

FINAL REPORT
OF THE
COMMISSION
OF INQUIRY
INTO THE
NON-MEDICAL
USE OF DRUGS

ACRP

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Commission of Inquiry
into the Non-Medical
Use of Drugs

Commission d'enquête
sur l'usage des drogues
à des fins non médicales

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Commission of Inquiry into the
Non-Medical Use of Drugs

Commission d'enquête sur l'usage
des drogues à des fins non médicales

December 14, 1973

The Honourable Marc Lalonde, P.C., M.P.,
Minister of National Health and Welfare,
Brooke Claxton Building,
Tunney's Pasture,
Ottawa, Ontario.

Sir,

The Commission of Inquiry into the Non-Medical Use of Drugs, established under Order in Council P.C. 1969-1112, has the honour to submit the fourth and Final Report of its findings and recommendations.

Respectfully yours,

Gerald Le Dain, *Chairman*

Ian L. Campbell, *Member*

J. Peter Stein, *Member*

Heinz E. Lehmann, *Member*

Marie-Andrée Bertrand, *Member*

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Part One

Introduction

The Work of the Commission

APPOINTMENT OF THE COMMISSION

The Commission of Inquiry Into the Non-Medical Use of Drugs was appointed by the Government of Canada under Part I of the *Inquiries Act* on May 29th, 1969, on the recommendation of the Honourable John Munro, then Minister of National Health and Welfare.*

The concern that gave rise to the appointment of the Commission is described in Order in Council P.C. 1969-1112, which authorized the appointment, in the following terms:

The Committee of the Privy Council have had before them a report from the Minister of National Health and Welfare, representing:

That there is growing concern in Canada about the non-medical use of certain drugs and substances, particularly, those having sedative, stimulant, tranquillizing or hallucinogenic properties, and the effect of such use on the individual and the social implications thereof;

That within recent years, there has developed also the practice of inhaling of the fumes of certain solvents having an hallucinogenic effect, and resulting in serious physical damage and a number of deaths, such solvents being found in certain household substances. Despite warnings and considerable publicity, this practice has developed among young people and can be said to be related to the use of drugs for other than medical purposes;

That certain of these drugs and substances, including lysergic acid diethylamide, LSD, methamphetamines, commonly referred to as "Speed", and certain others, have been made the subject of controlling or prohibiting legislation under the Food and Drugs Act, and cannabis, marijuana, has been a substance, the possession of or trafficking in which has been prohibited under the Narcotic Control Act;

That notwithstanding these measures and the competent enforcement thereof by the R.C.M. Police and other enforcement bodies, the incidence

* The Honourable John Munro was succeeded as Minister of National Health and Welfare by the Honourable Marc Lalonde on November 27, 1972.

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of possession and use of these substances for non-medical purposes, has increased and the need for an investigation as to the cause of such increasing use has become imperative.

The Order in Council sets out the terms of reference of the Commission as follows:

That inquiry be made into and concerning the factors underlying or relating to the non-medical use of the drugs and substances above described and that for this purpose a Commission of Inquiry be established, constituted and with authority as hereinafter provided,

- (a) to marshal from available sources, both in Canada and abroad, data and information comprising the present fund of knowledge concerning the non-medical use of sedative, stimulant, tranquillizing, hallucinogenic and other psychotropic drugs or substances;
- (b) to report on the current state of medical knowledge respecting the effect of the drugs and substances referred to in (a);
- (c) to inquire into and report on the motivation underlying the non-medical use referred to in (a);
- (d) to inquire into and report on the social, economic, educational and philosophical factors relating to the use for non-medical purposes of the drugs and substances referred to in (a) and in particular, on the extent of the phenomenon, the social factors that have led to it, the age groups involved, and problems of communication; and
- (e) to inquire into and recommend with respect to the ways or means by which the Federal Government can act, alone or in its relations with Government at other levels, in the reduction of the dimensions of the problems involved in such use.

THE COMMISSION'S INTERPRETATION OF ITS TERMS OF REFERENCE

Although the preamble to the Order in Council authorizing the appointment of the Commission draws particular attention to certain kinds of non-medical drug use, the Commission is directed by its terms of reference to inquire into the non-medical use of the whole range of psychotropic drugs or substances. Thus the Commission has been concerned not only with the so-called 'soft' drugs, such as cannabis and the other hallucinogens, but with the 'hard' drugs, such as the opiate narcotics, and also with two of the most widely used psychotropic drugs, alcohol and tobacco. Some observers have suggested that the Commission should not have concerned itself with alcohol. For reasons indicated in subsequent sections we believe that this would have been an inexcusable omission that would have created a false impression of the true extent and relative seriousness of non-medical drug use. Moreover, the relationships between the various forms of drug use and the phenomenon of multi-drug use have made it imperative to consider as many of the classes of psychotropic drugs or substances as possible.

The Commission was appointed to inquire into non-medical drug use, but it has had to consider medical use insofar as it bears on non-medical use. The line between the two is not always clear. Medical use can develop into non-medical use. As we said in our *Interim Report*, prescription cannot be the sole criterion of medical use. Some drugs for which there is a medical use do not require prescription. The use which is made of drugs under prescription may not be in some cases a justifiable medical use. *In our Interim Report we defined medical use as use which is indicated for generally accepted medical reasons, whether under medical supervision or not, and non-medical use as that which is not indicated on generally accepted medical grounds.* Moreover, it has been necessary for us to consider the bearing which the availability and use of drugs for medical purposes have on non-medical drug use. The medical use of drugs contributes to a climate of reliance on drugs for various purposes, and the availability of drugs for medical purposes creates a supply from which there may be diversion to non-medical purposes. Thus, in an inquiry into non-medical drug use, it is essential to consider the controls over the availability of drugs for medical purposes.

These two factors—the range of the drugs involved and the necessity of considering the implications of availability and use for medical purposes—have served to determine the scope of the inquiry. A third such factor, which is discussed in the next section, is the extent to which it is necessary, in considering what government may do, to comment on the role of other institutions and individuals in relation to non-medical drug use. Non-medical drug use is not only a matter of personal conduct but a social phenomenon. The inquiry into it has necessarily involved an examination of non-governmental as well as governmental influences on it.

THE PUBLIC HEARINGS

Because of the nature of the phenomenon—and the crucial role played by public attitudes—the Commission conducted public hearings across Canada. There were two sets of such hearings: one before the *Interim Report* and one afterwards. The schedule of these hearings appears in Appendix Q. The purpose of the hearings was not to attempt an accurate survey of opinion in Canada but to identify the issues and the range of opinion, and to afford an opportunity for public discussion. In this we believe the hearings were very successful. They provided an opportunity for adults and young people to exchange views at a time when strong feelings and, indeed, a polarization of opinion had built up over the issue of non-medical drug use. The hearings were conducted in a fairly informal manner, and in many cases in informal settings, with plenty of opportunity for participation by the audience after presentation of formal briefs. People of all ages spoke with candour, and often great depth of feeling, and the Commission received a

Part One Introduction

vivid impression of the extent to which the problem of non-medical drug use had touched the lives and the concern of Canadians.

Before it began its public hearings, the Commission wrote to over 750 individuals and organizations inviting them to submit briefs or to make oral submissions. In particular, the Commission solicited briefs from: federal and provincial government departments; law enforcement authorities; educational institutions and associations; members of university faculties and departments; medical and pharmaceutical institutions and associations; addiction research foundations; street clinics and other innovative services; correctional and welfare organizations; bar associations; youth organizations; student organizations; and a wide variety of other organizations and individuals having an evident concern or point of contact with the phenomenon of non-medical drug use in Canada. In addition to specific invitations, general public notices were issued and published in newspapers across the country, inviting briefs and attendance at the hearings. The Commission received a gratifying response to this invitation, and despite the relatively short time available in some cases for the preparation of briefs, individuals and organizations made a very commendable effort to prepare submissions for the public hearings which began in the middle of October 1969.

The Commission held public hearings in 27 cities, including Ottawa and all the provincial capitals. It visited several cities twice. In addition to these regular public hearings, the Commission conducted hearings in 23 universities, several junior colleges and high schools, and some informal settings of the youth culture, such as coffee houses in Montreal, Toronto and Vancouver. In all, the Commission spent 46 days in public hearings, and it is estimated that it travelled about 50,000 miles. In addition, the members of the Commission, both collectively and individually, held many private hearings. The anonymity of witnesses was guaranteed where requested. The nature of the public hearings and the impression they made on us are more fully described in our *Interim Report*.

The Commission received a total of 639 submissions from organizations and individuals, as follows: from organizations, 295 written and 43 oral submissions; and from individuals, 212 written and 89 oral submissions. Oral submissions were recorded at public hearings and transcribed. In addition, many persons who were not identified by name spoke at the public hearings, and the Commission received hundreds of letters which are not classified as formal submissions. A full list of organizations and individuals who presented submissions, written and oral, to the Commission is contained in Appendix P.

THE COMMISSION'S RESEARCH PROGRAM AND STAFF

The Commission research has been carried out by a staff of full-time scientific personnel and outside researchers working under contract. The full-time research staff has consisted of a research director, research associates

from various scientific disciplines and research assistants. Full-time staff members with the Commission during the production of this *Final Report* are listed in Appendix N. Former members of the staff, whose work contributed primarily to earlier Commission reports, are listed in those publications. The Commission's contract researchers and major consultants are noted in Appendix O.

