well spent in renovating a building such as this. It is one of the nicest rooms I have ever appeared in. Good job.

Getting to the bill before us, I don't know why I am here. I checked to make sure I was supposed to be here and I was told I was. What I've tried to do is assemble my 35 years as an emergency physician and as someone who advocates for injury to share with you what I think are the most salient points that I've heard to date and in my preparation for coming here today.

Canada already has one of the highest rates of utilization amongst our young, and they are already driving on our roads. For those of you who are foolishly thinking this problem is going to start in July 2018, the problem is before us right now.

That's why when the CDC takes a look at how we compare internationally with other countries, we don't fare very well. This gentleman, Michael, just alluded to part of the reason. He said these things are called “accidents”. They're not accidents. They're part of a disease process, and that disease is the leading cause of death for Canadians under the age of 45. Under the age of 35, motor vehicle injuries are the leading cause of death in that age group. Between the ages of one and 19, injury is the leading cause of death.

What Canada has is thus an injury problem that's about to be compounded by new legislation that's going to legalize the use of cannabis. What you're going to see is what we've seen in Washington and Colorado. There's going to be an increase in fatalities. There's going to be an increase in young people, especially, trying cannabis. One in six of them is going to become addicted.

Addiction is a disease. It's not a weakness of character. These young addicts—and they are before us today, showing up in our emergency department on a regular basis—are not getting the treatment they need. If we cannot meet the demand today, we are definitely not going to meet the demand in July.

My recommendation is that we stop for a second and say that if Canada is really only the third country starting to dabble in legislation, we could do something that's uniquely Canadian and establish robust datasets that allow us to actually measure the consequences—the human consequences, the financial consequences, the disruption to our health care system and to our justice system—so that we have evidence to base our decisions on.

Right now, you're about to meet an industry, the cannabis industry, that is going to be far more sophisticated than the tobacco industry. They're going to normalize marijuana use, as being good for you. This whole notion of medicinal marijuana has shown you that this is a drug looking for a purpose.

People who want to smoke marijuana can go ahead and smoke marijuana. I think our responsibility as physicians and your responsibility as policy-makers is to get this right. Other countries have not gone down this path for a very good reason. If we choose to go down this path because it's an election promise or we think it's the will of the public, then let's be prepared to put our thinking hats on and actually measure the consequences, because there will be consequences.

We're stuck in old paradigms. Who says that it has to be police officers who administer the sobriety test? If you go to the County of Strathcona in Alberta, I'll tell you, those ladies and gentlemen know how to keep their roads safe. They use peace officers, sheriffs, and a combination of different tools.

I'd like to get to the question and answer period, because I would like to make absolutely sure that the questions on your minds are answered before we leave today. I can tell you right now, however, that anything that takes away from that 1.6 seconds in a vehicle.... When a driver is fully attentive—eyes on the road, hands on the wheel—and sees something and decides what to do and reacts, it takes 1.6 seconds.

We have already passed legislation that says it's okay to use a cellphone hands-free, which is faulty legislation not based on evidence. That's already causing carnage on our roadways. The chief who was sitting here talked about the cumulative effect of marijuana, fatigue, alcohol, other drugs in our vehicles, along with all the distractions. It just makes natural sense that we're going to see an increase in the carnage on our roadways.

Now, the good news is that automated vehicles are coming down the pipeline. Once automated vehicles are on their own, that is truly about the only thing that's going to save us from this carnage. People can smoke as much as they want and do whatever they want in these vehicles. These vehicles will drive themselves, and they will not crash as long as humans keep their hands off the controls.

● (1650)

My advice is this. Let's set up some robust data-measuring systems to truly measure the consequences of what we're unleashing here so that not only Canadians can learn, but provinces can learn, and other countries can learn from our experiment, because this is an experiment in progress.

The Chair: Thank you very much for your testimony.

We're now going to go to questions.

Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you, Mr. Chair, and thank you to the witnesses.

I have a very brief question for Ms. Latimer. I don't believe you touched on mandatory breath testing, in terms of the John Howard Society's position. If you did, I missed it.

Ms. Catherine Latimer: I did not mention it. I should have mentioned it in terms of issues that will be subject to challenge in the litigation process, and that will slow the process and the court process down.

I have less of a difficulty with the mandatory breath testing than the mandatory blood testing challenge, mainly because it's a less intrusive process. When you're actually removing a blood sample from someone, there are a lot of uses to which that blood can be put that might not be strictly connected with sobriety or whatever.

We don't have a very strong position on it, except that we would worry about ensuring that the due process rights of those who are subject to it are protected.

● (1655)

Mr. Michael Cooper: Good. Thank you very much.

I'll now ask a question to Dr....

I'm sorry. How do you pronounce your name?

Dr. Louis Hugo Francescutti: Louis.

Mr. Michael Cooper: Louis. Okay, there we go.

Based on what you're saying, I take it that if you could make a determination as to whether to go down this road or not, we shouldn't go down this road. But now that we are going down this road, you talked about the fact that there are going to be more fatalities, more accidents, and more youth using marijuana. You gave a figure that one in six youths would become addicted to marijuana.

Certainly a number of physicians have come forward to express real concern about youth using marijuana and the impact that has on brain development. I don't know if you're able to speak to that, but on the basis of the impact it has on brain development, the Canadian Medical Association, for example, has recommended that no one under the age of 25 be lawfully able to use marijuana.

Dr. Louis Hugo Francescutti: I like to share stories. Taking the cab in from the airport, I had an older hippie driving me. He said, “What are you up to today?” I said, “I'm going to this committee to talk about marijuana.” He goes, “Holy shit, marijuana. I used to smoke that all the time when I was a younger man, but the other day I was in the garage and the kids were smoking it, and I tried a hit. I took a really big puff and I held it in, and everyone was going, 'Don't do that.'” He found out why, because one simple puff knocked him out for about 45 minutes. It brought out some paranoia feelings that he had inside of him, and he said to the people who gave it to him, “What the heck is this?” The THC content in today's marijuana is nowhere near what it was when you smoked it.

If I were to ask in this room, how many of you have smoked or are currently smoking marijuana, all of a sudden you would see people getting very nervous, but if I were to ask you how many of you are diabetic on insulin, you wouldn't hesitate to show me your latest pen. There's this stigma around marijuana use, and you're absolutely correct. Up to the age of 25, the brain is developing. Any exposure under that age will lower the IQ, lower the ability to reason properly. It will have devastating consequences in the people who are genetically predisposed to have either schizophrenia or psychosis. It will unmask psychosis. We see it in our emergency department on a regular basis.

The other thing is that this magical drug that's supposed to prevent nausea actually causes cyclic vomiting, so people who smoke it in excess end up in our emergency departments for hours upon hours, and they can't stop smoking.

You're absolutely correct. The most important thing, Michael, is that the risk assessment centre in the brain doesn't fully develop until about age 25 to 30, so our most vulnerable population, whether they are in utero or whether they are growing up, are going to be impacted by this. That's why we have to have good data to show how we are going to treat these young men and women when they end up in this situation, because we're not treating them well right now.

Mr. Michael Cooper: Given that the government is intent on going down this road—and I agree with you; I would prefer that we not go down this road—do you have any suggestions in terms of amendments to the bill?

Dr. Louis Hugo Francescutti: I can't talk about this bill specifically, but what I can tell you is that I teach advocacy. The first thing I teach my advocate students is why we need advocates in the first place. Why do we need organizations such as this? If governments were doing their jobs properly and passing the right policy and right legislation, there would be no need for advocates within our society. The fact that we need advocates tells us something is not working.

One of the projects my graduate students did last year was to present to the Government of Alberta what they should do if they're going to go ahead with legalization. Their answer was very simple, that 100% of the revenues generated provincially and federally should be going towards mental health, addiction, and injury, because those dollars are not going to come from anywhere else.

You're going to create the greatest addicts in this country once that revenue starts coming in from cannabis. The treasury department is going to love that revenue. If you put that revenue into general revenue, the people who need it will not see it.

You cannot advertise your way out of this problem, because the bud producers of the world you'll see will have very slick campaigns that are going to try to normalize it. With the very fact that we have Ontario picking age 19 and Alberta picking age 18. I don't care what the other provinces pick. They're all picking them for political reasons. They're not picking them based on science.

● (1700)

Mr. Michael Cooper: Based on science, what would you say the age should be?

Dr. Louis Hugo Francescutti: It should be age 25, at a minimum. With anything less than that, you're not following the evidence. That's if you're going to go down the legalization route.

If you're going to go down it, and it looks as though we are—I'm not for or against it, but I think you can read between my lines—then let's do it properly and put in place the data so that a year from now, or two years from now, we can measure the impact and we can course-correct.

Other countries will be very grateful to Canada for doing that, because Colorado hasn't really done it well and neither has Washington. The reason they don't is that policy-makers don't want to get the bad answers. The way you don't get bad answers is by not collecting the information.

The Chair: Thank you very much. That's your seven minutes.

Mr. Michael Cooper: Thank you.

The Chair: Mr. Boissonnault.

Mr. Randy Boissonnault (Edmonton Centre, Lib.): Thanks, Mr. Chair.

Thank you all for presenting today. I appreciate it.

I'll start with Ms. Latimer. Regarding the Irish experience after mandatory roadside testing, it's important to maybe correct something from your testimony. We're not compelling people to give blood in a mandatory roadside screen. It's Breathalyzer. It's breath; that's the mandatory screen, not blood. I think that's important for the record.

The Irish experience showed a decrease, from 2006 levels to 2015, of 40% in the number of charges laid, because of the sophistication of the roadside testing. That tells me there's less pressure on the Irish criminal justice system now than there was in 2006.

I understand you said there could be charter challenges. We saw that with per se levels in 2008. It's using legal testimony before it has rinsed its way through the system.

We heard from Professor Hogg, who put that through his own screen. He didn't see any grounds on which it would be objectionable from a charter challenge perspective on sections 8, 9, or 10, and we'd be saved by section 1. I wonder if you can tell us specifically where you think there would be a charter challenge.

Ms. Catherine Latimer: I read with interest the Canadian Bar Association's brief on this, when they indicated that they thought there would be charter issues raised. I feel that they are absolutely correct. The reason is that this set of people who get caught tend not to be the disenfranchised group. You're dealing with people who can afford non-legal aid lawyers, and they will challenge these issues. It's a big hit for them, the mandatory minimums, the whole thing.

The alcohol-impaired driving issues are an area of law that is really intensely litigated. It will be litigated to try to figure out what these individual elements mean. If you're moving from over point whatever it is, to this and above, that is going to be litigated. Lawyers are going to try to figure out what that means. They're going to bring it to the courts. They're going to ask for rulings, and it's going to slow the process down.

Going back to the Irish experience, I'm not familiar with what has transpired in Ireland. However, if you're actually looking at changing behaviour, I'm not a big fan of deterrents, but when you have two lawful activities such as driving and drinking and it is the intersection, you have two basically law-abiding groups of people who don't want to get caught in that intersection.

It's a slightly different group that can be influenced here by both public awareness, and maybe by deterrents, but most effectively the likelihood or the perception that they're going to get stopped and that enforcement will hit them.

Mr. Randy Boissonnault: Thank you very much. I need to move on.

Ms. Catherine Latimer: Okay.

Mr. Randy Boissonnault: Mr. Stewart, I appreciate your testimony. I want to ask you a question and then see whether you're aware of a move that our government has made in recent weeks.

Is it the opinion of your organization that mandatory roadside screening will reduce impaired driving offences and help police catch more people who are offending?

Mr. Michael Stewart: Mandatory breath testing has been brought up in our membership meetings before. We're of the belief that if the mandatory breath testing can survive a charter challenge, then we would fully support it. We're not experts on the law and on how it would deter people, but whatever steps the government can put in place to help prevent people from impaired driving and deter them, we fully support.

Mr. Randy Boissonnault: Based on the conversations with your members, would a mandatory roadside screen deter them from getting behind the wheel drunk?

● (1705)

Mr. Michael Stewart: Not that I am aware of. I would defer that question to Ms. Leonard to see whether she is able to—

Mr. Randy Boissonnault: It's over to you, Anne.

Mr. Michael Stewart: That's why I brought her.

Ms. Anne Leonard (President, Arrive Alive DRIVE SOBER): It's age before beauty, or something.

It was actually termed “random breath testing” when we discussed it at a general meeting in October 2013. Our membership is Ontario Students Against Impaired Driving, Traffic Injury Research Foundation, police services, health units—it's pretty big. In general, they would support it, whether you call it mandatory breath testing or—

Mr. Randy Boissonnault: Or random....

Ms. Anne Leonard: —whatever. I believe they would support it. Their concerns were that it might not survive a charter challenge and would lead to court backlogs.

Mr. Randy Boissonnault: Did you have a similar conversation about interlock devices? Do your members think that would keep people off the road?

Ms. Anne Leonard: Yes. Our membership discusses everything. We discussed interlock devices way back when Ontario brought in their original legislation, in 1999 or so. I think it took effect late in 2001 or 2002.

All of those measures—Back On Track, the reinstatement programs—are very expensive, and their burden is mostly on the driver, which we agree with. We have seen them all create more deterrence for drivers. One impaired driving charge, in Ontario specifically, will cost you at least $22,000 or $23,000 dollars, making your high-priced lawyers seem quite reasonable.

We fully supported ignition interlock for repeat offenders and for first-time offenders, and the Back On Track program.

Mr. Randy Boissonnault: Thanks, Anne. I need to stop you there. I have a question for Louis.

Before I get there, Michael, the government two weeks ago announced $274 million for providing the devices for police, capacity-building training, and a robust public awareness campaign. Make sure your organization knows where to apply for that funding through Health Canada so that you can be part of this, because it is important.

Louis, I have questions before I run out of time. Thank you for being here, as a fellow Albertan.

Where would these robust datasets reside?

Please continue to push your advocates to tell the provinces what you told us, which is to make sure that the money goes to the people who need it and to do a better job of what we're not doing already, because that will be a provincial decision in the fed-prov jurisdictional lines.

My question to you is this. In your career of getting people to focus behind the wheel, what works, from a deterrence perspective?

Dr. Louis Hugo Francescutti: That question is the easiest one. The perception of getting caught changes people's driving behaviour.

Engineering will always give you your greatest returns. Our vehicles today, driven at around 70 or 80 kilometres an hour, can crash, and everyone will pretty well survive in them. Engineering, then, is the first. The threat of enforcement is the next one. Education is the least effective.

Although what you just said sounds like a lot of money, it's not much money in terms of advertising to change a campaign against people who are going to be using probably 60 times that amount of money to get their message across.

If you want to reduce injuries, look for engineering first. The threat of or perception of enforcement is next. The last one is education.

Mr. Randy Boissonnault: Where would the robust datasets reside?

Dr. Louis Hugo Francescutti: The robust datasets should reside with groups that have the expertise right now. There are many national organizations across the country that have special interest in this. I would form a consortium for them and have them apply for the funding. The funding would be given out year by year based on performance.

I would not create a new government ministry. That is the last place I would put it, because then you have the wrong people watching what's going on.

The other thing I want to mention, if I may, is to take a look at today's *Globe and Mail*. There's a whole section on the WE organization, which mobilizes young people across the country. I would definitely have them involved, because those are your youth leaders. Youth listen to youth; they don't listen to us guys.

The Chair: Mr. Rankin.

Mr. Murray Rankin: Your last comment was really interesting, Dr. Francescutti. I'm a bit concerned when you talk about the datasets residing elsewhere than with government. I'm a big believer in your fundamental point, I think, which is that we need to have robust datasets so that we can manage the consequences, if we're going to have an evidence-based approach to all of this.

We have still, if I'm not mistaken, the Canadian Centre for Justice Statistics and the ability for researchers to get, from one vault, all the research evidence they need. I would want to be sure we didn't have it distributed too far afield, but rather held with full access rights for individuals.

Wouldn't that be a model we ought to consider? Would it be something you would recommend we actually put into the statute itself—the need to have a repository somewhere for these datasets that you speak of?

● (1710)

Dr. Louis Hugo Francescutti: The chief mentioned that we have, I think he said, “a wicked problem” in front of us. We're also on the verge of artificial intelligence. We have the capability today to link many different datasets and actually look for answers within those datasets. I'm not married to one model or another—you have more expertise than I in that area—but it has to reside somewhere where it's safe, has timely access, and is capable of feeding the information back to policy-makers, politicians, advocacy groups, and the public as well.

If things aren't working, then you have to course-correct. Usually, nimble organizations are not referred to as government organizations. That's why we're saying it should be linked somewhere outside, so that you have the ability to be more nimble.

Mr. Murray Rankin: Perhaps it could be co-managed, with university research teams and a government agency that has the statutory responsibility for maintaining it.

Dr. Louis Hugo Francescutti: That's an excellent idea.

Mr. Murray Rankin: I think you make an excellent point there.

I want to go back to Ms. Latimer of the John Howard Society and build on something that my colleague Mr. Boissonnault was asking you about.

It's pretty obvious that if there's going to be mandatory alcohol screening, we're going to have charter challenges. I'm playing devil's advocate here. If the benefits are so significant, as we've seen in getting people off the road and in fact reducing the number of people who are charged because of the deterrence effect, which we heard is the Irish experience—Mothers against Drunk Drivers told us that—so what if there's a charter challenge or two or three?

That's what happens all the time with criminal justice reform. Once we have those challenges under our belt, then we'll have an understanding of what the law is and we move on and save lives. What's wrong with that?

Ms. Catherine Latimer: I think there's nothing wrong with the challenge per se. I think there would be something unfortunate if the challenge were successful and it was found out that the framework and all the education of the enforcement officers was premised on something that didn't hold up against the constitutional challenge.

If you have something that looks like a prima facie breach of a guaranteed right, you have to justify it under section 1, which means that's where you would bring forward your evidence about the social benefits you would expect to see flow, and what other countries have done, and one thing or another.

You could try to make a section 1 case, but I think it's important to do it and to tend to the evidence and really address some of these charter issues before you pass the legislation.

Mr. Murray Rankin: The evidence we received from Professor Hogg was that yes, we would have a section 1 balancing test, but it was his evidence and his prediction that the courts would be sympathetic to the societal benefits we would be achieving. Even though there would be some impairment of rights, it would be justified.

That's the way the test works. That's what his prediction was. I take your point that it may not be what actually occurs. Isn't the benefit, however, significantly bigger than the burden, the benefit much better than the risk that you're talking about, to take a chance for the safety of Canadians?

Ms. Catherine Latimer: I think you could certainly advance your section 1 argument. If you're asking me what my personal opinion is, I'd like to take a look at the section 1 evidence that's being tendered. I'm not aware of it. When you start to go down a slippery slope to say that the social objective justifies the erosion of people's rights.... This is a big issue for us. This is a—

Mr. Murray Rankin: It's nothing new. It happens in every charter case that arises.

I just want to ask you about what you seem to be suggesting, that because you have a resistance to breath tests and blood tests, if I'm understanding you properly, you challenge the notion of a drug blood-based impairment test, and you talked about field sobriety tests and so forth.

Is it the very fact of the breath or blood test that causes you concern, or is it the fact that maybe we don't catch enough or we catch too many people? I wonder whether you could speak a little bit more about your concerns, because I think this is the first time I've heard that set of concerns expressed before this committee.

Ms. Catherine Latimer: What I understand is that among people who are acclimatized and use a lot of marijuana, the level of impairment is considerably less than that of people who are occasional users. People whose bodies have not adjusted to this use of marijuana would be more impaired with a lesser density of the drug in their system.

You're getting, then, a bit of a perverse kind of result, if you're solely relying on the amount of this drug in your bloodstream. Sure, maybe people should not be driving after they've been smoking at all, but the issue is whether they're driving impaired, and the blood test per se may not give you a fair testing of whether or not they're impaired. I think you need a better test to test whether or not they're impaired.

● (1715)

Mr. Murray Rankin: Do you mean to say, then, that you would like a test, if the technology isn't adequate and it may be that we're catching people who aren't in fact impaired...? Is there a danger of throwing the baby out with the bathwater, to use that horrible expression here? Isn't the objective to protect society from people who are going to cause death?

Ms. Catherine Latimer: Absolutely, and I'm not saying there should be no test. I'm saying that there should be a test that is an accurate test of impairment—something that tests perception, reflexes, things such as that.

Mr. Murray Rankin: It may be a poor proxy, but it's better than nothing. The evidence we've heard is that the field sobriety tests are also, particularly for cannabis, not particularly effective. We have to do something. Maybe it's a poor proxy, but isn't it far better than nothing? What's the alternative? Is it on field sobriety tests that we would land as the only thing we would do?

Ms. Catherine Latimer: I think the world of technology is such that you could have a program that tests how quickly people respond to stimulus, how quickly they...just by hitting a computer screen. How long does it take you to hit the button after something flashes yellow? If you're impaired with marijuana, is there a delayed reaction? Then you're talking about real impairment, not just levels of substance in the bloodstream.

The Chair: Thank you very much.

Mr. Ehsassi.

Mr. Ali Ehsassi (Willowdale, Lib.): Let me start off my questioning with Mr. Stewart. First of all, I'd like to congratulate you for all the great work that your organization does, Arrive Alive.

My question is this. In your testimony you refer to the experience in both Colorado and Washington. I assume you're familiar with the way they approached impaired driving. In your opinion, what did they get wrong? What are the lessons that we're supposed to draw, given that they did it a few years earlier than we are doing?

Mr. Michael Stewart: From what we've heard from our colleagues down there.... We had a speaker at our conference last year who was from Washington state. He was a police officer there and was in the governor's office in charge of highway traffic safety.

One thing he spoke to—and we've heard it from Colorado as well—was, if they could go back in time and fix what they did, to have a robust education program in place. They've all agreed that this is where they dropped the ball. They did not have education in place in time for legalization. They did education afterwards, and because of that, they saw increases in their drug-impaired driving incidents and fatalities.

What we would urge the government in Canada to do is to have a robust education plan in place not the day before July 1, 2018, but preferably by the end of this year, if they could, just to have as many months as possible before the July 1 date to make Canadians aware of the dangers of combining drugs and driving.

Mr. Ali Ehsassi: Great.

In your opinion, then, knowing what their experience was and also knowing about the package that the government put together for capacity building amongst officers, for raising public awareness, for bolstering research, do you think we're headed in the right direction and that this was a responsible approach?

Mr. Michael Stewart: I think that giving as much money as the government can to this situation is good. The number, as you stated earlier, was $270 million, give or take maybe a million or two. Obviously, we would prefer that number to be higher, but that is a good start, and it's good that the government has made the commitment.

We would just ask that the government accelerate their pace. It's one thing to make the promise of investing all this money into education and enforcement, but it's also important to reiterate that all this should be in place and ready for the July 1 date.

Mr. Ali Ehsassi: Also, this committee received a letter from the United States in which the Attorney General and the Governor of Colorado said that by investing more money in training police officers they have now seen a decline in 2017 from 2016, which essentially explains the package we put together.

Thank you for that.

Mr. Michael Stewart: Thank you.

Mr. Ali Ehsassi: Now let me ask Dr. Francescutti a question.

I'm quite intrigued by your idea of having robust datasets. Are you aware of any other public policy challenge for which a government was concerned about how to deal with something effectively and resorted to using robust datasets?

● (1720)

Dr. Louis Hugo Francescutti: Yes. Canada actually has a very proud record with its CHIRP program, the Canadian hospital injury reporting and prevention program. It's a rather unique program that was instituted in partnership with children's hospitals measuring childhood injury. Canada does have a track record, then, of doing something like that.

The trouble with this one is that this is a field that's changing very rapidly. You have to have multiple datasets that are going to be analyzed, and humans will not be able to do it. You're going to need artificial intelligence. This is an opportunity to partner with IBM Watson, which is in Canada and is looking for projects. Also DeepMind, at the University of Alberta, has just been granted permission to work with the DeepMind folks in the U.K. in solving problems that seem unsolvable.

I would do something, then, using the latest technology, which we're not even talking about, which is artificial intelligence.

Mr. Ali Ehsassi: Okay.

Are you aware of any other examples in other countries in which they have tackled public policy issues?

Dr. Louis Hugo Francescutti: Yes, the CDC in Atlanta has developed a program called WISQARS. WISQARS is a database that looks at injuries within the United States, broken down by county. It provides a lot of information.

This problem, however, is so unique that you can't design a system on our old way of thinking. You need a new way of thinking, with either DeepMind, or artificial intelligence, or IBM Watson, to solve this problem, because it's going to be very fluid.

Let me just make sure the committee understands. You will not be able to educate your way out of this problem. You're going to spend an enormous amount of money and you're never going to reach the tipping point at which it's going to make a difference. It is going to be similar to Nancy Reagan's "Just Say No" campaign, which makes you feel good but has absolutely no impact whatsoever.

Mr. Ali Ehsassi: I've noted that this is the second time you have highlighted your misgivings about educational campaigns. Where does that come from, what experience?

Dr. Louis Hugo Francescutti: It comes from the evidence. If we were to do things based on the evidence, education campaigns in public health have usually failed very miserably.

The best example I can give you is from when AIDS first came out in the 1980s. In Australia they came out with a clever campaign of a bowler, who was the Grim Reaper, throwing a bowling ball down a lane and knocking all these people over. What happened was that it had no impact on AIDS, but people stopped bowling.

The Chair: That's pretty scary. Thank you very much, Mr. Ehsassi.

Are there short questions from any members of the panel for any of these witnesses?

If not, I want to thank each and every one of you for having come before us today. It is enormously appreciated.

We're going to take a short recess while we change panels.

● (1720)

(Pause)

● (1730)

The Chair: It is a pleasure to reconvene with our third panel of the day.