Under the guidance of the Commission's librarian, Ed Hanna, we have developed a collection of over 14,600 articles, books, briefs and other documents. In addition, we have had full access to the library and documentation facilities of the Addiction Research Foundation of Ontario, to the Library of the Department of National Health and Welfare, to the National Library, and to the National Science Library. We have also received considerable assistance from other libraries in Canada and abroad through inter-library loan and special subject searches. Examples of these are the U.S. National Institute of Mental Health Clearinghouse for Drug Abuse Information, the U.S. National Library of Medicine, and the Science Information Exchange of the Smithsonian Institution.

The Commission's research program consisted of some 120 projects, many of which are listed in Appendix R. In addition, there was a variety of miscellaneous investigations which were not formally classified as separate projects. The areas covered by the research program include: chemical and botanical factors; physiological, psychological and behavioural effects; extent and patterns of use; motivation and related factors; social context; mass media; legal and illegal sources and distribution; legal controls; law enforcement and the correctional system; medical treatment and related services; innovative services; information and education; prevention and alternatives to drug use; and the response of various institutions, including government, to non-medical drug use. The methods employed in our research include critical review of technical and scientific literature and current investigations, surveys and interviews, participant observation, human pharmacological experiments, and chemical analysis of illicit drugs.

From the beginning of our inquiry it was apparent that there was a great need for more information concerning the nature and effects of the various drugs. Such information is essential for public policy and personal decisions, as well as programs of drug education. For these reasons the Commission invested a significant proportion of its resources in the study of drug effects. These efforts involved the use of data and information obtained by the various research methods mentioned above. The Commission's work in this area is reflected primarily in Chapter Two of the *Interim Report*, entitled "The Drugs and Their Effects"; Chapter Two of the *Cannabis Report*, entitled "Cannabis and Its Effects"; and in Appendix A of the present report, entitled *The Drugs and Their Effects*. Most of the work in this area has been conducted by the Commission's full-time research staff under the direction of Dr. Ralph D. Miller, Research Director, who drafted the above sections of the Commission's reports. Dr. Miller was assisted

at various stages in this work by Research Associate Dr. Ralph Hansteen; by Research Assistants Joan Brewster, Pat Oestreicher, Marilyn Bryan, Barry Hemmings, Penelope Thompson, Linda Wright, and Richard Paterson; by consultant Dr. Zalman Amit; and by other members of the research and consulting staff.

The work in Appendix B *Legal and Illegal Sources and Distribution of Drugs* was directed by Research Associate Mel Green. He was assisted by Research Assistants Marcus Hollander, Ken Stoddart, Dave McLachlen, Ann Lane and others. Robert Solomon participated in the empirical research on law enforcement and the correctional system, directed by Professor John Hogarth, and, with the assistance of Mr. Green, is responsible for the work on the sources and distribution of opiate narcotics (Appendix B.2).

The preparation of Appendix C *Extent and Patterns of Drug Use* was carried out under the joint direction of Mel Green and Judith Blackwell, Senior Research Assistant. They were assisted by Research Assistants Gordon Smith, Marcus Hollander, Dave McLachlen, Florence Hughes, Carolyn Petch, by consultants Dr. Taylor Buckner and Dr. Stanley Sadava, and by other staff members.

The Commission's national surveys were conducted by the Survey Research Center of York University, under the direction of Sondra B. Phillips and the general supervision of Dr. Michael Lanphier. The surveys in the Province of Quebec were carried out by le Centre de Sondage de l'Université de Montréal. Mel Green directed a project of participant observation in the summer of 1970 to determine patterns of non-medical drug use in certain urban centres of the drug subculture. He and Judith Blackwell also conducted a monitoring project in the spring and summer of 1972 by which the Commission sought, through contacts with informed observers across the country, to identify further developments in extent and patterns of drug use.

Appendix D *Motivation and Other Factors Related to Non-Medical Drug Use* is based on research by full-time members of the staff and outside consultants. Dr. Lynn McDonald, former Research Associate of the Commission, made a significant contribution to the research on which this appendix was based, and Mr. Green and Ms. Blackwell played a substantial role in its final drafting. Consultants Dr. Roderick Crook, Dr. Zalman Amit and Dr. Jim Hackler also contributed background materials employed in preparing this appendix.

Research Assistants Ann Lane and Byron Rogers conducted the research for Appendix H *Treatment Capacity in the Provinces*. Ms. Lane and Brian Anthony carried out the background work for Appendix G *Opiate Maintenance*. Mr. Green provided much of the research for Appendix L *Civil Commitment in California* and Mr. Rogers did the investigation for Appendix M *Innovative Services*. Michael Bryan, Special Assistant and Editor, made a major contribution to the research on the correctional system and the drafting of Appendices I, J, and K.

CONSULTATION AND ADVICE

During the course of its work the Commission had the benefit of consultation and advice from a wide range of organizations and individuals. Many of these are listed in Appendices O and P. The Commission is especially grateful for the assistance it has received from federal and provincial government departments and services in connection with its research. In the preparation of this *Final Report* the Commission has made particularly heavy demands for assistance on the Health Protection Branch of the Department of National Health and Welfare, and in particular, the Bureau of Dangerous Drugs, the Drug Advisory Bureau, the Drug Research Laboratories, and the Field Operations Unit. We have also received valuable assistance from the Canadian Penitentiary Service, the National Parole Board, the Judicial Division and the Health and Welfare Division of Statistics Canada, as well as from several provincial government departments, including those concerned with probation. The Commission has continued to receive the full cooperation of the R.C.M. Police, as it has from the beginning of its inquiry.

Significant assistance was provided to us at various stages of our inquiry by the Addiction Research Foundation of Ontario. Information provided by Eric Polacsek of their Documentation Center and by the Foundation's library greatly facilitated our work, as did the chemical analytic services provided by Dr. Joan Marshman and her staff. In addition, we are appreciative of the generous advice and consultation provided from time to time by numerous other members of the Foundation's research staff. The personnel of the Narcotic Addiction Foundation of British Columbia have also been helpful in our work.

The Commission has received valuable assistance from a number of organizations and individuals in other countries. Particularly noteworthy was the assistance it received from the United States Bureau of Narcotics and Dangerous Drugs and other American law enforcement authorities in determining patterns of drug trafficking, from the U.S. National Institute of Mental Health, from the officials of the California Civil Commitment Program, and from public officials and treatment personnel in connection with the treatment of opiate-dependent persons in Great Britain. Members of the Commission and staff visited many foreign countries, observing conditions and consulting local experts, and attended most of the major scientific conferences around the world dealing with non-medical drug use. We also sought the views of experts from North America and abroad in a number of private meetings and symposia held in Canada.

ADMINISTRATIVE STAFF

James J. Moore, Executive Secretary of the Commission during the period in which the Commission produced its *Interim Report*, *Treatment Report* and *Cannabis Report*, was obliged to leave the Commission to take

up another position in the fall of 1972. By the time he left, however, the work on the *Final Report* was well advanced, and it owes much to his participation in planning and direction. We take this opportunity to express our appreciation of his invaluable contribution to the work of the Commission.

Since Mr. Moore's departure the Chairman of the Commission has been ably assisted in administrative matters by Frederick Brown, who also carried out a variety of research tasks, and by Michael Bryan, who has had responsibility for coordinating all editorial and other operations involved in the preparation of this report for publication.

Appreciation must also be expressed to Mr. C. W. Doylend, Office Manager of the Ottawa office of the Commission, and his assistants, and to the secretarial staff for their devoted service.

THE REPORTS OF THE COMMISSION

This is our fourth and final report. It presupposes and relies, in varying degrees, on the previous reports, which are referred to as the *Interim Report*, the *Treatment Report* and the *Cannabis Report*. On certain points our perspective has evolved beyond that expressed in previous reports, and in some cases we have changed our views. Wherever we have been conscious of such a change we have drawn attention to it. As far as possible, we have attempted to profit from reaction to previous reports and from additional knowledge and understanding acquired in the intervals between our reports. The four reports reflect the evolution of our thinking over a period of approximately four years. This evolution is, of course, related to changes which have taken place during that time in the phenomenon of non-medical drug use and in the social response to it. Although the differences of opinion between members of the Commission on certain points have tended to increase with the passage of time and the concentration on the detailed implications of its general policy perspective, there has been a significant measure of cohesion and continuity in that general perspective, considering the highly subjective and controversial nature of the value judgments involved.

By and large we have regarded the four reports as having a cumulative effect, and we have not hesitated to reproduce parts of previous reports that we have felt were pertinent to matters being discussed in this report. Although the *Interim Report* was published in 1970 much of what was said there remains an essential part of the Commission's general perspective today. The *Treatment Report* is the principal statement of the Commission on this subject, but we have resumed the discussion of certain treatment issues in this report. Since a separate final report was devoted to cannabis, the present report has concentrated on the other psychotropic drugs, and in particular, on the opiate narcotics, the amphetamines and the strong hallucinogens. There has also, however, been considerable emphasis on other psycho-

tropic drugs which are the subject of non-medical use, and in particular, on alcohol and tobacco. We have not attempted to carry the discussion of cannabis, in any significant degree, beyond the *Cannabis Report*, which must remain our final word on that subject. But there is much in the *Cannabis Report* that is pertinent to the discussion of other forms of non-medical drug use, particularly in the areas of law and scientific issues, and we have drawn on some of these discussions from the earlier report.

THE APPENDICES

The appendices of this report form an integral part of it. They are not background papers but contain our conclusions on the subject-matters with which they deal. The appendices reflect the findings and conclusions of all the members of the Commission. There is no difference of opinion (at least any explicit difference of opinion) with respect to anything contained in them. The relationship between the parts of the report which are designated as "sections" and the appendices is simply one of convenience in the treatment and disposition of material. The chief purpose has been to try to avoid breaking the continuity of discussion by the intrusion of too much detail. The sections are chiefly concerned with conveying our general perspective, although in some cases they contain the whole of the discussion on a particular subject. They also contain our recommendations, although there are some exceptions, as in the case of Appendix M *Innovative Services*. On the whole, the appendices are intended to contain the detailed examination of certain subjects which is considered to be necessary or useful for a consideration of the various policy issues. As indicated, however, we have not followed an inflexible rule; generally there is discussion of a subject in both the sections and the appendices; in some cases the whole of the discussion is to be found in one or the other. The point to be emphasized here is that the appendices are as essential to an understanding of the Commission's perspective and assumptions of fact as are the sections of the report.

TRANSLATION

The four reports of the Commission were translated by Michel Coupal, director, and the staff of Les Traductions 530, Inc., Montreal, Quebec, who are to be commended for the high quality of their work.

Section II

Some Preliminary Observations

THE PROBLEMS INVOLVED IN NON-MEDICAL DRUG USE

The Commission's terms of reference require it to make recommendations to the Government of Canada as to what it can do, alone or with other levels of government, to reduce the dimensions of the problems involved in the non-medical use of psychotropic drugs and substances. They do not suggest what the government considers to be problems, although the preamble to the Order in Council which authorizes the appointment of the Commission expresses concern about the *increase* in certain kinds of drug use in recent years, particularly among young people. In the *Interim Report* we suggested that the following were problems involved in non-medical drug use: the harm (whether personal or social) produced by certain non-medical drug use; the extent and patterns of such use, and in particular its increase among certain groups in the population; the aspects of our personal relations and social conditions today which encourage such use; the proliferation and adulteration of drugs; the lack of sufficient scientifically valid and accepted information concerning the phenomenon of non-medical drug use; the lack of a coordinated and otherwise effective approach to the timely collection and dissemination of such information as does exist, including appropriate drug education programs; our present approach to treatment and other supportive services required to assist people suffering from the adverse effects of non-medical drug use; and the content and application of the criminal law in the field of non-medical drug use.

These certainly remain problems, although the relative priority and emphasis to be given to them have in some cases altered since the *Interim Report*. The degree to which they are still problems has changed. The overall perspective in which they were identified as problems is not the same. For example, there has been an increase in research and in the attempt to gather and disseminate valid information since the *Interim Report*; there has been a development of drug education programs; there has been a constructive change in the general attitude of the medical profession towards drug users;

there has been generous government support for innovative services of all kinds; and there has been a more enlightened approach to the use of the criminal law. Nevertheless, serious problems remain in the fields of research, information and education, treatment, other supportive services, and the law. Moreover, since the *Interim Report* our perspective has changed as to the nature and extent of the more serious forms of non-medical drug use. The principal concern is now with chronic multi-drug use. Prominent in this picture is the increasing experimentation with stronger drugs, and in particular with the opiate narcotics.

THE IMPORTANCE OF MULTI-DRUG USE

The relative importance of the problems referred to above varies according to the different kinds of drug use. With cannabis, for example, the problem of the content and application of the criminal law has been more important than the problem of treatment. With the opiate narcotics, treatment—and in particular opiate maintenance—is a major issue, as well as the extent to which the law is to be used for purposes of control. Thus, there are general observations which are applicable to the various kinds of drug use, but it is necessary to make distinctions on particular points. It might be desirable to be able to formulate a general response, but we are dealing, in multi-drug use, with a complex phenomenon that presents itself under many aspects. For purposes of systematic, detailed analysis it may be helpful to consider the various forms of drug use separately. In practice, however, the drug use of many individuals is complicated by the fact that they use several drugs. It is essential to bear this perspective of multi-drug use constantly in mind, or we shall think unrealistically in terms of separate, quite distinct forms of drug use which do not bear on one another.

SOCIAL POLICY AND INDIVIDUAL POLICY

In the *Interim Report* we developed the concept of 'social response'. We suggested the nature of this concept in the following passage:

We see non-medical drug use generally as presenting a complex social challenge for which we must find a wise and effective range of social responses. We believe that we must explore the full range of possible responses, including research, information and education; legislation and administrative regulation; treatment and supportive services; personal and corporate responsibility and self-restraint; and, generally individual and social efforts to correct the deficiencies in our personal relations and social conditions which encourage the non-medical use of drugs. We attach importance to the general emphasis in this range of social responses. We believe that this emphasis must shift, as we develop and strengthen the non-coercive aspects of our social response, from a reliance on suppression to a reliance on the wise exercise of freedom of choice. [Paragraph 389.]

It is necessary, however, to distinguish the response which we make as a society—working in an organized, collective way—and the response which we

make as individuals at various points of contact with the phenomenon of non-medical drug use. The individual response is an essential part of the social response, but it is also something which may be considered from an entirely different perspective. For example, we may, as individuals, have an attitude towards non-medical use which we may consider inappropriate or simply not feasible for attempted implementation as social policy. In this report we are concerned with the search for a wise social policy—that is, a policy which the society may consciously pursue as a whole. Such a policy must of course be carried out not only by government and other institutions but also by individuals influencing the phenomenon of non-medical drug use at the various points at which they have contact with it. Within this framework of social policy there is room for a wide range of individual policy. On the whole, however, individual policy or behaviour must reinforce social policy, if the latter is to be effective.

GOVERNMENTAL AND NON-GOVERNMENTAL ACTION

While the Commission's terms of reference require it to recommend to the Federal Government what it can do alone or with other governments to reduce the problems involved in non-medical drug use, it is impossible to consider the appropriate role for government without reference to what other institutions and individuals are capable of doing. The government's role must be seen in the context of the society's response as a whole. Government acts directly by legislative prohibition or regulation, but it also acts by supporting the efforts of others. Action by government in the form of legislation can have a beneficial or an adverse effect upon non-governmental efforts in various areas. For example, a certain use of the criminal law may affect efforts in the fields of education and treatment. Government, through legislation and the kinds of social response it supports, conveys its own characterization and perspective of the phenomenon. It conveys an impression as to how seriously it regards a social problem. The extent to which this impression actually influences attitudes is another question. The attitude concerning the potential of harm of cannabis has been at extreme variance with the impression given by its classification in the law with the opiate narcotics. Conversely, the absence of an offence of simple possession for the amphetamines has not impeded the development of a widespread understanding concerning the dangers of 'speed'.

Although our terms of reference only require us to recommend the action to be taken by the Federal Government, we feel that this necessarily involves a commentary upon what should be done by other institutions and individuals. This non-governmental response is a necessary assumption or basis of any governmental action. What it is prudent for government to do or not to do will depend on what it may reasonably expect from other kinds of intervention and influence in the society.

The terms of reference speak of action in cooperation with other governments. Clearly, then, we are not to be confined, in considering a

wise social policy, to the limits of Federal Government jurisdiction under the constitution. We also have to consider what provincial and municipal governments may do and how the Federal Government may assist them.

THE OBJECTIVES OF SOCIAL POLICY

The legal distinction between medical and non-medical drug use turns essentially on medical judgment as evidenced by prescription. There is no such basis for distinguishing between non-medical drug use which may be relatively harmless, in particular circumstances, and that which is not. With drugs which have an accepted medical value, the law relies in the final analysis on the judgment of physicians to assure a proper medical use of them. As we have seen, we cannot take prescription as the infallible criterion of the distinction between medical and non-medical use; the issue is whether the drugs are in fact prescribed for generally accepted medical reasons. In other words, the judgment and general prescribing practices of physicians must be subject to critical review. But in the final analysis the law relies on medical judgment to confine the use of such drugs to medical purposes. The physicians are the final gatekeepers. Some drugs with medicinal value do escape this control by medical prescription. Such are the over-the-counter drugs which are available for self-medication and use at the discretion of the individual. Where such drugs present a particular potential for harm they may be brought under the control of the requirement of a prescription.

Where drugs do not have an officially recognized medical value there is no regulatory means such as medical judgment to distinguish acceptable from non-acceptable use. There is no judgment or discretion to which the law can delegate the responsibility for making this distinction. In such circumstances, the law is faced with the choice of making the drug legally available or prohibiting its distribution altogether. There is no intermediate system of control to distinguish between harmful and relatively harmless use, between moderate use and excessive use, between use and 'misuse' or 'abuse'. It is difficult through legal regulation to pursue a policy of moderation, as distinct from one of abstinence. If the decision is to make a drug legally available for non-medical purposes the law must rely on individual judgment and other influences to assure a level of use that avoids harm.

Such a policy presupposes that a particular drug is capable of controlled, moderate and relatively harmless use. Here we encounter other difficulties in an attempt to formulate wise social policy with respect to non-medical drug use. Is any drug which has a potential for significant harm capable of a controlled non-medical use? It is, of course, a matter of degree and the price we are prepared to pay for certain satisfactions. It is a question of what we are prepared to regard as 'significant harm'. Theoretically it may be possible to restrict one's smoking of cigarettes to the point which avoids any appreciable danger of harm, but comparatively few

people are able to maintain this level of consumption. In the end a very high proportion of smokers are inevitably exposed to the dangers of tobacco.

This is a difficulty which we encounter in attempting to formulate social policy. We know comparatively little about safe and unsafe levels of consumption of drugs for non-medical purposes. Such knowledge can only be produced by long-term research into effects at various dose levels. For example, although cannabis, like alcohol, is susceptible of controlled use, we are not yet in a position, as we pointed out in the *Cannabis Report*, to give assurances as to what are moderate and relatively harmless levels of use. Thus, even with drugs which are capable of controlled use, we may not be able to provide the information required for wise personal decisions.