I would like to welcome, from the Canadian Society of Forensic Science, Ms. Rachelle Wallage, who is the chair of the drugs and driving committee.

From the Canadian Safe Boating Council, we have Mr. John Gullick, who is the chair and Mr. Michael Vollmer, who is the vice-chair.

By video conference, we should have Professor Barry Watson, who is an adjunct professor in the faculty of health of the Queensland University of Technology, in Brisbane, Australia. Professor Watson is in the process of connecting. He will be the last witness of the panel.

We will start with you, Ms. Wallage. The floor is yours.

Ms. Rachelle Wallage (Chair, Drugs and Driving Committee, Canadian Society of Forensic Science): Good evening. I want to thank you for this opportunity to speak on behalf of the drugs and driving committee, or DDC, of the Canadian Society of Forensic Science. I will take the time I'm allotted to introduce myself, tell you about the DDC, explain our process and our role, and give some background information, and I hope to clarify any scientific questions regarding the proposed new provisions.

My name is Rachelle Wallage. I'm a forensic toxicologist. I work at the Centre of Forensic Sciences in Toronto, where I have been employed for 17 years.

The Centre of Forensic Sciences is a provincial laboratory that functions both as a coroner's lab and as a crime lab. The predominant role of a forensic toxicologist is to provide expertise on drugs, including alcohol, and interpret concentrations as detected through analysis performed by the toxicology section.

This interpretation of prescription, over-the-counter, and recreational drugs can include concentrations that are subtherapeutic, therapeutic, recreational, toxic, or fatal in the context of many different types of cases, as well as opinions offered regarding impairment. All of these interpretations come with further explanation of what the terminology means or implies, the exceptions to the interpretation, or conditions that make it more or less likely. This frequently culminates in testimony provided to courts or coroner's inquests.

To put into context our court responsibilities, here are some examples.

I have testified five times in one workweek on different cases. I have colleagues who have testified twice in one day in two separate courthouses. Furthermore, it's not unusual to have anywhere from three to five days in a week scheduled for court appearances throughout the province. My shortest testimony I estimate as approximately four minutes, and my longest as four days. Court is like a box of chocolates; you never know what you're going to get.

I fully realize that not all laboratories are this busy, but this is the reality for many of us. With the opioid epidemic that is currently happening, the legalization of cannabis, and the extensive changes being proposed for the Criminal Code of Canada, I would be remiss if I didn't take this opportunity to address the pressure on the laboratories. The lab systems cannot continue to absorb the escalation of submissions for analysis, court appearances, and the need for technical expertise, especially in a time where there is an increased emphasis on timely trials.

Additionally, I am the chair of the drugs and driving committee. The role of the DDC is to advise the Department of Justice on issues related to drug-impaired driving. Obviously this is no easy task, considering the hundreds of impairing drugs that are available, each of which has associated complexities. When it comes to analysis, interpretation, and predictability, alcohol is the exception rather than the rule in its simplicity.

The DDC is comprised of six scientists in the field of drug-impaired driving, predominantly from the forensic laboratory systems across Canada. The DDC is a volunteer committee. We have demanding careers outside of our role on the committee, so our time is limited, and the DDC work generally occurs on weekends, on vacation days, and in any spare time we can muster that would otherwise be well spent decompressing from a hectic workday.

We are a committee comprising individuals from across the country, and in-person meetings generally occur once a year. Funding of this committee is a rate-limiting factor. The Department of Justice provides a grant, which is shared between the Canadian Society of Forensic Science, the alcohol test committee, and the drugs and driving committee. There has been a dramatic increase on the demands for our time and knowledge, and the funding is not sufficient.

The alcohol test committee has 10 members and we are at six, and I would make the argument that we, too, should be at least 10. The concern becomes that if we are 10, the yearly DDC allotment will not be sufficient to cover the cost of travel, accommodation, and meal allowances for everyone for one meeting per year, which I would also argue is insufficient at this time. There are other branches of the government that currently see the value in our expertise, and it's time to re-examine investing in the future of the DDC.

Of particular interest in the last few years has been the use of per se limits for drugs other than alcohol. Some countries and states have moved toward this approach. The DDC was asked to turn our collective expertise to the idea of per se limits or a zero tolerance approach to certain drugs.

This process started years ago, when we formulated a long list of drugs that were of particular concern to the safety of our roads. Research was conducted into each of these drugs, and the feasibility of establishing a limit was assessed. Factors that were considered included the potential for tolerance to develop with regular use; whether the drug was available by prescription, over the counter, or for recreational use; residual concentrations; and the prevalence of use in the population.

● (1735)

From that list, a short list was created. Further research was conducted and discussion occurred. The ultimate report outlines a per se approach for four drugs and a zero tolerance approach for five drugs. The factors that were considered when coming to the ultimate decision included analytical, storage, and stability issues; pharmacological properties; established per se levels elsewhere; the inevitable time delay to sample collection; and a lack of an acceptable back extrapolation formula for drugs other than alcohol.

To briefly explain back extrapolation or calculation, this means that for alcohol, the time between sample collection and incident can be accounted for, and a blood alcohol concentration at the time of the incident can be provided. There is no established formula for any other drug to offer a concentration at the time of the incident; therefore, the concentration detected in the sample, generally reflective of the time of sample collection unless the drug breaks down in the test tube, will be the only available information regarding the level.

There was also a request for the DDC to assess drug screening equipment, namely, oral fluid drug-screening devices. These are devices that can be used to indicate drug use. The DDC is currently looking into screeners that detect THC, cocaine, and methamphetamine. Evaluation standards are an ongoing process. Once they are set, the manufacturers will submit the devices for evaluation. The DDC will then review the data, make the final assessment, and provide recommendations for the drug-screening equipment approval list. Services that choose to purchase these devices will then have to train their officers on their use.

I will now define some terms.

"Impairment" is a decreased ability to perform a certain task, a deviation from the norm, so that if you test an individual in a drug-free state and then dose that individual with a particular drug, impairment would be present in the individual when they demonstrated performance decrements in a particular measurement. This can be differentiated from intoxication, which would be the physical signs of drug administration, such as difficulty with balance and walking.

Impairment is described by the faculties affected by the drug. Examples of such are divided attention, vigilance, reaction time, and decision-making. An individual does not need to be experiencing gross motor incoordination to be deemed impaired. Obviously, an individual experiencing those pronounced drug effects is impaired, but an individual can also be impaired without the overt symptomology.

I would like to thank the members of the DDC for their time, the sharing of their knowledge, and their dedication. I would also like to thank the Centre of Forensic Sciences librarians for their ability to jump into action as soon as I needed yet another publication.

Furthermore, I want to thank my colleagues, as the whole is greater than the sum of its parts. Also, it has been a pleasure to work with the Department of Justice counsel and crown attorneys from across Canada, where I've learned that a roomful of lawyers is just as much fun as a roomful of toxicologists.

Voices: Oh, oh!

• (1740)

The Chair: What about a roomful of parliamentarians?

Ms. Rachelle Wallage: Yes, the same.

The Chair: Thank you very much, Ms. Wallage.

We're now going to the Canadian Safe Boating Council

I will turn to you, Mr. Gullick and Mr. Vollmer, for your presentation. I believe you have a PowerPoint presentation.

Mr. John Gullick (Chair, Canadian Safe Boating Council): That's correct.

Thank you very much to the chair and the committee for inviting us to sit before you today. We're now going to take the focus away from our roads to our waterways.

I'm going to take a few minutes to talk a bit about our organization and who we are, so that you have an understanding. We're a national organization. Directors and members come from coast to coast to coast. We have 20 directors, with me and an executive committee. We're run by volunteers. We have no ongoing paid staff and no ongoing government funding support, and we've been established for over 25 years.

Our mission is to reduce the incidence of deaths that occur as a result of boating activities; to cultivate partnerships with government, water safety organizations, and the boating industry; and to partner to provide significant boating safety outreach to various boating communities across Canada.

As for what we do, we offer safe boating campaigns. We conduct research. We have a number of boating safety resources. We carry out cold-water training. We offer the Canadian safe boating awards to recognize the efforts of others. We conduct an annual symposium. We conduct international and government liaisons with organizations such as the U.S. National Safe Boating Council, which would include the International Lifejacket Wear Principles agreement, and also with the national recreational boating advisory council and the Canadian marine advisory council.

I'd like to say in starting that we support the amendments in Bill C-46. We're in strong support of the amendments in the bill, and we also believe that the bill should reflect the consequences of the operation of all modes of transportation while under the influence of alcohol and/or drugs.

We have a recommended change to the current proposed amendments. In proposed section 320.11 currently, the definition of vessel "includes a hovercraft, but does not include a vessel that is propelled exclusively by means of muscular power" or human power. The Canadian Safe Boating Council's proposed change to the definition of vessel is taken from the Canada Shipping Act, 2001:

> vessel means a boat, ship or craft designed, used or capable of being used solely or partly for navigation in, on, through or immediately above water, without regard to method or lack of propulsion, and includes such a vessel that is under construction. It does not include a floating object of a prescribed class.

Really, in simple terms, this is the change we're requesting: the consideration that muscular-powered or human-powered vessels not be excluded under the definition of vessel. In the Canada Shipping Act, just to point this out, some of its objectives are to "protect the health and well-being" of individuals who participate in marine transportation, to "promote safety in marine transportation and recreational boating", and to "encourage the harmonization of marine practices".

Here are some statistics from the Canadian Red Cross on recreational and daily living boating immersion deaths by type of craft, by alcohol involvement, for victims of 15 years of age or older in Canada through the 20-year period from 1991 to 2010. The total number of boating deaths is 3,324. The total number of boating deaths with alcohol suspected or involved is 1,066, or 32%. For all powered vessels, it's 611, with alcohol involved or suspected in 18%. For all unpowered vessels—so this would be muscular-powered vessels, human-powered vessels—it's 375, with alcohol involved or suspected in 11%. Then there is the unknown type of vessels at 80, with alcohol involved or suspected in 3%.

According to a 2016 economic impact study by the National Marine Manufacturers Association, the NMMA, about 43% of Canadians, or 12.4 million, go boating each year. There are about 8.6 million boats in use in Canada. About 60% of those boats are human-powered vessels, such as canoes, kayaks, stand-up paddleboards, etc.

For our conclusion and our recommendation, we at the CSBC believe that the definition of a vessel in Bill C-46 should include all vessels, even those that are exclusively muscle powered, and be consistent with the definition used in the Canada Shipping Act, 2001.

We are encouraged by the preamble of Bill C-46, which states that dangerous and impaired driving "are unacceptable at all times and in all circumstances". As this is intended to modernize the statute to better reflect current impairment issues, societal changes to boating activities should also be considered.

• (1745)

Incidents involving powered vessels often include other vessels and others in boats. In the case of muscle-powered vessels or human-powered vessels, these incidents also involve the lives of others in the boats, the rescuers, and the consequences experienced by family members and the systems that support them. One just has to look at the statistics to see that we have a very high number of incidents involving alcohol in both powered vessels and muscular- or human-powered vessels.

I offer my thanks and will see if Michael has anything to add.

Mr. Michael Vollmer (Vice-Chair, Canadian Safe Boating Council): I'd like to give you a graphic example from this spring with respect to human-powered craft and the risks involved.

This occurred on the Muskoka River near Bracebridge. A father and an eight-year-old were out paddling. The father is alleged to have been impaired. The canoe rolled over. The child was swept over high falls and killed...an eight-year-old, sitting in that pointy end of the canoe. The father was charged with impaired operation of a vessel causing death and operating a vessel with blood alcohol of over 80 milligrams causing death. That would be eliminated under the proposed change here.

When you look at 60% of the boats in Canada being these.... As shown in a survey done of some 3,291 cottagers on the Muskoka Lakes, paddle-boards are increasing from 16% of the fleet to 42% of the fleet. These are the stand-up paddle-boards. Kayaks increased by 10% between 2013 and 2017. All you have to do is drive down the street and look at the roofs of cars; they all have canoes, kayaks, and paddle-boards on them.

We have worked very hard as a group at the Safe Boating Council. We run a safe boating awareness week. We generate about 170 million impressions a year for about $300,000, which is an incredible ad buy, and one of our messages is “Don't drink in a boat”. We're going to change that to “Don't drink and don't smoke dope in a boat”. There are all of these things: “Wear your life jackets” and “Take a boating course”.

Fundamentally, we need the law to back up our position, and changing this definition is a very difficult concept, I'm afraid, from our point of view, so please consider this. It's in the law now, it works now, and we need it from the boating community's point of view.

Thank you.

The Chair: Thank you very much for your very clear presentation. It's much appreciated.

We are now joined by Professor Watson, straight from Brisbane, I believe.

Thank you so much for joining us. It's a real pleasure to have a true Aussie amongst us. We look forward to hearing your presentation. The floor is yours.

Dr. Barry Watson (Adjunct Professor, Faculty of Health, Queensland University of Technology, As an Individual): Thank you.

Good morning from Brisbane, Australia. I would like to thank the committee for the opportunity to speak to you today about Australia's approach to reducing alcohol-related road crashes. I hope this will assist you in your deliberations relating to Bill C-46.

Over the last 30 years, there has been a substantial reduction in alcohol-related road fatalities in Australia, as well as a major shift in community attitudes relating to drink driving. Today I would like to give you a brief overview of the various countermeasures that have contributed to these changes.

To set the scene, this graph shows the long-term trend in the percentage of drivers and motorcycle riders killed in Australia with a blood alcohol concentration of .05 grams per 100 millilitres or more, which is the general alcohol limit across the country. As can be seen, Australia experienced a major decline in alcohol-related fatalities during the 1980s and 1990s, similar to many other motorized countries around the world, including Canada. While the number of fatalities plateaued during the early 2000s, there has been a renewed decline since 2008. This long-term reduction in alcohol-related fatalities is one of the major road safety success stories in Australia, and has involved the introduction of a range of countermeasures.

Moving to the next slide, I would like to summarize the evolution of drink driving countermeasures in Australia. This list is not meant to be exhaustive, and I've kept the time frames relatively broad, since the countermeasures were implemented at different times across our states and territories. The foundation for our approach was laid in the late 1960s and early 1970s, when all the states adopted per se drink driving laws. During the 1980s, this approach was strengthened by the lowering of our general alcohol limit from .08 to .05, and by introducing random breath testing, or RBT, and mandatory penalties for drink driving, including licence disqualification for all offenders.

During the 1990s there were further refinements, with the introduction of a zero alcohol limit for learner, provisional, and professional drivers, and ongoing strengthening of penalties. While most states introduced some form of rehabilitation for offenders during the period, it remains voluntary in some states. Since the early 2000s, most of the Australian states have introduced alcohol ignition interlocks and vehicle impoundment for high-range and/or repeat offenders.

To illustrate the impact of these countermeasures, I would like to present a case study from my home state of Queensland. We commenced breath testing in the late 1960s, and moved to a .05 alcohol limit in 1982. However, we delayed introducing random breath testing, despite its widespread adoption in other states, due to the perceived civil liberty concerns on the part of the then Queensland state government. Instead, the government introduced a weaker form of breath testing in 1996, called “reduce impaired driving”, or RID. This program was similar to the sobriety checkpoints currently relied on in many countries. The police could randomly pull over drivers, but could only breath test those they suspected of drinking. Finally, after mounting pressure from road safety advocates and encouraging evaluations from other states, the Queensland government introduced full-blown random breath testing in 1988, which enabled the police to pull over drivers at any time or place and request a breath test. These changes were each supported by the strengthening of penalties and extensive public education.

To illustrate the effects of these initiatives, this graph compares alcohol-related fatalities in the time periods following the introduction of each of the key countermeasures. As can be seen, the introduction of the .05 limit, RID, and random breath testing were all associated with stepwise reductions in the number of alcohol-related driver and rider fatalities, all of which were significant and consistent with other evaluations. The data indicated that the introduction of .05 was associated with a 12% decline in alcohol-related fatalities, while the introduction of random breath testing was associated with a further 18% decline in fatalities over and above what was the case when the sobriety checkpoint program was in place.

The next slide leads me to tell you a little bit more about random breath testing, since it is the primary drink driving law enforcement tool used throughout Australia. As already mentioned, the legislation underpinning random breath testing allows the police to pull over and breath test drivers at any time, irrespective of whether or not they suspect that they've been drinking. The majority of RBT operations across Australia are conducted in a highly visible stationary mode, using either large buses, colloquially known as “booze buses”, or marked police cars. While these operations are designed to catch drink drivers, the key goal is to promote general deterrence through their highly visible nature.

● (1750)

Over the years, RBT has been supported by extensive mass media advertising, and various evaluations have confirmed that it has produced long-term reductions in alcohol-related crashes. Importantly, there is also very strong community support for RBT, with a recent survey showing 98% approval nationally for the countermeasure.

Here are some photos of different types of RBT operations. In the top left, you can see a booze bus parked on the side of the road. Depending on the traffic volumes, the police will either pull over every driver that passes by or randomly select vehicles from the traffic stream to administer a preliminary breath test. This process is relatively quick, with drivers only detained for a minute or two. However, if the driver fails the preliminary breath test, that driver is then required to undertake an evidentiary test in the bus.

On the right and bottom left are examples of car-based RBT operations. In this mode, drivers who fail the preliminary breath test are transported to a police station to undertake the evidentiary breath test.

As already noted, considerable police resources are devoted to RBT, with many states conducting the equivalent of one breath test per licensed driver every year. In a state like Queensland, where we have over three million drivers, that means over three million breath tests are performed each year.

As a result, exposure to RBT has steadily increased over time and now is very high across the country. As shown in this graph, around 80% of drivers surveyed nationally now report having seen RBT in the last six months. More particularly, over one-third of those surveyed report having actually been breath tested in the last six months.

To conclude, over the last 30 years, Australia has experienced a major decline in drink driving fatalities. However, challenges remain. Alcohol remains a significant factor in around 20% of our driver and rider fatalities. Recidivist drink drivers remain a concern, as they are overrepresented in offences and crashes. The uptake of alcohol ignition interlocks and rehabilitation programs remains relatively low in some states.

Lastly, as will be explained further in a later session by another of my Australian colleagues, Assistant Commissioner Doug Fryer, all the Australian states and territories have now introduced random roadside drug testing based on the RBT model. This has inevitably created competition for scarce police resources, and it highlights the need to strike a balance between the amount of testing performed to detect alcohol versus other drugs. Given that research continues to show drink driving as being riskier than drug driving alone, it is essential that current breath testing levels are not compromised in order to conduct more roadside drug tests.

● (1755)

The Chair: Thank you very much, Professor Watson. It is much appreciated.

Since you can't see us, I'll let you know that now you and the different panel members will be getting questions from each of the different parties on the committee.

We are going to start with Mr. Cooper.

Mr Cooper, the floor is yours.

Mr. Michael Cooper: Thank you, Mr. Chair.

Thank you to the witnesses.

I want to start out with Ms. Wallage regarding per se limits. I have reviewed the “Report on Drug Per Se Limits” issued by the Canadian Society of Forensic Science in September 2017.

The very first line of the executive summary notes that "a drug per se limit does not imply all drivers below this limit are not impaired and all drivers above this limit are impaired." There really is a question about the correlation between impairment and THC levels. I found it troubling or concerning, at least, to see what a study that's cited here found when comparing chronic users with occasional users. The 11 individuals who were occasional users didn't register really any THC levels immediately after they started smoking, and they were basically under one nanogram eight hours later. By contrast, of the chronic users, one was at five nanograms before he even began to smoke marijuana, and "3 of the chronic users had THC blood concentrations of 2 ng/mL or greater 8 hours after smoking". Another study cited found that nine of 21 regular users had five nanograms or more at least 24 hours after they had last used marijuana.

I'd just like you to comment on that because it's a real concern to me that if we're going to establish a per se limit, there has to be, surely, a correlation with impairment. Otherwise, what we have is an arbitrary limit.

Ms. Rachelle Wallage: Okay, just to put this in context, you're citing the report we wrote, in which we tried our best to flush out all of the issues with respect to cannabis and driving, as well as the other drugs. I will say that cannabis is not a simple drug. There are a variety of considerations with respect to different types of users, different types of use, and effects in the body.

That whole paragraph was about chronic users, so people who routinely administer a cannabis product. Predominately this was about smoking or the inhalation route, because there is obviously another route, which is the edibles, as people do consume it as well, and that comes with a whole different interpretation.

With respect to this, THC, which is the parent ingredient, the primary psychoactive ingredient in cannabis products—and I'll just use the short form, because I'm assuming we're all familiar with the short form—is a lipid-loving drug, which means it goes into fatty tissues. If you are an occasional user, then inhalation will result in a THC concentration rapidly rising and rapidly declining in a blood sample and then it being redistributed to all the fatty tissues, including the brain, and that's where it has its effects.

In a habitual user, so someone who uses on a daily basis or multiple times a day, this THC will then redistribute through the same mechanism. The THC concentration rapidly escalates or rapidly declines in a blood sample and it then goes into the fatty tissues. But in a chronic user, the THC will accumulate in the fatty tissues. In an occasional user, the THC concentration in the blood will decline to an undetectable level, whereas in somebody who repeatedly administers this drug via smoking and then for a period of time, for experimental purposes, stops using the drug, there tends to be residual levels of THC in their bloodstream.

● (1800)

Mr. Michael Cooper: In some cases amongst chronic users, at least in the case of the studies, there are rather high THC levels 24 hours or eight hours after the fact. I note that your report says that with regard to these per se limits, the detection of THC would be well beyond the period during which they would be expected to experience acute intoxication. Later, it refers to zero to six hours after smoking cannabis as the time period in which there is really an acute concern about impairment. Is that correct?

Ms. Rachelle Wallage: For smoking, that's correct.

Mr. Michael Cooper: Okay.

A witness who appeared last week raised a number of concerns about per se limits, and it was his evidence that drivers testing below five nanograms per millilitre of THC can be just as impaired as those testing above five nanograms. Would you agree with that observation?

Ms. Rachelle Wallage: I would agree with the point that a person can be impaired below a concentration of five nanograms per millilitre. They can be impaired at a concentration of one nanogram per millilitre. Directly correlating a concentration to impairment is very difficult. With respect to impairment and THC, there are a number of factors that toxicologists consider. You consider the route of administration and that will tell you something about how quickly it could come on and how long it will last, so the duration of action.

If you have something like smoking, it's very fast to go into the bloodstream and into the brain, and it has its impact and can last up to approximately six hours. It may be less. If a person consumes it, ingests it, then it takes longer for that active component to get into the bloodstream. That active component, THC, is then metabolized into another active compound. Both of those compounds are contributing to the activity, but you don't see a high peak concentration as you would with smoking. The duration then can be longer than six hours with consumption.

On top of the route of administration, we also consider the potency of the products. Obviously, if it's of greater potency or a person is a more effective smoker.... Chronic smokers tend to be very good at getting all of the active ingredient into their bloodstream and therefore into their brain. The main part about whether we can offer an opinion on impairment is the time elapsed since use. If I have a time and a concentration and all kinds of information, I certainly can be more helpful. Unfortunately, I don't work in that world. I work in the world where I have maybe a concentration and maybe some additional information, but that's certainly not ideal for me to offer a fulsome opinion.

● (1805)

The Chair: Thank you very much.

Mr. Michael Cooper: I just—

The Chair: You're at eight and a half minutes.

Don't worry. We'll come back at the end.

Mr. Fraser, go ahead.

Mr. Colin Fraser: Thank you, Mr. Chair.

Thank you all very much for being here. I very much enjoyed your presentations.

Professor Watson, I'll start with you. Thanks very much for the presentation you gave. The charts are very helpful. I want to ask you a question. When we are contemplating random breath testing here in Canada, many have talked about the possibility that irrelevant considerations would be taken into account when somebody is pulled over. For example, a minority who may be pulled over for irrelevant considerations more often would then be subject to more random breath testing as a result.

I wonder if you can talk about the Australian experience dealing with racial profiling or other irrelevant considerations, and whether the evidence bears that out with regard to random breath testing.

Dr. Barry Watson: In fact, I believe random breath testing is a way to overcome the very problem you talked about. To set the scene, prior to the introduction of RBT in Australia, the police would breath test people using their discretion. This tended to mean that they used to surveil or hang around drinking venues and look for telltale signs of drivers being impaired. Also—and, having studied the direction of random breath testing, I've spoken to police officers who confirm this—there was a tendency to keep an eye out particularly for older vehicles, vehicles driven by younger people, and in many cases vehicles that weren't considered to be driven by more affluent people.

What happened under random breath testing was that the guideline for the police was that they were to pull over all drivers randomly. What that means, particularly in the booze bus operations, is that, as long as capacity can take it, the police actually pull over everyone in the traffic stream, so they aren't showing any discretion at all. They are testing all drivers.

The practice varies a little from state to state. In the state of Victoria, for example, they've been known to shut down all freeways and breath test everyone. In cases where there is very heavy traffic, there will be a selection process occurring, but what happens is that they will select a cohort of vehicles or a group of vehicles coming along, and it's very rare for them to wave a particular vehicle on.

Overall, having observed RBT operations and spoken to police, I think the key essence of it is to breath test people on a random basis without showing any discretion.

Mr. Colin Fraser: What about routine traffic stops and the police being able to demand a breath sample in any routine traffic stop without any suspicion or cause? Do you see that as being problematic, if there are issues with racial profiling making it more likely that a racial minority will be pulled over to begin with?

Dr. Barry Watson: There is a potential for that, but in fact the advice given in Australia by road safety advocates like me is that everyone who is pulled over by the police and comes in contact with them during a traffic stop should be breath tested, whether that's for speeding or distracted driving of any sort. That practice does vary a little from state to state, and once again, it depends on the workload of the police.