Some drugs are not susceptible of controlled use. There may be risk of harm at any level of use, even initial, experimental use. Such is the case with the strong hallucinogens such as LSD. There are particular dangers in ever using heroin or 'speed'. It is irrelevant to speak of a policy of moderation with respect to such drugs. Excessive use certainly increases the risk of harm, but harm may occur on any occasion of use. The effects of a number of these drugs at a normal level of use are quite unpredictable. In such circumstances the law must decide whether the risk of harm from these drugs is such as to call for total prohibition. There are, of course, other factors to be taken into consideration in determining what is a feasible legislative policy, including the price one pays for certain use of the law, but the actual risk of harm is the first factor to be considered. The fact that a drug has a significant potential for harm and does not lend itself to a controlled use does not automatically lead to a policy of prohibition. We may decide for a number of reasons, as we do with other risks, to rely on peoples' judgment, wisdom, self-interest or learning capacity to avoid harm.

Another difficulty which we encounter in attempting to formulate the objectives of social policy is the possible relationship between any drug use and excessive or harmful use. There can be no harmful use unless in the first instance there is some use. Moreover, the lines between occasional use, moderate use, and excessive use, or between harmless and harmful use, are not clearly marked. They are levels of drug use which slide into one another. Finally, the climate of drug use as a whole and the prevailing attitudes towards it are factors which can influence use at various levels. There is a view which holds that the potential for harm—the total incidence of harmful effects—increases as drug use increases generally, and that if we wish to reduce the total incidence of harm we may do so by reducing per capita drug consumption generally. This point of view is based on evidence that the distribution of the per capita consumption of alcohol in the population of users follows a certain pattern or curve (referred to as "log normal"). (See Appendix C *Extent and Patterns of Drug Use*.) It is hypothesized that regardless of an increase or decrease in drug use in any sector of the population, the overall shape of the distribution is constant and the relative pro-

portion of occasional, moderate and heavy users in the population would remain the same. According to this view, a general increase in drug use would increase the number of heavy or excessive users; if we wish to reduce the number of such users we must reduce the consumption of essentially all users. Further research will be necessary to evaluate the general validity of these hypotheses.

Another point of view is that it is wrong in principle to make any use of drugs for the purpose of altering our state of mind—that such a practice interferes with the full development of our potential as human beings. This is a concern with the effect of any kind of drug use on the personal development of the individual. The reasoning is that each time the individual turns to a drug instead of his own internal resources to cope with stress, anxiety, disappointment, and the like, he diminishes his capacity to deal with these situations or conditions by natural means and increases his ultimate reliance upon drugs for such purposes. This view tends to exaggerate the extent of our independence of external aids of various kinds. It does, however, reflect a concern with the tendency of occasional reliance to develop into permanent reliance.

Whether drug dependence is to be considered an evil in itself is also a matter of some debate. Some would argue that it is not the fact of dependence itself but the degree to which it actually interferes with effective functioning that is the evil. Others would argue that the evil lies in the impairment of autonomy or freedom of choice that is brought about by dependence. It is seen as a significant loss of personal dignity for the individual. This issue is brought into focus by the use of methadone maintenance to manage opiate dependence. The individual is enabled to function more effectively but he exchanges one form of opiate dependence for another. The serious secondary effects of heroin dependence are removed—the need to have contact with an illicit market and to commit crime to support the habit—but the individual is left with a dependence which is just as strong, if not stronger, than heroin dependence. Those who see drug dependence as an evil in itself, regardless of its effect on the individual's capacity to function, tend to see methadone maintenance as a mere transfer of the problem from one form to another. Those who tend to judge dependence in terms of its actual effects on behaviour are not so concerned about the fact that the individual remains dependent if he is able to function more or less in an otherwise normal fashion.

The individual who is dependent upon drugs is less free than one who is not. He is dependent not only upon the drug but upon others for his ability to function. If the system by which he obtains the drug fails, he is faced with a crisis which can overturn his entire equilibrium. This is, of course, true of the individual whose life is kept alive by a drug or a mechanical device—as, for example, in cases of diabetes or heart disease. Why should drug dependence which is managed by legally available maintenance doses be regarded any

differently? Does the fact that drug dependence (unlike diabetes) is self-imposed make the difference? If such is the case, we are no longer characterizing drug dependence in terms of its effect upon the individual but are investing it with a moral judgment which we pass upon the individual. Drug dependence becomes an evil not simply because of its effect upon the individual but because it is a state into which he has voluntarily entered. This tends to ignore the extent of personal responsibility for various forms of ill health. Illnesses which result from neglect or abuse of one's health—poor diet, lack of exercise, insufficient rest, overwork, excessive worry or stress—all these can be said in some measure to be self-inflicted. Yet they do not carry the same connotation or stigma of personal responsibility as drug dependence. If we search for reasons for this difference in attitude we may be led to the conclusion that in the one case the behaviour which causes illness—for example, overwork—is regarded as socially acceptable, if not desirable, or at least normal, while in the other case the behaviour which is associated with drug dependence—escape from stress, self-indulgence and so on—is regarded as socially unacceptable, at least in that form. Work addiction produces useful results for the society (although it may inflict considerable harm on the individual and those with whom he has contact), but drug addiction does not. In the final analysis we are not nearly as concerned about the effects of self-destructive behaviour on the individual himself as we are about the effects on the society as a whole. It is this which accounts for the difference in our characterization of self-indulgent behaviour which renders the individual impotent or virtually useless socially and that which makes some contribution, however distorted, to social utility. Thus the social drinking which lubricates business relations is accepted as a necessary, if not desirable, part of business behaviour, although it often lays the foundation for problem drinking and alcoholism and no doubt frequently results in impaired judgment.

On the whole, then, we tend to characterize non-medical drug use according to its behavioural manifestations, actual or presumed. This is the approach which distinguishes moderate from excessive use according to its actual effects upon the individual and society. If the individual can function effectively and continue to discharge his responsibilities, despite reliance on drugs, we are not overly concerned. The logical conclusion of this point of view is that the law should not attempt to interfere with non-medical drug use that does not produce apparently harmful effects for the individual or society, and even then it should confine its concern to the behavioural manifestations of use that result in harm to others. This is in effect the present policy with respect to alcohol, which makes alcohol legally available to persons above a certain age but punishes harmful behaviour resulting from the use of alcohol, such as impaired driving.

In the face of all these considerations what are we to conclude is a sound general attitude towards non-medical drug use and a realistic objective of social policy? Non-medical drug use is too deeply rooted and too pervasive to be eliminated entirely. It cannot be swept away. There will always be a very

high proportion of our population who will engage in non-medical drug use of various kinds. The proportion that can remain strictly abstinent—that is, avoid the use of psychotropic drugs of any kind, including those which are present in coffee and tea—will remain infinitesimal. If one considers the number of persons who are likely to continue to use tobacco and alcohol, then one develops a realistic appreciation of the inevitable proportions of non-medical drug use. If one also thinks of the number who are likely to continue to use tranquilizers and barbiturates, one has an overwhelming impression of a climate of reliance on psychotropic substances. As we said in the *Interim Report*:

One could go on. The point is that there must be very few people who do not use some psychotropic drug for non-medical reasons. The general climate, therefore, is not one of moral condemnation of the use of drugs for mood-modifying purposes, but rather one of acceptance of such use. [Paragraph 390.]

In the face of such widespread and persistent non-medical use of drugs a social policy of abstinence is not a feasible one. It is unrealistic to expect the majority of people to give up non-medical drug use altogether. But it is feasible to attempt to persuade people to reduce their overall use in order to reduce harmful use and to set a better climate of example for young people. To the extent we engage in non-medical drug use at all, we must bear our share of responsibility for the more harmful forms of use. We contribute to a general climate which encourages use. *Our objective of social policy should be to discourage the non-medical use of drugs as much as possible and to seek a general reduction in such use, but at the same time, to equip those who persist in use with sufficient knowledge to enable them to use drugs as wisely as possible.*

THE MEANS OF SOCIAL RESPONSE

How such a social policy is best pursued is another question. The identification of problems does not automatically indicate solutions. We must distinguish between the potential for harm of a particular form of non-medical drug use and the measures of social policy which it is feasible to adopt in relation to it. The fact that we are confronted by harmful behaviour does not necessarily mean that we are justified in using the most drastic measures of social intervention at our command. We have to determine what it is reasonable and feasible to attempt to do, having regard to the benefits and costs of alternative policies.

There are basically two kinds of intervention with respect to non-medical drug use: the preventive and the remedial. Both forms of action are necessary in an attempt to check its growth and impact.

The preventive approach presupposes that we know something about cause and the remedial that we know something about treatment. Unfortunately, our knowledge leaves much to be desired in both of these areas.

In the area of prevention, not only do we know little about the motivating or predisposing factors with respect to various forms of non-medical drug use but we know little about the efficacy of the various methods of prevention. In particular, we know little about the effect of education on behaviour or about the deterrent effect of the criminal law.

With respect to remedial intervention, we have indicated in our *Treatment Report* how relatively unsuccessful have been most attempts to treat drug dependence. Our most successful response is still the attempt to manage dependence, rather than to cure it, by the substitution of one dependence for another. And even this method must still be regarded as in the experimental stage and subject to very serious critical re-evaluation.