Overall, the key aim is to create the impression of drivers that whenever they come into contact with the police, there is a high likelihood that they will be breath tested, and in doing so, really create that deterring threat. The point I'd really like to stress about random breath testing is that, although it catches drunk drivers, its key goal is to deter drunk drivers. What's more important is the threat of being breath tested, rather than everyone always being breath tested.

Mr. Colin Fraser: If people think they're going to get caught, then they're not going to be impaired drivers to begin with.

Dr. Barry Watson: Exactly.

That was the problem with the previous program we had, called RID, which was a form of sobriety checkpoint. The drivers always had the possibility that, even though they were pulled over, if they didn't breathe on the policeman or they could act appropriately and the policeman didn't suspect they had been drinking, they might not be breath tested. Now, in practice, I think the police are fairly good at that, but the key aim was to create the impression in the public's mind that when you are pulled over, you are highly likely to be breath tested.

● (1810)

Mr. Colin Fraser: Thank you very much, sir.

Turning to the Canadian Safe Boating Council, thank you for your presentation.

I didn't quite understand what you were asking for that's different in this legislation from what currently exists. Are you saying that right now a vessel being propelled by muscular propulsion is in fact covered and that this legislation wouldn't cover that?

Mr. John Gullick: Exactly.

This legislation specifically exempts muscular or human-powered vessels, so you're exempting over half of the vessels.

Mr. Colin Fraser: Like a canoe or a kayak, or whatever you were talking about.

So right now people are charged with impaired canoeing. That's happening.

Mr. Michael Vollmer: Yes.

I have some notes from the Ontario Provincial Police. Since 2002, the OPP have investigated 144 fatal accidents involving non-motorized boats, with a loss of 160 lives, and 32.6% of these reports determined that alcohol or impairment was involved. Those charges would have been laid because they had the same definition that the Canada Shipping Act has.

Mr. Colin Fraser: Okay.

Do you have any sense of why that is not reflected in the current legislation? Have you been telegraphed any reason for that, or...?

Mr. Michael Vollmer: Is it one of the three people in the country who haven't been out on a boat? I don't know.

Mr. John Gullick: One thing we've heard is that there is a perception that with human- or muscular-powered vessels, it's like a bicycle. The only person who gets hurt is the person riding the bicycle.

In the case of muscular- or human-powered vessels, there can be many more people in the vessel. It also affects people around the vessel, first responders, people who are searching for people who get lost or get in trouble, and the families. I mean if you look at the numbers, there is really no difference between the canoe and the powered vessel as it relates to potential outcome.

Mr. Colin Fraser: In the example that Mr. Vollmer made with regard to being on the water, obviously if a child is involved, it could be much more dangerous than being on a bicycle.

Mr. John Gullick: Or another person.... It doesn't matter.

Mr. Michael Vollmer: Interestingly, the people who responded to this were two OPP officers on highway duty. They found a guy wandering along the side of the road obviously in a confused state, and they discovered that there was a child in the water. They attempted to get into the water to rescue this child. This was April. The water temperature is enough to bring on cold shock and hypothermia very quickly. They risked their lives to try to save the child.

Mr. Colin Fraser: Right.

Thank you, gentlemen.

The Chair: Thank you very much.

Mr. Cannings.

Mr. Richard Cannings (South Okanagan—West Kootenay, NDP): Thank you.

I want to follow up on that line of questioning about boating, and perhaps bring in the random breath testing testimony we just heard.

I haven't encountered any, but is there any testing or police presence on busy docks or boat launch areas? It always seems that you're talking about incidents where it's after the fact. People drown, so then we test people.

Mr. Michael Vollmer: Unfortunately, the level of marine policing across Canada varies dramatically.

The Ontario Provincial Police has one of the largest on-water police forces in North America. The Sûreté du Québec has some. After that, it gets pretty hit and miss, and as you say quite rightly, it's often after the fact.

Mr. Richard Cannings: I live in the Okanagan Valley where boating is a huge thing in the summer, and I've never heard of this happening. It's like you say, we hear about it after the fact.

Mr. John Gullick: I was out on the water a couple of weeks ago with one of the regional police forces here in Ontario. They have exactly the same facilities to use for a person drinking while driving a boat as they would if they were an officer on the road pulling somebody over in an automobile.

Mr. Richard Cannings: Yes, we do have police out on the lakes. I just wondered if there was this random breath testing before people got into boats.

Mr. Michael Vollmer: Certainly, the easiest way to do marine policing is at the launch ramp before the boat gets wet—“blow here”—or to catch them when they are coming back.

In Ontario, the Liquor Licence Act says that you can only have alcohol on board to be consumed if it's a residence, which requires permanent sleeping accommodation, galley, and head facilities—toilets—and you have to be at anchor, aground, or tied to a dock. It's very restrictive.

I was chatting with Mr. Blair earlier. I do a lot of accident reconstruction in my line of work, and the number of accidents where people have gone out for a day of drinking and using, typically marijuana..... Going boating and drugs and booze seem to be very popular. We in fact worked on one case with John doing the reconstruction and me writing the report for one of the sides in a civil suit.

This has been a problem for a long time, and it's one that the police struggle with. However, as John said, they are equipping themselves better and taking this into more of an account.

● (1815)

Mr. Richard Cannings: Okay.

Ms. Wallage, I'd like to talk about some of your concerns with regard to the time-consuming nature of members of your society having to testify and go into court. I'm just wondering if you've done any extrapolation of how much more work your members would be doing once marijuana gets added to the mix, and how those resources look.

Ms. Rachelle Wallage: Is this with regard to testifying in court?

Mr. Richard Cannings: Yes.

Ms. Rachelle Wallage: With the new bill, some work will be taken away from us, in theory, with regard to calculations for blood alcohol. The simple BAC calculation, or BAC extrapolation, can be done by somebody within the court system, by a judge or whoever is tasked with doing it. That will be taken away. We've also had quite a bit of testimony regarding disclosure wars, as my colleague said earlier. Hopefully that is minimized, but I'm not overly optimistic about that.

In conjunction with the new legislation and the legalization of cannabis, I anticipate that there will be immense pressures on the lab and probably a lot of requirement for us to go out and testify, especially because it will be new.

Mr. Richard Cannings: I don't know how many forensic scientists there are in Canada who do this sort of thing.

Ms. Rachelle Wallage: Not enough.

Mr. Richard Cannings: Is that a limiting factor as well, not only the time but also the number of people?

Ms. Rachelle Wallage: Yes. It's about the number of people. From my personal perspective, it takes approximately three years to train somebody after they've been hired. You don't just start the job, hit the ground, and go to court. It takes time to train people in this specific field.

Mr. Richard Cannings: Okay.

Dr. Watson, I have a question about the booze buses and the random breath testing. Who decides where those buses are parked? I'm just thinking back to Mr. Fraser's questioning around racial profiling. Is there any concern that those buses are habitually parked along routes that might create that effect?

Dr. Barry Watson: The deployment of the booze buses is controlled by operational police, but senior police set various targets for the amount of breath testing that should be performed and the locations where that should occur. In keeping with the principles of general deterrence, I know that the police try to achieve a broader spread of the booze bus operations across their areas of control. In fact one of the things that prevents or discourages them from parking the bus always at the one time is that drivers quickly start to learn and spread the news that the bus is parked in a particular place. One of the challenges for police is to ensure that they can keep uncertainty about where the buses are being placed. An issue there is that the larger the bus, the more constraints there are on where it can operate. There are particular occupational health and safety issues that need to be kept in mind for the police.

There are a couple of other things I should mention. Often with the big booze buses they'll use a patrol car in combination. For example, a typical style of operation is that you have the booze bus on a major road, but if there are any turnoffs as the drivers approach the bus, they'll have a patrol car parked down that street to try to create a kind of satellite effect.

Coming back to your general point, the essence is to get a widespread effect of the booze buses. This whole issue about avoiding drivers and having some predictability about where the booze buses are tends to offset the issue you've raised.

● (1820)

Mr. Richard Cannings: Thank you.

The Chair: Thank you very much.

Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Ms. Wallage, is there any level for alcohol or THC, for example, where below this level it's safe to drive and above this level it's not?

Ms. Rachelle Wallage: No. With respect to alcohol, because that's really predominantly what I testify on, as I am the chair of the drugs and driving committee but most of our cases are alcohol, certainly, within the scientific literature, impairment has been demonstrated at as low as 15 milligrams of alcohol in 100 millilitres of blood. I notice a lot of people are speaking in grams, but for the purposes of the Criminal Code, it's in milligrams. This may equate to one drink. That impairment has been demonstrated in a lab setting.

With respect to THC, the easiest answer is that if you compare somebody who has been smoking, regardless of their concentration, and somebody who has not been smoking, I would expect impairment in the person who has been administering the drug.

With regard to the question about concentration and correlation to impairment, when we were asked this question about coming up with a per se limit, of course we looked at what other countries were doing and things of that nature. We really did focus in on smoking, because ingestion of cannabis has such low THC levels that potentially they won't be caught in these per se limits. They could be lower than five and potentially lower than two. We looked at the literature.... Granted, these are not the high-potency types of products that are used recreationally now, and there's a reason for that. People don't want to study high-potency products because of the adverse drug reactions that are potentially possible—

Mr. Ron McKinnon: I am trying to separate the concepts of safety and impairment.

Ms. Rachelle Wallage: Then the answer is yes. If you smoke, regardless of your concentration, it's ill-advised to drive a car. There is a window during which I would expect that drug to have an effect.

Mr. Ron McKinnon: I note that the charge we're talking about here would be driving in excess of a per se limit, not an impairment charge. I guess the argument there is that if you're driving over this limit, you're not safe, so the per se limit, whether or not it denotes impairment, would go towards fulfilling a public good. Would you agree with that?

Ms. Rachelle Wallage: I would agree with that, yes.

Mr. Ron McKinnon: Okay.

Dr. Watson, I'll transfer my attention to you. Welcome and good morning. I know it's very early there.

You mentioned a number of activities, a number of efforts, over the years, around deterrence. Would you care to comment on the relative efficacy of mandatory minimums versus, say, random breath testing? Which is more effective, or is one more than the other?

Dr. Barry Watson: Unfortunately, it's difficult to disentangle the Australian experience, really, to answer your question, because one of the key things is that although when random breath testing was introduced across the states it was the initiative that caught a lot of public attention and really, I think, the driving force behind the general deterrent effect, at the same time, we enhanced our penalties. It was very much the case that mandatory loss of licence, licence disqualification, was introduced for drunk drivers.

Now effectively, in all the states, with a few anomalies, if you get caught for drink driving in Australia, you will lose your licence. We have a graduated set of penalties, so the higher your blood alcohol concentration, the higher the penalty will be. That includes the fine and also the period of disqualification. There's no doubt that the threat of losing your licence, that general deterrent threat, has had a big part in our success in terms of reducing drink driving. At a public level, that has largely been through the highly visible random breath testing, but that threat had teeth to it, had meaning, because drivers were concerned about losing their licences. I think the two go together, and I would certainly be encouraging that.

As a psychologist, I would argue that you want to ensure that there is a higher degree of unpredictability in the activity but a high degree of certainty that if you are detected you will be punished, and that punishment will be reasonably severe. In fact, the literature suggests that it's the certainty of the punishment and not necessarily the severity that's most important.

I would certainly be encouraging you to think about them as a package of initiatives in which you have the random breath testing to increase that general deterrent effect, and some form of mandatory penalty, which means that the likelihood that drivers will lose their licences if it is detected is very high and in fact there's a very high certainty of some form of penalty.

● (1825)

Mr. Ron McKinnon: The random testing goes to the certainty of detection, which ties to the certainty of a penalty. Is that correct?

Dr. Barry Watson: That's right.

From a criminological perspective, you're wanting to optimize that general deterrent that relates to the likelihood of detection, and then if you are detected, the punishment you will receive will be certain, reasonably severe, and also swift.

Mr. Ron McKinnon: Okay.

Thank you.

The Chair: Thank you very much, Mr. McKinnon. That's it for your questions.

Mr. Liepert.

Mr. Ron Liepert (Calgary Signal Hill, CPC): Thank you, Chair.

I have one quick question. I don't know about you, but I'm getting to the point where I could really use a drink. I'm walking back to my apartment, not driving.

Professor Watson, your presentation was around mandatory breath testing as applied to alcohol. Our government here is proposing to legalize marijuana. We probably wouldn't have this particular piece of legislation before us if we weren't going down that path.

Do you have any advice around the legalization of marijuana, some suggestions on how we may ensure that smoking and driving isn't a problem? I'd like to see if you have any thoughts around that.

Dr. Barry Watson: At the moment in Australia, there's no push to legalize marijuana. There is beginning to be a push for it to be used for medical purposes. In that respect, the Australian situation is quite different. Indeed, as you may be aware, as early as 2003, the Australian states started introducing random roadside drug testing. We have it for three specified drugs: cannabis, methamphetamine, and MDMA—ecstasy. I know one of my Australian colleagues will be telling you more about that later.

A point I'd like to make about that is that I think there was strong support for that at the time in the community. It was not necessarily controversial partly because at the time the legalization of marijuana wasn't something being considered. The Australian experience is that there's growing concern about the use of cannabis and its effect on driving. That's what underpinned the introduction of random roadside drug testing.

A point, though, that I would like to make is that, as we introduced random roadside drug testing, that meant that police resources were being used for that purpose as well as for testing for alcohol. I think sometimes there's been a tendency to think that we can take resources from drink driving enforcement, in other words from random breath testing, and devote them to random roadside drug testing.

Whilst I am not at all expressing a concern about random drug testing per se, the point I want to make is that, if you go down the track of some form of increased drug testing, it's important that you don't sacrifice breath testing for alcohol as a result of that.

If I look at the literature, from what I've seen, the highest crash risk is still being shown for the use of alcohol. Whilst there's also an increased crash risk for drugs, when it's most pronounced is when it's being used in conjunction with alcohol. From a road safety point of view, I'd be arguing that a very high priority is increasing the amount of breath testing in order to reduce alcohol-related crashes. If you go down the track of introducing some form of drug testing, that shouldn't in any way detract or cause some compromise of the amount of breath testing that is performed.

The Australian experience is that, if you can achieve high levels of random breath testing, it produces results in terms of reducing alcohol-related fatalities.

● (1830)

The Chair: Thank you very much, Dr. Watson.

Mr. Cooper, you can ask a short question, then so can Mr. Cannings and Mr. Fraser.

Mr. Michael Cooper: Thank you, Chair.

I'll just to follow up with Ms. Wallage.

Maybe it would be helpful if you could explain to me what the connection is between impairment and THC levels. I look at some of the studies, and some of the evidence said that if you have five nanograms or more, you may not be impaired, and if you're under two nanograms, you may be impaired.

What is the connection? It seems to me that THC tells us that someone has used marijuana, but on the question of impairment, what is it telling us when someone has five nanograms versus one nanogram?

Ms. Rachelle Wallage: Perhaps I could explain our process going into this when we were discussing the numbers.

As I said before, we did look at other countries. Predominantly this is about smoking because of how THC gets in so slowly with regard to edibles. What is important is recency of use.

You could take a number like 100 nanograms per millilitre and say that it is very recent use. Basically, the person is smoking and somebody is taking a blood sample at the same time. Toxicologists could get behind that. It would be recent use. But this is not reality for how it looks on the road, so we are trying to incorporate studies that looked at concentrations that could potentially be associated with recent use, as well as incorporating that no back calculation can be done, and that it takes time to get a blood sample.

On that note, with regard to the legislation, a blood sample has to be taken within two hours of the offence or else there is nothing to catch that result afterwards. If a blood sample is taken two and a half hours later, there's nothing in this bill that can happen, because there is no back calculation.

Five was the number that was decided upon because in general the literature pointed towards occasional users, among them five would mean recent administration for smoking. This comes with a caveat that it does not include those chronic users who have residual levels in their bloodstream for extended periods of time. As well, there aren't a lot of studies on the increase of potency that's available now.

That was our idea behind coming up with these numbers. One nanogram meant recent administration, as far as we can say that. I mean, there will always be exceptions to the rule. All those other factors were built in. Two was suggested just because there are people who can certainly be impaired below a concentration such as five, and the THC drops so rapidly that you could be at two even though there was recent administration.

The Chair: Mr. Cannings.

Mr. Richard Cannings: Dr. Watson, I have some quick questions about the roadside drug testing you mentioned for Australia.

How is that structured? How random is that? In terms of the amount of time and the resources it takes, how long does it take per individual tested compared with, say, the booze buses?

Dr. Barry Watson: The random roadside drug testing does take a considerably longer time than the random breath testing. In the case of random breath testing, drivers are really only detained for 30 seconds to a minute, let's say.

In the case of the roadside drug testing, there's an initial saliva test done. I believe that takes about five to 10 minutes. If that's positive, the drivers are then taken to a bus, where they are given a second oral test, which takes about another 15 minutes. The overall process for testing is a longer process.

In addition, the random roadside drug testing is quite a lot more expensive than random breath testing. For example, in the case of breath testing, once you've invested in the preliminary breath-test kit, the ongoing costs are really just the cost of the tube into which the driver blows. In the case of the random roadside drug testing, the saliva tests are more expensive. I believe they're in the order of $30 each. I'd suggest that you ask that question of my colleague from Victoria, who I believe will be talking to you.

The upshot of this is that in Australia nowhere near the number of drug tests are performed at the roadside as compared to breath tests. As a result, there does tend to be more targeting of that activity. It tends to be focused more towards recreational users, and also towards truck drivers, and that is because of their use of methamphetamines for staying awake whilst driving. In other words, the drug testing tends to occur more at particular times, and particularly late at night, in areas where recreational drug users or truck drivers might be.

The overall upshot of this is that in terms of the very strong boots-and-all effect that was obtained for breath testing in Australia, it's been difficult to achieve that for the drug testing. From a resourcing point of view, the police have needed to allocate additional resources to cover the higher costs of the saliva drug tests. This really requires a specific allocation of budgets to the police for them to be able to do additional drug testing, in order to maintain the breath testing at the current levels.

● (1835)

The Chair: Thank you very much.

Before we wrap up, I just want to follow up on Mr. Cooper's question to Ms. Wallage.

Ms. Wallage, you made it clear that there's not necessarily a direct correlation between five milligrams of THC in the blood and impairment. As we know, the law basically has different categories of offences. One is driving while impaired under alcohol or drugs. Another is exceeding a per se limit. Would you agree with me that it would be the same in the case of alcohol? You could have somebody below .08 who is very impaired because they're not used to drinking alcohol, and you could theoretically have somebody over .08 who was not showing signs of impairment. Wouldn't it essentially be the same?

Ms. Rachelle Wallage: I would pick something like 50, because my opinion is that people are impaired at a concentration of 50 milligrams of alcohol in 100 millilitres of blood. Just for your example, you could have somebody who is not used to drinking who could be impaired below 50, and then you could have somebody who is used to drinking, who routinely consumes alcohol, and they might not demonstrate outward signs of intoxication from the alcohol consumption. They may be able to get from point A to point B without too much difficulty. If they are challenged on the roadside, meaning if there is a sudden or unexpected task, that's when impairment becomes an issue.

The same goes for THC, in that if you are a chronic user, you do develop some tolerance to the drug. That doesn't mean the drug is having no effect on you, but it does mean that you would have to increase your dose to achieve a similar effect to what you are looking for, so there can be people who are impaired at quite a bit lower level than others.

The Chair: There could be people who are over that, but you would consider them impaired even if they were showing fewer visible signs of impairment than somebody else was, the same as you would for somebody over 50 for alcohol based on the level that you propose to use.

Ms. Rachelle Wallage: That's correct. I would still consider that person to be impaired by alcohol above a concentration of 50, but can you look at them and see that they're having difficulty with walking and talking? Potentially, no. However, if you put them in a car and a sudden event happens, that's when they require all their faculties to respond to it.

The Chair: Thank you.

I want to thank this witness panel. You have provided a lot of very useful information.

I especially want to thank you, Dr. Watson, for testifying from so far away so early in the morning.

I'd like to thank everyone. We're going to take a short recess till the next panel comes up, and I'd like to ask the members of our fourth panel to please come up.

● (1835)

(Pause)

● (1845)

The Chair: We are now ready to move forward with our fourth panel of the day.

It is a great pleasure for me to welcome Mr. Thomas Marcotte, who is from the department of psychiatry at the University of California. He is representing the Center for Medicinal Cannabis Research. Welcome, Dr. Marcotte. It's a pleasure to have you.

From Australia, the Victoria Police, we have Doug Fryer, who is the assistant commissioner of road policing command. Thank you so much, Mr. Fryer, for joining us. It's very much appreciated.

We're going to start with the testimony of Mr. Marcotte.

Mr. Marcotte, the floor is yours.

Dr. Thomas Marcotte (Assistant Professor, Department of Psychiatry, University of California, Co-Director, Center for Medicinal Cannabis Research): Thank you.

Good evening. I appreciate the opportunity to share some information as you consider Bill C-46, an act to amend the Criminal Code.

I'm Tom Marcotte. I'm a professor of psychiatry at the University of California San Diego, and co-director of the University of California Center for Medicinal Cannabis Research. I'm an investigator on two current studies examining the impact of cannabis on driving.

Today I'd like to provide some background on the challenges in determining whether an individual's driving has been impaired by cannabis.

In controlled simulator and on-road studies, it's been well established that acute cannabis intoxication results in slowed reaction times, including delays in braking, reduced ability to maintain one's lane position—in other words, swerving—and reducibilities relating to the judgment of speed and distances. The effects of cannabis are amplified by alcohol, although it's not resolved as to whether this is an additive effect or synergistic, in which the two combined are worse than simply adding the effects together. Also, in contrast to alcohol, cannabis users are more likely to judge themselves to be impaired and to adjust behaviour, by driving more cautiously, as one example. However, of course, this is not universal.

Findings from the real world have been mixed. Some studies have found a twofold increase in crash risk when THC is present, while other studies have found no increased risk once adjusting for factors that often travel with cannabis use and risky driving, such as younger age and being male.

Here's one example of the difficulty in interpreting crash results from the states that have legalized cannabis.

In Colorado, it was widely publicized that there was a dramatic 50% increase in the number of fatalities in which marijuana was present following legalization. However, as seen in this next graph, there was only a marginal increase in the total number of crashes in that same period. This mirrored recent data demonstrating that, at a national level, there was also an increase in fatal crashes.

What is clear is that at this same time, the State of Colorado increased the amount of screening they were doing to detect THC. Therefore, it is unclear whether the increased prevalence of fatalities with THC present represents a situation in which increased cannabis use might have led to more fatalities, or whether it is primarily a case that authorities are more frequently looking for the presence of cannabis and finding it.

On the other hand, a recent report has indicated that there has been an increase in insurance collision claims in states where recreational cannabis has been legalized compared with other states. These are the much more common non-fatal crashes. When examining claim rates in Colorado, Washington, and Oregon, the authors found a 3% increase in claims relative to states that did not legalize use, with there being some variability between the states.

What might be some of the reasons that we see significant effects during controlled studies but a more modest effect in the real world? There are a number of possibilities, but to name just a few, in part, epidemiologic findings are based upon imperfect data. For example, the fatality reporting system in the United States often has incomplete reporting, and there's typically a significant delay between the time of a crash and the collection of blood. In addition, THC can be detectable in the blood long after the impairing effects have resolved. Thus, the impact of acute intoxication may not be readily apparent in these analyses, since the THC-positive group includes a much larger number of individuals who might have smoked much earlier and were not impaired at the time that the blood was collected.

On the other side, it is also possible that in some of our studies, while we're able to detect acute effects of cannabis on tasks such as swerving, they may not be of significant magnitude to dramatically affect real-world driving. As an example, in a study of low-dose THC for the treatment of spasticity in multiple sclerosis, we found a significant effect on driving two to three hours after dosing. However, the magnitude of that effect was not dissimilar to what other studies have found for individuals in the initial phases of starting antidepressants, or the residual morning-after effects of taking a sleeping medication the night before.

Drug recognition evaluations are the current gold standard for establishing substance-impaired driving. We're currently in the midst of a large study, funded by the State of California, to better characterize the impact of cannabis on driving, and to investigate whether there are additional effective approaches to identifying those individuals who are or are not impaired due to cannabis.

● (1850)

As part of this study we're working with DRE instructors to explore the validity of select components of the DRE evaluation, as well as assaying for the presence of THC, its metabolites, and other cannabinoids to determine whether they might provide reliable information regarding the time since the participant smoked or, ideally, relating to driving impairment.

Another unique aspect of this study is that we are utilizing novel iPad-based assessments to see if such tests might serve as a useful adjunct to the DRE evaluation. Unlike alcohol, where impairment readily presents itself physiologically, such as staggering and difficulty walking, cannabis effects are primarily cognitive and a current DRE evaluation includes only modest assessments of these abilities.

Particularly relevant to Bill C-46, studies to date raise concerns regarding the validity of using THC levels in blood to identify cannabis-impaired drivers. For example, a study by the American Automobile Association examined 602 cases in which DREs have identified drivers as being impaired, with THC being the only substance identified in the blood.

In this graph, the level of THC runs across the *x* or the horizontal axis and a per cent of drivers with that THC level is represented on the *y* or the vertical axis. As you can see in these impaired drivers, there was a wide range of THC levels. The median value or number where half the drivers were above and half the drivers were below was around five, indicating that 50% of these impaired drivers had values below the five nanograms per millilitre cut point at the time the blood was drawn. Thus, drivers can be impaired, yet have THC blood levels below a cut point that some governments have chosen as being indicative of driving under the influence.