Despite this relative lack of knowledge and the essentially discouraging outlook for treatment, we must persist in our efforts to develop a more effective social response to non-medical drug use and its effects. What we have to avoid are unreal expectations of success. This has a very important bearing on the measures which are considered to be justified on a weighing of benefits and costs. In the field of non-medical drug use we have to learn to live with a discouraging rate of apparent failure. At the same time we have to demonstrate persistence and endurance and enormous patience. Up to now the field has been characterized by exaggerated and competing claims of success because people have been conditioned to expect a rate of success comparable to that which may be attained in other fields. As a society we are gradually becoming aware of the extremely baffling and intractable nature of this phenomenon, and this discovery may be expected to result in more realistic expectations. This in turn will make it possible to share our respective experience and knowledge with greater candour and less defensiveness. The field of non-medical drug use is one in which we need very tough self-evaluation and the maximum of co-operation in sharing bad news as well as good. The problems are far too difficult to be successfully confronted by divided and conflicting responses, although there is room here, as elsewhere, for a healthy competition directed to testing rival theories in a spirit of underlying cooperation. In other words, a successful assault upon this phenomenon calls not merely for the massing of effort behind the most promising lines of solution but the maintenance of an essentially cooperative competition among a variety of methods. We have to avoid over-commitment to any particular response, recognizing that we are dealing with human beings whose needs and responsiveness vary enormously. There is no room in this field for monolithic responses. Variety and flexibility should be the watchwords. We have to leave room for a great variety of human intervention and relationships—in a word, for the personal touch. We have to leave sufficient room and flexibility within our institutional arrangements for the creative play of the human spirit. For it is that which contains the capacity for profound change.

THE APPROPRIATENESS AND EFFECTIVENESS OF THE VARIOUS INSTRUMENTS OF SOCIAL POLICY

In considering the extent to which we may rely on the various means of social response we must have some general impression of their relative appropriateness and effectiveness. So often it is said that we should shift from one emphasis to another. Such suggestions generally rest on an assumption that the proposed alternative will be at least as effective as the policy to be abandoned. Yet this is not always the case. One policy is to be preferred to another if it is a more efficient policy—that is, a better policy on a balance of benefits and costs. Here we are considering not merely the effectiveness of a policy in terms of its ability to achieve a certain result, but also the price which must be paid for the result. It may pay us to forego some effectiveness, or at least to risk such a loss, in return for paying a less onerous price. Still, the *result* in the form of a reduction of certain kinds of use is so important and so much to be desired in the field of non-medical drug use that many may feel it is worth almost any price. At least, they may be relatively unimpressed by talk of the price. Thus, an analysis of policy options requires consideration not merely of the balance of benefits and costs—the net yield, so to speak—but also of the ability of alternative policies to produce a desired result.

It is also important to be quite clear as to how far it is necessary to choose between various policies or means of social response, and how far they may be pursued in combination. It is not essential that we think in terms of alternatives if there is not something mutually exclusive about the various options.

THE WISE EXERCISE OF FREEDOM OF CHOICE

In our *Interim Report* we said that the emphasis in social policy should “shift, as we develop and strengthen the non-coercive aspects of our social response, from a reliance on suppression to a reliance on the wise exercise of freedom of choice.” The important qualifications here—not always given due weight in references to this passage—are, of course, the words “as we develop and strengthen the non-coercive aspects of our social response” and the word “wise”. Such a shift in emphasis is only possible in the measure that we have developed effective alternatives to the punitive approach. The objective is not freedom of choice as such, but the wise exercise of freedom of choice—that is, choice that will avoid harm.

While most people would agree with such a shift of emphasis as an ideal, there is a serious question as to how far people are capable of wise exercise of freedom of choice in actual practice, and how far we may rely on non-coercive means of social response. People do not question the soundness of the ideal; they question its practicality.

The capacity for wise exercise of freedom of choice is certainly not to be taken for granted. Wisdom does not automatically flow from the

provision of ample and accurate information, important as such information is. Information has not deterred millions of people from continuing to run the risks inherent in the smoking of tobacco and the excessive use of alcohol. In a word, there does not appear to be any magic in information alone. The wise exercise of freedom of choice in relation to drugs depends on at least three factors: the possession of accurate and adequate information about the effects of drugs; the capacity (generally based on some experience and maturity) to make rational judgments in using this information; and the personal motivation, security and discipline required to abide by the behavioural directives issuing from these judgments. While adequate information on drugs can be imparted with relative ease by a variety of educational techniques and media, the capacity to make appropriate rational judgments in actual life situations is much less easily controlled by educational techniques. The factors of personal motivation, inner security and behavioural discipline—for example, the wish and the power to delay immediate gratification on rational grounds—are difficult to reach by traditional, short-term educational methods, and are mainly developed by the profounder influences of character formation in the family, religious life, and peer-group relations. They find their main basis in the early relationship between parent and child. The ideal of a wise exercise of freedom of choice is not an easily attainable one, but it is one towards which we must continue to strive, beginning with the early influences on child development.

The wise exercise of freedom of choice must take place within a framework of influences that support and reinforce the capacity for such choice. Some of these influences may be coercive and some non-coercive. They may be either preventive or remedial in their effects, or both. Together they will constitute a climate or continuity of influence that will contribute to knowledge and judgment.

The Causes of Non-Medical Drug Use

Our terms of reference require us to inquire into the "motivation underlying the non-medical use of drugs" and the "social, economic, educational and philosophical factors" relating to such use. In the *Interim Report* we attempted to touch on some of the dominant themes concerning the causes of non-medical drug use that had emerged from the public hearings and other sources of interpretation available to us during our first year. At that time our attention was attracted chiefly to the motivation and other related factors associated with drug use by young people—in particular, the use of cannabis, the strong hallucinogens and the amphetamines. It was an attempt to place the new upsurge of non-medical drug use in some social perspective, particularly in relation to the basic concerns underlying youthful dissatisfaction and protest. It did not purport to be a comprehensive discussion on the subject. It emphasized the extent to which curiosity and the simple desire for pleasure were primary motivations for the use of cannabis, it touched on the apparent association between youthful drug use and the search for a new meaning and approach to life, and it referred to the personality problems underlying some of the more dangerous forms of drug use, such as the intravenous use of amphetamines. Among the themes which this discussion touched on were pleasure, curiosity, the desire to experiment, the sense of adventure, the search for self-knowledge and self-integration and for spiritual meanings, the collapse of religious values, the division of life into work and play, role rejection, the search for authenticity, alienation and anomie, the loss of faith in reason, the emphasis on feeling and immediate experience, the relief of stress and tension, the bombardment of the nervous system by stimuli of all kinds, depression, the feeling of powerlessness, and a lack of belief in the future. Reference was also made to pathological causes of drug use, although the Commission expressed the view that the majority of non-medical drug users were not suffering from mental illness.

Since the *Interim Report* we have attempted to develop a more comprehensive discussion of motivation and other factors related to non-medical

drug use referred to in our terms of reference. Our purpose here is not to sum up the detailed discussion of motivation in Appendix D or the discussion in other appendices of related factors, but to state the conclusions which may be drawn from these discussions for the purpose of developing social policy with respect to non-medical drug use.

As we have seen, there are many theories about the causes of non-medical drug use and no overall explanation. In fact, we cannot be sure that we know the causes or predisposing factors in any particular case. What this means is that it is extremely difficult to identify the populations at risk to non-medical drug use or to predict whether any individual is likely to become a user of drugs, and if so, one whose drug use will lead to harm. The extent to which individuals engage in non-medical drug use is very much a reflection of opportunity. Opportunity is presented by availability and by someone who gives the individual the necessary invitation, encouragement or assistance which he may need to make the first attempt. Initial drug use may reflect nothing more in the personality or environment of the user than the fact that he has associates who bring him into contact with the opportunity for use. The extent to which a person becomes involved in regular-heavy drug use, or in patterns of use that may engender harm to himself or others, may depend in some measure on particular factors in his personality and social environment. The effects of the drug itself, if pleasurable, play an important role in influencing a person to continue use, but the fact that certain persons will seek such pleasure or relief despite obvious risk of harm is probably due in part to the particular makeup of the personality, although this has not, as yet, been adequately ascertained. In many cases, it can be hypothesized that persons will seek such gratification despite the risks because they have a low tolerance for discomfort, a poor self-image or a self-destructive impulse. In other cases, the physical or mental anguish of an individual is such that recourse to drugs can be viewed as a form of self-medication.

Although it is impossible to generalize about the motivation behind non-medical drug use, certain dominant themes keep recurring. One of these themes is that many excessive users suffer from a lack of self-acceptance. They do not like themselves, and they seek escape from this pain in the oblivion of intoxication. We could reduce the vulnerability to harmful drug use very greatly if we could remove the conditions that contribute to this lack of self-acceptance. People in the treatment field attest over and over to the fact that persons who make an excessive use of drugs have this sense of failure or personal inadequacy.

Another theme that recurs is the desire to escape from an intolerable bombardment of the nervous system by environmental stimuli. There is here both a sense of discomfort and a sense of personal inadequacy. The human being feels overwhelmed by the demands upon him. He seeks, by

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the effect of drugs, to insulate his nervous system against the shower of stimuli from the environment. A very prevalent condition which accounts for much drug use is stress produced by the nervous strain of modern living. Much adult non-medical drug use has the relief of stress as its main objective, particularly in the case of depressant substances, such as alcohol or barbiturates and tranquilizers.

The continued use of stimulants, in particular the amphetamines, seems to appeal in particular to those who feel depressed, incompetent, impotent or suffer from low self-esteem. Such people may seek relief from a painful consciousness of self in sedation or they may seek escape in an increased sense of energy or power. These are simply two different ways of trying to dispel the painful awareness of personal inadequacy.

An explanation that has frequently been offered for non-medical drug use, particularly by young people, is the notion of alienation. It is said that there is a widespread feeling of estrangement from established institutions and values. They no longer convey a sense of relevance. There is an inability to identify with them. The notion of alienation is used in many different senses to characterize prevailing attitudes or reactions. It is used very often to convey the dissatisfaction which young people feel with the existing educational system.

Closely akin to alienation as a feeling or condition that can lead to drug use is boredom. Many people fail to be adequately stimulated by their environment and consequently are involved in a restless search for pleasure and for new experiences. Boredom is simply one form of mental discomfort that persons can seek relief from through the use of drugs.