Conversely, the table on the left shows that individuals who are likely unimpaired can also have detectable THC levels in their blood, even days after smoking. In this case, participants stayed in a hospital for 30 days so they could be monitored for any cannabis use. They then smoked cannabis and blood was subsequently drawn each day. As you can see in this table, some individuals were registering values of two nanograms per millilitre of THC, even though it had been up to a week since they smoked.

Why is it that we can have individuals with low levels of THC who are impaired, as well as individuals with low levels who are not impaired? The graph on the right is from Dr. Marilyn Huestis, a researcher in cannabis pharmacodynamics. Across the bottom we see THC levels and on the side we see, in essence, how high the person is feeling. This figure shows time in a counter-clockwise fashion, so as you see 1.8 minutes is the first and second is 4.5 minutes and so forth. After smoking, THC levels rise very rapidly so they reach a peak in about 10 minutes. At the same time the person is increasingly feeling high, so you see going to the right it's increasing, but it's also going up, so they're feeling higher. At this point, however, THC levels begin dropping to the point where about an hour after smoking they're now down to fairly low levels as you move across to the left in this graph.

The person, though, is still feeling high during this time. A few hours after smoking the highness starts diminishing, so it starts dropping down the vertical, but THC levels are not changing dramatically during this period. As you can see, it's between zero and 10. This tells us that someone can be high with elevated THC levels, someone can be high with modest levels, someone can be high with low levels, and someone can also have low levels and not be high. To further complicate this, Dr. Huestis has demonstrated that these patterns vary, depending upon whether one is a frequent or infrequent smoker.

At least for screening, oral fluid instruments hold some promise, they're easy to administer, relatively non-invasive, and may help identify individuals who recently used cannabis. This approach, however, is also not without complications. This graph shows results from a study of oral fluid THC levels in individuals who smoked a 6.8% THC cigarette. More studies are needed and ours is assessing the issue, but in general it's believed that the most significant impairing effects happen within the first few hours of smoking and then dissipate over the following few hours.

● (1855)

As you can see here in this graph, however, at least in this one study, a proportion of individuals were at or above a five micrograms per litre cut point in oral fluid eight to 10 hours after smoking.

I mentioned earlier that we have a study going on. If the group is interested, during the discussion I'd be happy to provide more details, but for this purpose I'll skip it and just end with a few concluding points.

Per se laws can be very effective, but this is particularly true when there is a robust relationship between fluid levels and actual driving impairment, as there is with alcohol. As can be seen in some of the data presented earlier, I don't think this is yet the case for cannabis. I'm also aware from attending many meetings that prosecutors remain concerned that a cut point designating impairment may lead the public to assume that a driver below that cut point is not impaired or is less impaired. As seen in the DRE data I presented earlier, low levels do not necessarily mean low impairment.

Some individuals have also expressed concern that the DRE evaluations may not be adequately sensitive to the effects of cannabis and that one should use fluid levels to identify impairment. I would argue that it is very important to continue to use behaviour as a key indicator of driving-related impairment given the uncertainty in interpreting fluid levels.

Last, I encourage you to support additional research into identifying new methods that might help law enforcement identify both those who are impaired and those who are not impaired due to cannabis. This includes biological, psychophysical, and behavioural approaches.

As you know, the complexities associated with detecting cannabis-related driving impairment also have increased our awareness regarding the continuing problem of impairment due to prescription medications. Perhaps new approaches to detecting impaired driving would end up being applicable to these drug classes as well.

Thank you, and I'm happy to take any questions.

The Chair: Thank you very much, Dr. Marcotte.

We're going to turn it over to Mr. Fryer for his presentation.

Welcome to our committee.

Assistant Commissioner Doug Fryer (Assistant Commissioner, Road Policing Command, Victoria Police): Thank you, and thank you for the opportunity to address the standing committee, and hello from way down at the bottom of Australia.

My name is Doug Fryer. I'm the assistant commissioner of road policing in my state. Just to paint the landscape, Victoria has a population of six million, and we have a driving population of four and a half million people who either ride or drive. My role as the head of practice for road policing is to guard the state around all activities of law enforcement. Our police force is quite large. We have about 19,000 police for our state, and my command of just road policing is about 1,100 highway patrol professionals.

Relevant to your standing committee, I suppose you have activity around both drink and drug driving. To lay the landscape, Victoria, Australia, was the first in the world to bring in randomized drink driving testing in 1976. In 1976 we had about 950 people die on our roads. The population was then three million. Close to 450 of those who died had in excess of .05 in their system for alcohol, and that is our legal limit right across Australia. In contrast 40 years on, last year we had 291 die on our roads, and we had 26 people who had in excess of .05.

In 2007 again Victoria was leading the world in studying randomized drug testing. Unlike, I believe, both the United States and Canada, we practise a general deterrence model in both drink and drug driving. We aim every year to test 4.5 million people for alcohol on the side of the road. We do very general deterrence. We block roads and put everyone through drink driving testing, but our drug testing regime, again, is leading our nation with 100,000 randomized drug tests of drivers or riders every year.

What concerns us, whilst I mentioned that 26 people died in excess of .05 last year, was that we had 57 who died with illicit drugs in their system, and there were a further seven who had both drugs and alcohol.

Relevant to your committee in relation to cannabis, last year we tested 100,000 people. We used a roadside saliva test 100,000 times. That's the style. It takes just a swipe of the tongue, and within six minutes we get a result. Of the 100,000 tests we did, we had 9,200 then move to the evidentiary test, so 9,200 people out of 100,000 tested positive for illicit drugs at a strike rate of one in 11, which really concerns us.

The idea of a general deterrence model with the preliminary oral fluid test is not around impairment. If we see drivers we believe to be impaired by either drugs or alcohol, my members are supposed to do what you would call a roadside sobriety test, and if they fail the sobriety test, we then take blood from them. The method we used for the 100,000 tests is around general deterrence, and it's off the back of our learnings from our drink driving general deterrence.

Of the 9,200 that were positive last year, about 73% were with methamphetamine, and the rest were with cannabis. We have zero tolerance. I know there was discussion around the five-nanogram level. Our threshold is that if we can detect it—and this has been tried and tested in our courts since 2007—then there is impairment. As Dr. Marcotte advised, the level of impairment we see for any detectable level is equivalent to that of about .1 for alcohol and doubles the chance of having a crash. For me, it's about separating the behaviours of using any type of illicit drug and driving. It's not the moral debate of whether they should use it or not. It's around separating the behaviours of getting behind a wheel, and really the human rights of other road users who have a right to be safe from those who may choose to use drugs and then drive.

● (1900)

I was over in Banff only last month at an international road policing conference and I presented on this there. Some of the road policing models in both Canada and America are very different to ours because we have the luxury of a general deterrent model. As I've said, we test 4.5 million people just in Victoria for alcohol, and we have 4.5 million people who are licensed, so we aim for one test per year per driver.

I'm happy to take any questions or I could keep talking, if you like, but perhaps your questions may be more relevant.

The Chair: Thank you so much, Mr. Fryer.

We're going to move to questions right now. We are going to start with Mr. Nicholson.

Hon. Rob Nicholson: Thank you very much, Mr. Chairman.

Thank you to both our witnesses. It's much appreciated in many ways.

I'll start with you, Dr. Marcotte. It underlines how complicated this situation is, to tell you the truth.

The first thing that surprised me was your indication that people who have been smoking or using cannabis are more likely to recognize the fact that they're impaired. We heard some testimony that there's a substantial portion of people who smoke marijuana who believe it increases their ability to drive. They're not impaired; they get better at it. Is that just a minority? Are there other people who realize that by smoking a few joints they're going to be in trouble?

● (1905)

Dr. Thomas Marcotte: I certainly have heard a number of anecdotal comments like that, and I hope they're in the minority because it's unlikely to improve your driving. That said, there are some people who have anxiety and so forth, and maybe at a low dose there may be some benefit, but I certainly would not argue that it is something that would improve your driving.

I think most studies have shown that, when people are high on cannabis, they tend to be much more aware. Unlike with alcohol where you tend to take more risks, etc., you would drive more slowly, etc., but that's not universal. Certainly the report from the DRE has shown data that they've.... In fact, in the study I showed you, a lot of those people were arrested for speeding and so forth. It's not a universal thing. Most studies show that, on average, people are much more aware of their cognitive status than when using alcohol.

Hon. Rob Nicholson: That's interesting. You said you heard it's anecdotal that some people believe that their ability to drive gets better, but it's only anecdotal. You've seen no evidence of that.

Dr. Thomas Marcotte: I just do research, so we just see people in the lab. Perhaps the officer could comment on his own experience, but certainly, talking DREs, etc., the people they stop think they do better.

Hon. Rob Nicholson: One of the things that surprised me as well was that, in one of your charts, you indicated that there are people who could have a level of five nanograms of cannabis in their system after eight to 10 hours. That's pretty amazing. I would think that most people, if they're smoking a few joints one night, just like having a few beers, are sober when they wake up in the morning, but this is an indication that they're not, that it's in their system. Does it also impair them?

Dr. Thomas Marcotte: Unfortunately, you really have to separate. The action is not in the blood, so unlike where there's this nice correlation—I'm sure people have said here—with alcohol, it's not the same with cannabis. It gets really complex because chronic users will have chronic levels in their blood. There have been some studies showing some impairments for prolonged times, but really the most significant impairment happens within a few hours or five to six hours, as another one of your witnesses testified. Seeing five nanograms the next day is probably not indicative of cognitive impairment.

Hon. Rob Nicholson: Okay. That's fair enough.

Mr. Fryer, thank you for your testimony here today. You gave us a number of statistics about the number of people who get tested. Give us your view of how effective this is. Is this something that has worked in your state in Australia to stop people from taking drugs, or is it just a better recognition that there are people out there taking drugs?

Does it have a preventative effect? That's one of the things we're looking at in terms of mandatory testing. It's not just a question of finding the people who have alcohol or drugs in their systems, but it also hopefully discourages people from taking a chance. What are your views on that?

A/Commr Doug Fryer: It's a good question, sir.

We base our general deterrence model and drug testing regime on that of alcohol. Unfortunately, it's taken 40 years for our community to really understand and find drinking and driving quite repugnant. It's socially unacceptable here, so few people now do it, but that's because of a 40-year testing regime.

We've been testing for drugs for over 15 years. While statistics are that for our 100,000 tests we get one in 11, that is absolutely not saying that one in 11 drivers are using drugs and driving. This is probably relevant to your question to Dr. Marcotte. Our strike rate is so high at one in 11 because we are detecting drivers committing traffic offences because of their impairment, and we pull them over and test them. Whether it's speeding or whether it's swerving all over the road, there is some activity that gets my highway patrol members' interest to pull them over. We certainly don't have one in 11 drivers driving impaired, but we do have that many who are driving in an erratic manner that causes us to pull them over.

Our testing regime is quite expensive, and we're looking at ways to expedite that. Of 9,200 positive tests last year, we forensically analyzed every single one—at significant cost—but only 2% of those people pleaded not guilty. We're trying to bring about a streamlined way of processing so we can do more testing. Our ideal number to bring in general deterrence is 600,000 tests every year, but it's cost-prohibitive at the moment.

Each of the 100,000 of those we do is $30. Of those, 9,200 go positive. We do those. They're $30. Then every single one of those 9,200 gets sent off for forensic testing at about $400 a pop.

● (1910)

Hon. Rob Nicholson: Congratulations on the job that you're doing.

Thank you very much, Mr. Chairman.

The Chair: Thank you very much, Mr. Nicholson.

Ms. Khalid.

Ms. Iqra Khalid: Thank you, Mr. Chair.

Thank you, gentlemen, for your testimonies today. It was very interesting to listen to your perspectives.

Mr. Fryer, as our police services prepare now to use these new devices on the roads, what lessons can they use from your experience in this? How frequently do your police officers get trained? How frequently does equipment get updated or calibrated? What kinds of measures do you take in staying up to date with technology?

A/Commr Doug Fryer: We are trying to look at technology now that will streamline our drug testing to mirror drink testing. We would like devices that will do both. At the moment, they're completely separate activities. The legislation is completely separate.

I mentioned before that my police force is quite large. While it's 19,000, we have about 14,000 sworn members. It's only my staff, the highway patrol staff, of which there are 1,100, who are qualified to do the drug testing. Our general police are really keen to get the drug testing as well, but at the moment, it's just cost-prohibitive. It's a bit of kit that our members right across the board really like because it is so easy. It's a six-minute test. If they get a positive, then we go through a process.

I suppose the challenge is how to inculcate a general deterrence model rather than just targeted testing. How do you get all of your community to know that they run a chance of being drug tested? If they get that into their hearts and minds, it's around their learning that they just need to separate their behaviours. If they want to have a joint or a bong, they can do it at home but they can't get behind the wheel.

There was a question asked a moment ago. We are still detecting people, sometimes up to 18 hours after they admit using, with either cannabis or other drugs in their system. Most people that we detect think that it will already be out of their system when they get behind the wheel.

For me, in this state—indeed, in all of Australia—it's the general deterrence model that works. People don't know if they're going to be tested. They may go through a testing station just on the side of a highway, and there's nothing that's drawn their attention as to why police have pulled them over. I'm not sure that Canada has that general deterrence model.

Ms. Iqra Khalid: Thank you.

How are officers trained on roadside testing?

A/Commr Doug Fryer: We run our internal courses. All of our members have gone through a one-day training course. It's a very basic saliva test: swab the tongue, leave it flat for six minutes, and the bars will come up. It's very similar to a pregnancy test. Depending on what drugs.... We test for methamphetamine, ecstasy, and cannabis on the test that I've just shown you. If we detect impairment, we will take blood from them, and we test for 110 different types of drugs, both licit and illicit. All of the hired patrol officers, of whom there are 1,100, have done formal training, which is done internally.

Ms. Iqra Khalid: You mentioned that of the people you charged with impairment, only 2% plead not guilty. Is that correct?

A/Commr Doug Fryer: That's correct.

Ms. Iqra Khalid: Would you, then, extrapolate that there is a 2% error margin with the device that you are using to detect impairment?

A/Commr Doug Fryer: No, that's 2% who plead not guilty, not because they are challenging the test. They have a right to plead not guilty, for a variety of reasons. It's not to do with the accuracy of the testing. They've just invoked their right to have the matter heard at court. The benefit we have in this state, compared with other states in Australia, is that our first offence for drug driving is an infringement, a penalty notice, so they don't have to go to court, and it's an immediate suspension of their licence for three months. That happens 9,200 times. Only 2% of those, when they get the infringement, elect to go to court and have it heard before a judge.

● (1915)

Ms. Iqra Khalid: Is there any process that you use to detect the accuracy of the tests or the equipment that you are using?

A/Commr Doug Fryer: No, they calibrate it to detect.... Our legislation has allowed us, and it's tried and tested at the higher courts.... If there is any detectable level of illicit drugs, whether it be amphetamine or cannabis, our legislation advises that there is impairment in that driving.

Ms. Iqra Khalid: Thank you.

Mr. Marcotte, I have a question for you. In your statement earlier, you said that equipment is not enough to detect impairment, that there have to be behavioural indicators as well. How would you propose to provide that training to officers or those who are doing the detection in the first place? What kinds of indicators would they be looking for? Is there a way to have that concrete training for officers?

Dr. Thomas Marcotte: One thing we're trying to do—again, we have close collaboration with the DREs in California—is take the measures they think have the best possibility for being accurate detectors of cannabis-related impairment and doing further validation. There are some good studies out there in the field looking at how they relate to impaired drivers, one of which I showed, but there aren't really any blind clinical trials to say, if you don't give someone cannabis and you do these tests, how well do they do, and how well do the officers detect those people who are impaired or not? In our study, we relate it to actual driving performance.

The first thing is to see if we can help improve the validation for the current measures. We are also in the process of trying to do additional measures—again, these are some iPad-based tests—to really get a cognitive task. That might be complicated to implement, but it would probably be worthwhile, because there is so much complication when it comes to testing for other drugs, like prescription medications. On those tests, we are looking at the ability to divide attention and the ability to track objects in real time. We're also doing a measure of time estimation and working with the DREs—on some of the measures, they look at balance and sway—to see if we can give them some more objective outcomes rather than having to sort of eyeball how well the person is doing.

Ms. Iqra Khalid: Thank you.

The Chair: Mr. Cannings, go ahead.

Mr. Richard Cannings: Thank you, both, for your enlightening talks.

I'm going to start with Dr. Marcotte. You mentioned briefly that there was perhaps some hope to use metabolites to look at a better way of detecting impairment, through chemicals rather than behaviourally.

Dr. Thomas Marcotte: Yes. As THC breaks down in the body.... THC may hang around for a long time in fat cells and so forth, but it also creates a bunch of metabolites downstream that may or may not have different time courses. Some things may go away after a couple of hours. In cannabis right now we keep focusing on THC. There are other cannabinoids in marijuana that may have a similar effect. Whether or not those directly relate to impairment.... Perhaps some of those metabolites might give us a good idea as to when the person likely last smoked, which would be very helpful. In addition to having impairment and behavioural measures, you would know that a person smoked roughly three hours ago or something like that.

Mr. Richard Cannings: This might be just a little detail, but you said that you were using 6.8% THC cigarettes in this study, or in one of the studies you mentioned.

Dr. Thomas Marcotte: That was someone else's study. In our study we're up to 13.4%. We're limited to what NIDA can provide.

Mr. Richard Cannings: We have heard that American researchers are using a strength of joints, or whatever you want to call them, that is nowhere near the strength that's available.

Dr. Thomas Marcotte: It's getting better, but we're still behind the curve. Most studies you'll see were done with 6% THC. Right now they're up to 13%, which is what we're using. On average, drugs confiscated in America were about 12% to 15%. If you go to dispensaries, what they're putting out is around 30%.

One thing to keep in mind is that there are a number of studies showing that people self-titrate, so just because you can get a marijuana cigarette in a higher dose doesn't mean you smoke the whole thing. They smoke half of it to get high. I'll just add that other methods like dabbing will give you a big boost. With these methods, you can't self-titrate—that's a whole other area to get into.

● (1920)

Mr. Richard Cannings: Mr. Fryer, I'd like to ask you about Australia's zero tolerance for any detected amount of THC in the system in all your roadside tests. I take it that this kind of system wouldn't work in a regime such as we're facing if we legalize cannabis. We've heard testimony that people can have detectible amounts of cannabis in their system for hours or maybe even days if they're a regular user. Is it the case that this just wouldn't stand up?

A/Commr Doug Fryer: Mr. Cannings, I think the challenge is to get into the hearts and minds of the community, to convince the people that if they choose to use cannabis they should separate this behaviour from driving.

I suppose we have the luxury of not having to prove impairment at all. If we detect cannabis or illicit drugs in the system, the courts can uphold drug driving. The challenge for you is whether it's a public awareness campaign, an enforcement campaign, or both. We do both in Australia. We certainly have proactive advertising around separating behaviours.

I think there needs to be some sort of stick around enforcement. People should fear that if they run the gauntlet of having illicit drugs in their system, then they may get detected and charged. I think there are challenges if you don't have a general deterrence model in your law enforcement activity. People will think they'll be able to run the gauntlet and they'll be putting other road users at risk.

Mr. Richard Cannings: I want to be clear on the 100,000 roadside saliva tests that you ran. Were all of those on drivers who had been pulled over because of suspected impairment, or were some randomized?

A/Commr Doug Fryer: These were absolutely randomized. Under my command, we have drug and alcohol buses. These are very large buses that we put on freeways and put everyone through the bus. The whole freeway will be blocked and we'll filter people through. This is for general deterrence and a good result for that activity is one in 44. My highway patrols are single-officer patrol vehicles. If they detect people driving erratically, their strike rate is as low as one in three. When you combine it, that's how we come up with one in 11 for the 100,000. We practise general deterrence on our drug and alcohol buses, but when our highway patrol detects people driving erratically, one out of three come up positive in tests.

Mr. Richard Cannings: What is the ratio of the number of drivers you test for drugs versus alcohol on the buses?

A/Commr Doug Fryer: With our buses we do anywhere from 3 million to 4.5 million tests a year. On the buses, our strike rate for alcohol is one in 370. For drugs it's one in 44. We have 10 police on a highway testing people as they come through, but our highway patrol has a lower strike rate when it comes to alcohol because they're seeing impairment.

Mr. Richard Cannings: How many people are tested for drugs on those buses, versus alcohol? Is everybody tested for drugs?

A/Commr Doug Fryer: Not everyone, because it's too cost prohibitive. They will select people coming through the line, but they'll be tested for both drugs and alcohol. It's not every person who comes through.

The buses do 50,000 drug tests, and the other 50,000 are done by the single-officer patrols and highway patrol. My alcohol buses do about 1.5 million breath tests a year. The highway patrol and general duties do the other three million.

Mr. Richard Cannings: Okay. Thanks.

The Chair: Thank you very much.

Mr. McKinnon.

Mr. Ron McKinnon: Thank you, Chair.

Commissioner Fryer, I'd like to talk to you some more about this oral fluid testing.

You showed us a couple of different units. Are they actually different units or different variants? Do they detect different things?

● (1925)

A/Commr Doug Fryer: The first one I showed you, the blue one, is what we call the POFT, the preliminary oral fluid test. That is what we do a 100,000 times. If they then test positive to that, they do the OFT, the oral fluid test, the red one, which is our evidentiary test. It is that one that we then send off to our forensic laboratory for analysis.

Mr. Ron McKinnon: With the first one, it's a yes-or-no sort of test. We detect some level of a particular drug, or not.

A/Commr Doug Fryer: Yes.

Mr. Ron McKinnon: What's the ratio of false positives in that situation?

A/Commr Doug Fryer: We're comfortable that we don't have the false positives.

What has been occurring, and it still occurs.... This is the oral fluid test, the evidentiary test that we then send off to our lab. Of these, about 2% come back as not sufficient sample to be tested. It's about 2% that come back that they can't detect an amount that we would put before a court.

It is very rare to not have the actual statistic, but I don't have the data that says of the preliminary tests, how many come up negative on the evidentiary test. I'm thinking that's probably about 1%.

Mr. Ron McKinnon: The oral tests they use for evidentiary purposes do not actually involve the taking of blood. It's just strictly oral at this point.

A/Commr Doug Fryer: Our testing regime is supposed to be—and it's hard to educate our members not to do this—a general deterrence model. If they see someone they believe is driving impaired, they are supposed to do an impaired driver test similar to your sobriety test. What many of them do is just go straight to these tests, because it's quicker and easier.

The benefit of doing a sobriety test is that if they fail it, they then have to get blood off them and we get absolute analysis of what type of drug and the level of drug. It doesn't happen that often. I'd like it to happen more.

Now that they have this bit of equipment, our members default to it because it's quite easy and quick to use. The sobriety test takes up to an hour and a half, by the time you end up getting a nurse out to take the blood.

Mr. Ron McKinnon: If I understand correctly, you do the mandatory drug screening stops where everybody who comes along gets stopped. Do you actually stop every car that comes along, or do you select the cars?

A/Commr Doug Fryer: On a proper roadside testing, we have buses that are the size of a coach. They are decked out just for driving alcohol testing. We have 10 of those, and we will put them across the state. We will block an entire freeway and have about 10 to 12 officers standing in a line, and every vehicle will be flagged through. Everyone who gets flagged through will be tested for alcohol, and then the officers on the line will go through a ratio of doing drug testing as well. We don't test all of them because it's cost-prohibitive.

They will not really target, but they'll selectively choose people to be drug tested as well. That happens 50,000 times on our larger deterrence buses. Our single officers on highway patrol almost always use their 50,000 drug tests because they see impairment on the road. They pull them over and then they do a drug test.

Mr. Ron McKinnon: I guess a concern about a selection process like that is profiling.

Do you have a concern about that, and what control would you have to prevent that?

A/Commr Doug Fryer: I suppose if I separate the single-officer patrols, they've already seen a level of impairment that's indicated that the vehicle needs to be pulled over and checked. I'm relatively comfortable with that. On our bigger drug buses that are pulling over everybody, the concept is that it be randomized, whether it's every 15th car that will be tested or.... We are getting people who are 70 years old tested for drugs. For me that's an indication that at least it's random, and they're not picking on the 22-year-old with dreadlocks.

The idea is that it's randomized. We haven't had any challenges come back that we're profiling in our testing, and all our roadside large drug testing operations are supervised by senior officers. We're pretty comfortable with it.

● (1930)

Mr. Ron McKinnon: You indicated that you had individuals detect as positive 18 hours after using marijuana. Would you consider that person impaired and would that person be charged with an offence?

A/Commr Doug Fryer: They'd absolutely be charged with drug driving, if we can detect it. The courts have already set the benchmark through legislation that if it's detectable through our testing regime, they'll now be convicted of drug driving. Our first penalty is three months' loss of licence and a $500 fine. A second time of drug driving is about a $3,000 fine, and we can seize their car as well.

Mr. Ron McKinnon: As Mr. Cannings suggested, it is zero tolerance for drugs or alcohol.

A/Commr Doug Fryer: It's absolutely zero tolerance.

The research we rely on is that any detectable presence is an equivalent of about .1 when it comes to alcohol. We know when we have a .1 when it comes to alcohol, there's at least double the chance of having a crash on the road. For us, it's protecting the other road users who are not driving either alcohol or drug impaired.

Mr. Ron McKinnon: Thank you.

The Chair: Thank you very much.

Does anybody still have any short questions? If not, I want to thank Assistant Commissioner Fryer and Dr. Marcotte. It was a great pleasure to have you here. It's always nice for us Canadians to get the foreign perspective. Your testimony was extremely helpful.

Members of the committee, we are going in camera for a very short session. I'd ask everybody who is not supposed to be here for an in camera session to clear the room as quickly as possible so we can do that. I promise it will only be about five minutes.

[*Proceedings continue in camera*]

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