It is incorrect to assume that all drug use has some underlying psychopathology, but it is equally incorrect to assume that some people are not more prone to excessive use than others. It is necessary to distinguish between the occasion of initial use, for which nothing more may be necessary than the opportunity and curiosity, and the persistence which leads to excessive use and excessive involvement in a pattern of life oriented around use. For the latter transition to occur there is probably some combination of individual and social factors which explain the continued and in some cases even obsessive use of a drug.

To a person who can relax and find peace of mind by other means a sedative obviously does not represent as strong an attraction as it does to one who cannot. The peculiar quality of psychotropic drugs resides precisely in the change of mental state which they can produce. If one can produce these desired states by other means then there is less likely to be a compulsion to resort to mind-altering drugs. We all have to cope with the problems for which drug use may appear to offer some relief. The difference in degree to which we become dependent on drug use lies, to some extent, in our access to viable alternatives and our ability and willingness to make effective use of them. All must cope at some point with stress, pain, over-

whelming demands, self-doubt, anxiety, and boredom. Some are able to use conventional and sanctioned resources to cope with these states; others do not have the ability to deal with inner conflicts or have access to the means of resolving these conflicts.

While it is necessary for purposes of analysis to concentrate on the motivations for specific kinds of drug use, the single motivation which is of most concern is that of the chronic multi-drug user—the person who engages in indiscriminate and reckless drug use. Obviously, there must be motivations common to a number of drugs to explain the behaviour of such individuals. The chronic multi-drug user would seem to be driven in some cases by a strong impulse towards self-destruction. He appears bent upon oblivion, often as a result of a profound dissatisfaction with self.

Some recent studies have suggested that family influences can have an important bearing on drug use.* It is said of white middle-class families that the *high risk family* (i.e., a family in which the children have higher chances of becoming drug users) is one in which the parents are uncertain of their roles, both as parents and husband and wife; in which the mother tends to be dominant and the father lacking in leadership in the family; in which the parents are permissive, hesitant to convey their values, and indeed unsure of their values, except the belief that children should be given freedom to develop their personalities; in which there is not a proper balance of affection and discipline; in which emotions are not expressed with freedom and confidence but problems tend rather to be intellectualized; in which the relations between husband and wife do not inspire a sense of security in the children; in which there is poor communication between the parents and children; in which there is fairly heavy reliance by the parents on drugs of various kinds; in which there is a lack of religious belief, a hostility towards authority, and a progressive leaning on political and social issues. The low-risk families, by contrast, exhibit a very strong, warm, well-integrated pattern of family life, with a good combination of affection and discipline; there are warm and happy relations between the parents who accept their role as parents and as husband and wife, with leadership from the father that is authoritative but not autocratic—gentle but firm and tempered with humour; the parents are confident they know how to bring up their children and are clear as to the values which they want to transmit, with emphasis on faith in God, respect for parents, self-control, tolerance and respect for one another. Within this framework of standards and discipline children are in fact given considerable scope for freedom and personal responsibility. Because they know what their parents expect they appear to be much more confident in their judgments. The children of the low-risk family are found to be resistant to peer group pressure. Because of the direction and support they receive in the families they do not seem to be as dependent on the approval or guidance of others. It is noteworthy

* R. H. Blum, & Associates, *Horatio Alger's Children* (San Francisco: Jossey-Bass, 1972).

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that the parents and children of low-risk families are much more forgiving of themselves and each other. They like themselves and each other. They do not expect too much of each other. Blum's conclusion that a certain quality of family relationships provides the necessary conditions for self-restraint and the capability to resist group pressure and resolve personal conflicts without resorting to drug use is certainly an interesting hypothesis which warrants further attempts at empirical verification.

There is no doubt that children are influenced by the importance which their parents attach to drugs and by the example of drug use which their parents give. Parents convey more by their conduct than by their words. If parents show that they rely on drugs to relieve discomfort and to change their mood, how can they expect their children not to follow their example? No doubt there are exceptional cases where children may become so disgusted by the effect of drug use on their parents that they are turned off it for good, but studies show that the children of alcoholics are more likely to become alcoholics themselves, and that the children of parents who make extensive use of prescription and other drugs are at greater risk to drug use than the children of parents who do not.

From the public point of view most concern focusses on the question of what leads people to experiment with heroin, and having experimented, to go on to the regular use which leads to dependence. There have been a great many theories, psychological and sociological, to explain opiate narcotic use and dependence, but there seems to be little in the way of a general consensus which is firmly supported by empirical evidence. There are, however, a number of hypotheses which are attractive because of their plausibility. They fit at least some part of what we intuitively feel must occur; in each case there must be some combination of psychological and environmental factors, although the circumstances vary so much that it is virtually impossible to generalize. The following factors appear to be worthy of particular consideration: the factors which produce the opportunity of first use and the willingness to accept this opportunity or invitation; the role played by the personality, the effects of the drug, and personal associations and pattern of life, in the continuing use which develops into dependence; and the factors which make for the tenacious hold of dependence and the difficulty of remaining abstinent without relapse.

It would appear that sociological or environmental factors are far more important than psychological ones in the opportunity and willingness to use an opiate narcotic like heroin for the first time. The crucial factor in initial use is availability or access to the drug, and for the non-user this almost always means coming into contact with a user. The user may also be a dealer but this initial contact is usually of a casual, friendly nature, and does not ordinarily arise out of a dealer forcing himself upon a prospective user. If an individual decides to use heroin it is generally because his curiosity has been aroused by what he has heard or observed in his contact

with another user. Why some persons who are exposed to this opportunity for use take advantage of it and why some do not is a matter of pure speculation. Obviously the initial or experimental user does not have such reservations about heroin use that he is unable to overcome them. Some studies have suggested that those who decline the invitation have more negative knowledge or attitudes about heroin than those who accept it. An increasingly important factor influencing response at this point must be the now wide-spread knowledge that one does not become instantaneously dependent on heroin but that it takes some time to develop dependence. The person who is prepared to experiment with heroin will almost always have a background of multi-drug use (although this was not necessarily true prior to the mid-1960s, and there are still important exceptions) and must be favourably disposed to drug experimentation. Today; it will generally be involvement in the multi-drug use pattern of life that will have brought the individual into contact with a user of heroin in the first place.

The personality background and makeup of this multi-drug user who is prepared to experiment with heroin is difficult to characterize. Obviously, he must be someone who has become sufficiently involved in a pattern of multi-drug use to be able to overcome any inhibitions about the use of the hypodermic needle. Consequently, those who are most at risk to heroin use and dependence are undoubtedly the intravenous users of amphetamines or 'speed'. They are already familiar with the use of the needle, and heroin offers them relief from the strain of amphetamine use. There seems to be agreement that the 'speed freak' generally suffers from serious personality problems. He frequently comes from a disturbed family background and, according to some authorities, often shows feelings of sexual inadequacy as a result of slow maturation. These characteristics have also been noted in heroin dependents. Indeed, there is a marked similarity in the background of these two types of drug users.

For those who have not used 'speed' intravenously, something more is required to permit this critical step in drug use than simply the kind of curiosity that may lead to the initial use of cannabis or even to one of the strong hallucinogens. Certainly, curiosity is there in many cases, but there is probably also a background of multi-drug use and risk-taking. Nevertheless, one must not forget that opiates are the most powerful of analgesic drugs, and therefore, they may be sought in cases of very severe physical or mental pain.

The factors which lead to repeated use and finally to the increasingly regular and frequent use which ends in dependence include the reinforcing effects of the drug and the attraction of a certain pattern of life and associations. The gratification afforded by the drug is obviously a major factor in causing an individual to repeat his use of the drug until he becomes dependent. There is both gratification in the form of a pleasurable sensation and gratification in the form of relief of distress or discomfort of some kind. The discomfort in a great many cases may be a strong sense of personal

inadequacy. This feeling of personal inadequacy may proceed from a failure to perform satisfactorily in the educational system or to find and hold satisfactory employment. A high proportion of heroin users drop out of the educational system before the end of high school, despite the fact that they are quite often above average in intelligence. Most of them have a poor record of employment in their background before heroin use. A high proportion also have a record of delinquency or antisocial behaviour of various kinds which pre-dates their use of heroin. There is also often a background of unstable family life without a strong father figure. For males, this may result in a weak masculine self-image and fears of sexual inadequacy. These observations by clinicians and others who have had the opportunity of examining heroin addicts may not have all the empirical foundation which might be considered desirable, but they are recurring themes which have to be treated as serious hypotheses. The truth about the motivation to heroin use does not seem to lie in an exclusive emphasis on factors in the pre-use personality of the user, nor on factors in the personal and social environment of the user before he took up use, nor again in the reinforcing effects of the drug and the pattern of life and associations developed after use, but rather in a combination of all of these factors. Although it is impossible to predict with any degree of assurance what types of persons are likely to come into contact with the opportunity for heroin use, likely to take advantage of the opportunity, and likely to continue use until they become dependent, there are certain generalizations that we can make of importance to the development of social policy.

Important factors in connection with heroin use are the early family influences which may produce a vulnerable personality; the existence of a multi-drug-using subculture which allows for a bridging of the traditional gap between drugs such as cannabis and the hallucinogens, on the one hand, and methamphetamine and heroin, on the other; and the pattern of life and associations which the heroin user acquires once he becomes dependent. The key factor is undoubtedly availability which turns on contact with a heroin user. Many persons of vulnerable personality are never exposed to an opportunity for heroin use. Many who are exposed do not take advantage of the opportunity. Others do not pass beyond the stage of experimentation. Still others do not pass beyond occasional, non-dependent use. What seems to be of chief importance is the formation of a close relationship with a heroin user. It is a combination of a person being psychologically or socially vulnerable to heroin use, and receiving encouragement or persuasion from another person on whom one feels somewhat dependent, that explains becoming a heroin dependent.

In the United States social conditions in the depressed urban core of large metropolitan centres have created the desperation and extreme vulnerability which is particularly fertile ground for heroin use, especially because heroin is so readily available in these same areas. We have not had similar conditions on the same scale in Canada, particularly the plight of underprivileged racial minorities. There has been some evidence, however,

that among Canada's newer heroin dependents, there are many first generation Canadians whose traditional parental values conflict with the dominant normative system.

It is necessary to place the role played by multi-drug use and so-called 'contagion' or 'infection' in some reasonable perspective. Obviously, there are not clearly defined causal relationships between the various kinds of drug use, but there are associations between them of a predisposing nature. For example, there is the association between the smoking of tobacco and the smoking of cannabis, the use of cannabis and the use of LSD, and the intravenous use of the amphetamines and heroin. Alcohol figures in the background of most multi-drug users. There is a strong correlation between it and the use of other drugs. Multi-drug use exercises an overall influence which makes it more likely that persons who have used certain drugs will use other drugs. It increases interest in drugs and drug experimentation. The more heavily involved a person is in multi-drug use the more likely he is to move on to new drug experiences. This increases the chance of the progression to heroin use, although it does not necessarily predict heroin dependence. Involvement in multi-drug use brings the users into contact with persons using a variety of drugs and is more likely to expose them to the opportunity for use of potentially more dangerous drugs.

The 'contagion' or 'infection' theory holds that drug use spreads mainly through contact with users. It is a use of the term contagion or infection by way of analogy. Obviously, the process is not strictly like that of the spread of infectious disease since in drug use the 'victim' is not infected without an intervening act of volition on his part. However, the opportunity to use heroin depends on contact with other users and, in many cases, his curiosity or interest in the use of the substance would not be sufficiently aroused without the influence of others. Nor indeed would he in many cases learn the particular procedure or practice required for effective use. In these senses, then, contact with another user is generally necessary for the spread of drug use. Controversy about the contagion or infection theory seems to be of a semantic nature. To this extent it is much like the controversy about progression. No doubt there are many factors which account for drug use in a particular case, but previous experience with drugs and contact with the users of other drugs which have yet to be tried must certainly be significant factors. Experience with other drugs whets the appetite for drug experiences, and contact with users creates the essential condition of availability. The real question is how much relative importance is to be attached to these factors and what, if anything, we can or should do about them as a matter of social policy.

One cause of drug use which has been much emphasized is peer group influence. The source of such influence is the desire of young people to be accepted by a group of their contemporaries on the street, at school or in a university. Such acceptance is necessary for the formation of friendships, the

opportunity for participation in social and recreational activity, and generally for the sense of well-being and identity which derives from belonging to a group. It seems to be a necessary form of recognition for the building of youthful self-confidence. Children who have difficulty gaining such acceptance experience considerable mental pain. Since there will be many such groups in practice into which one may gain access there will be considerable range in the choice of possible companions. But the need to win the acceptance of some group, however small, makes a child particularly vulnerable to influences which indicate the kinds of behaviour required for acceptance. Sometimes a child may overestimate the degree of compliance or conformity which is required or the extent to which a refusal to conform on some point will keep him out of the group, but the anxiety not to be considered so odd or different as to risk exclusion is a very understandable one. There is reason to believe, nevertheless, that a strong, supportive family can be an effective counter-balance to deleterious peer group influence.

The influence of the media on drug use is a subject about which there is much controversy, and it is probably impossible to evaluate the full extent of its impact. The influence of the media is no doubt not the most important factor, but it is probably one which has a significant bearing on use. Surveys have suggested that contact with users has been more important in initiation to drug use than the media—and this is what one would expect—but this does not exclude some influence for the media. It is one of many factors contributing to a general climate of awareness and the formation of attitudes about drug use. The advertising media cannot have it both ways: the vast expenditures on modern advertising are based on the assumption that advertising can influence behaviour, and the advertisers claim credit for their clients' increase in sales; they cannot now disavow any effect on drug use as a result of their efforts to make it as attractive as possible. Of course, the advertisers are only concerned with legal use, but we may assume that not only does their advertising encourage legal use but that the extent of legal use has a bearing and influence on the extent of illegal use. It is legal use in the form of tobacco, alcohol, sedatives, stimulants, analgesics and a host of over-the-counter remedies that creates the general climate of reliance on drugs to change our mood and relieve discomfort. It is this general climate that propagates the notion, overtly and subliminally, that such reliance is not only acceptable but the intelligent course of action when one is troubled by physical or mental discomfort of some kind.

Apart from advertising, the media have certainly had an influence on attitudes toward drug use. In many ways they have played a constructive role, helping to point up the issues and to spread useful information. In other ways they have tended to exploit the sensationalism in illicit drug use and to arouse unhealthy and voyeuristic interest. For example, some 'rock' lyrics and the pronouncements of several youth-oriented radio stations have probably contributed to the development of a climate of drug acceptance

among many Canadian adolescents. Similarly, it is difficult to see the constructive purpose served by a graphic television portrayal of how to use certain drugs as this is bound to arouse interest in those who are vulnerable to such experimentation. The 'how-to-do-it' approach of the media on occasion has probably been their gravest fault in their exploitation of popular interest in non-medical drug use. They have also tended to excite emotional concern and to emphasize and exacerbate the polarization of opinion in the country. The media feed on controversy, and they may also on occasion try to stimulate it. The gradual decline of the media's interest in the subject of non-medical drug use has probably been a good thing on the whole for the country.

The sensationalization of drug use can only lead to adverse results. It tends to obscure the real issues, it encourages emotional over-reaction, and it stimulates unhealthy interest. It interferes with the dissemination of accurate information and prevents the development of a balanced perspective. This, however, is a negative aspect of the influence of the media. By and large, the contribution of the media to the better understanding of the phenomenon of non-medical drug use has been a constructive one. They have made the complexity of the issues and the range of opinion more accessible to Canadians. The media, then, can be a force for good and a force for harm. It is certainly an impressive form of power, and like all forms of power it must be used with discrimination and self-restraint, and an overriding sense of public responsibility.

Now, to attempt to sum up about motivation and related factors of a social, economic, educational and philosophic nature as they bear on social policy:

1. We cannot begin to think and act effectively in the field of prevention unless we can come to some consensus about motivation and other related factors which influence the cause of non-medical drug use.
2. In the absence of some sound understanding about motivation, all that prevention can fall back on is fear—fear of the criminal law and fear of the dangerous effects of drug use.
3. Although it is likely that fear has some deterrent effect, reliance on fear has not been able to prevent a steady increase in non-medical drug use. This is partly a reflection of the extreme difficulties of law enforcement in this field, but it is also a reflection of a readiness to take risks, particularly if they are the price of present pleasure, and also in some cases of a general scepticism about the alleged dangers of certain kinds of drug use.
4. There has to be a more varied strategy than fear in order to compete with pleasure and the desire for experience. It is not enough simply to say "No". We cannot take away the drugs without putting something in their place. There has to be much more emphasis on viable substitutes and alternatives.

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5. Habit plays a very large part in drug use. Breaking up habit patterns is an important aspect of stopping excessive drug use. Persons can be diverted from certain habits by involvement in other activities which fill up the space occupied by habits that are thought to be harmful.
6. While it is true that many of the theories about the causes of non-medical drug use have little empirical basis, they nevertheless represent working hypotheses, some of which can be tested empirically. We have little to lose by testing the more plausible explanations of drug use by making such explanations the basis of attempts at prevention and treatment. This is the way experimental effort has to proceed in other areas, on the basis of testing reasonable assumptions. If we take reasonable precautions, the individuals concerned will not be the worse off for our acting on plausible assumptions.
7. Several authorities have contended that there is a drug-dependent or dependence-prone type of personality. While critics of this theory have pointed out that there is little empirical evidence to support it, the notion that some people, given sufficient opportunity for drug use, are more prone to excessive use than others has strong intuitive appeal. It appears that certain personality characteristics are likely to have an influence on the decision to use or not use drugs, initially or on a continuing basis.
8. Among these psychological factors which may be presumed to have a bearing on drug use, one of the most important is the opinion which the individual holds of himself. We see much non-medical use as having its origins in a poor self-image or a lack of self-acceptance. We believe that anything that seriously undermines the individual's sense of personal adequacy is likely to render him or her more vulnerable to involvement in excessive reliance on drug use. Conversely, we feel that any influence that strengthens the individual's acceptance of self is likely to play a prophylactic role in relation to drug use.
9. Other factors of a personal nature that increase vulnerability to excessive involvement in non-medical drug use are inability to accept one's natural emotional cycle and swings of mood without recourse to drugs, a low level of tolerance for frustration or boredom, and an inability to cope with tension and anxiety by exercising self-control.
10. Both the family and the school have an important role to play in laying the foundation for self-acceptance and self-esteem and for helping the individual to develop the resources and skills for coping with mental discomfort without reliance on drugs.
11. Availability—that is, the opportunity for use and access to a supply of the drug—remains a primary matter of social concern. Without availability the vulnerability which is created by certain factors of a psychological and social nature would never be tested. Thus availability remains one of the most important causal factors. So also does contact with users. The two go closely together. It is a user who generally serves as a source of supply. The prevention of contact with users must

therefore be an important consideration, especially when persons are young, inexperienced and perhaps less able to make prudent choices.

12. One of the most compelling factors in the use of illicit, dependence-producing drugs is the pattern of life and associations which the drug user develops. He generally breaks or loses his contacts with conventional society and living. He may no longer have a legal means of livelihood, he lacks the support of individuals in the "straight" world, and he lacks a variety of normal social and recreational activities which could fill the place of his preoccupation with drugs. He becomes involved in a pattern of delinquency and crime, and he becomes dependent on his associations in the drug subculture. This dependence is almost as strong as the dependence on the drug itself; indeed, it may be stronger, or at least an important aspect or component of the drug dependence as a whole. The obsessive character of the dependence of someone who relies upon a legal drug is no less involving, but the licit nature of his drug does not compel him to divorce himself from conventional society or engage in criminal enterprise.

It is very difficult to win the chronic drug user away from this pattern of life and supportive relationships. An adequate understanding of the role played by the life style and pattern of relationships in reinforcing the hold of drug dependence and precipitating relapse is fundamental if treatment and rehabilitative efforts are to be successful.

13. In speaking of motivation we must be careful to distinguish between experimental or occasional drug use of a relatively harmless nature which is prompted mainly by curiosity, and persistence in chronic, multi-drug use which carries a high risk of harm. The motivation for the latter kind of drug use passes well beyond mere curiosity and generally involves serious social and psychological problems. At the same time, there are no clean-cut lines of demarcation between the various stages of drug use, and one stage tends to slip fairly easily and imperceptibly into another. The general climate and extent of non-medical drug use also contributes to the extent of harmful drug use. Thus it is not realistic to attempt to deal with any one form of drug use, as if it can be separated or isolated from the others, nor to attempt to base a general strategy of prevention on distinctions between harmful and non-harmful use. We have to be concerned with drug use which has a potential for harm as a whole.
14. There are certain conditions in modern life which are conducive to non-medical drug use. Among them is the bombardment of the nervous system by stimuli of all kinds. This leads to a desire to seek relief by withdrawal or insulation of some kind.
15. Influences of various kinds toward conformity in order to achieve acceptance within the adolescent peer group or the adult social group also play their part in encouraging non-medical drug use as a means of facilitating social relations and winning social acceptance.

16. Modern advertising reinforces the impression that there is a chemical relief for all states of physical and mental discomfort. It fosters a general climate of acceptance of drug use by its promotion of tobacco and alcohol. It conveys the message that these substances facilitate social relations and serve to change one's mood for the better. The impression that is created is that one cannot get along effectively without them. It is not the particular substance that is important but the idea of mood-modifying substances as a necessary aid to effective living.
17. As we have seen, the massive extent of adult drug use and the ease with which adults resort to pharmaceutical and alcoholic substances are major influences on illegal and non-medical drug use by adolescents.
18. Non-medical drug use, particularly among young people, has been seen as expressive of a general dissatisfaction with the conditions of modern life, in particular the dehumanizing conditions of urban living and employment. It is thought to reflect the sense of alienation or estrangement from modern institutions and values which many young people feel. In this sense, non-medical drug use is seen as an aspect of a general protest against or retreat from modern conditions. While its symbolic significance seems to have declined somewhat in recent years, and there is much less ideological connotation to non-medical drug use than there was a few years ago, there is still in our opinion a close association between non-medical drug use by the young and a general feeling of dissatisfaction and pessimism about the prospects for a satisfying and self-fulfilling life. This is related to the rapid rate of change, doubts about the continuing relevance and utility of knowledge acquired in the formal educational system, doubts about the ability to find appropriate employment after a long period of formal education, and concern about the future of the human community arising from such problems as over-population, pollution, racial tension, economic instability and the threat of global war. These conditions give rise to a certain degree of depression for which relief is sought in non-medical drug use.

In summary, there are factors in the personality or psychological make-up of the prospective user, in his close personal relations and environment in the family, school, and the peer group, in social and economic conditions, and in the general attitude of the society towards drug use, as reflected by advertising, the media and the practices of the adult population, which predispose and encourage the individual to engage in non-medical drug use. The drugs themselves, as a means of relieving discomfort and affording pleasure, exercise a powerful attraction for people who have been conditioned more and more to seek comfort and pleasure. Modern advertising encourages the notion that there is no reason to put up with discomfort. A whole consumer industry turns on keeping people in pursuit of pleasure. While such a philosophy has its uses, it conveys a hedonistic approach to life which makes it increasingly difficult for people to tolerate the dissatisfactions of everyday living.

Section IV

The General Proportions of the Problem

The outstanding characteristic of the phenomenon of non-medical drug use is that it is always changing. Moreover, there are great differences in the drugs used and the levels of use among the different using populations. It is, therefore, virtually impossible to sum up the phenomenon at any given time with a reasonable degree of accuracy. At the same time, there is a strong desire for a sense of the general direction in which the phenomenon is moving, for an identification of its significant trends, and an estimation of the relative seriousness of its various manifestations. Despite the limitations of generalization about such a multi-faceted and rapidly changing phenomenon, there is an understandable desire for some general perspective. What people wish to know may be expressed in a general question such as: Is the situation getting worse or better?

Such a general question, however, requires some definition. We must know what we mean by the "situation" and what we would consider an improvement or a deterioration. What, in the terms of the title of this section, is to be considered the "problem" for purposes of an attempt at a general appraisal? The "situation" or the "problem" might be considered to encompass all the negative aspects of the phenomenon of non-medical drug use, including not only the harm caused by the drugs themselves, but also the harm caused by various aspects of our individual and social response to non-medical drug use. In subsequent sections we address ourselves to social policy. In the present section we propose to limit ourselves to a very general commentary on the relative potential for harm and the extent of the various forms of non-medical drug use.

It is not possible to summarize the detailed discussion of effects, sources and distribution, and extent and patterns of use which is contained in Appendices A, B and C. For an adequate understanding of the Commission's findings on these matters it is necessary to read these appendices. Nevertheless for the reader's convenience, certain general observations may be made here to draw attention to particularly significant points. The reader should

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bear in mind, however, that many of these general statements will inevitably be oversimplifications, and he should have recourse to the appendices for a fuller understanding of the necessary qualifications.

It is our impression that the overall extent of non-medical drug use, in one form or another, is increasing rather than decreasing in the general population. In any event, we do not see any signs of a marked trend in the opposite direction. The rate of overall increase may be diminishing, and it may even be reaching some kind of plateau or stabilization, but there are no clear signs of a movement in the direction of a general reduction in the extent of use. This observation is of particular significance, since the attitudes reflected in the general drift or tendency of non-medical drug use have an influence on individual decisions.

The widespread use of alcohol and tobacco continues to provide the supporting climate for other non-medical drug use. So long as their use continues to spread in all age groups of the population, including adolescents, there is little hope of being able to develop a general climate of restraint with respect to non-medical drug use. The damage caused by alcohol and tobacco is now so well understood that our continued toleration of these forms of non-medical drug use, and our apparent inability to bring about any significant reduction in them, raise profound doubts about our seriousness of purpose with respect to the phenomenon of non-medical drug use as a whole.

The effects of alcohol, its distribution (as well as the dependence of government on it for revenue), and the extent of its use are set out in Appendices A, B and C. A careful reading of this material can leave one in no doubt that alcohol is, and is likely to remain, Canada's most serious non-medical drug use problem.

From almost any point of view the effects of the excessive use of alcohol are more harmful than those of any other form of non-medical drug use: in physical and mental injury to the user, in increased mortality from a variety of causes, and in drug-related behaviour causing personal injury to others. If we take the total incidence of such effects—which reflects the total numbers engaged in the excessive use of alcohol—there is little comparison with other drugs. To name a few, alcohol is a major factor in a large proportion of traffic accidents, violent crimes, suicides, serious family disruptions, and numerous physiological and psychological disorders in North America. Estimates of the extent of the use of alcohol vary, but we think it is reasonable to assume that at least three-quarters of the population over 15 years of age have used alcohol. The proportions who use it regularly and the proportion who use it excessively are, of course, much smaller, but they represent populations of considerable size. For example, there are probably at least twenty times as many alcoholics in Canada as there are opiate dependents. In addition, there are another several hundred thousand problem drinkers who would not be considered alcoholics at this time.

As a public health problem the excessive non-medical use of alcohol is in a class by itself. Although there is growing public awareness of the seriousness of this problem, and a good deal of editorial leadership from the press, the liquor industry continues to fight a rear-guard battle to persuade the public not only that alcohol is not a drug, but that the problem presented by its excessive use is grossly exaggerated. Governments are expressing increasing concern about the problem, but so long as they draw a substantial revenue from the sale of alcohol, their own seriousness of purpose may be suspect. It would appear that in the present social context the answer lies in greater self-restraint by the general public. The existence of a highly profitable liquor industry, legal distribution, and a large government revenue from sale, all make it clear that we cannot look to any significant restrictions on availability as a potential mechanism to reduce the extent of alcohol use.

The decision of several provincial governments in recent years to lower the drinking age to 18 or 19 is also in apparent conflict with public expressions of concern about the problems of alcohol, particularly among young people. From local surveys since this change in the law there is reason to believe that it is likely to have led to an increase in the consumption of alcohol by persons above the age of 18 or 19 and to an increased availability of alcohol (through friends) for persons under that age.

It has been proposed that raising the relative price of alcohol (in relation to disposable income) would be an effective means of reducing the use of this drug in the general population and thus decreasing the problems associated with heavy alcohol consumption. While some change in patterns of use would undoubtedly occur in some individuals as a result of an increase in the cost of licit alcohol, we feel that this is not likely to be a practical or effective method of bringing about a significant reduction in compulsive dangerous alcohol use. Although such measures might reduce the incidence of some of the acute adverse effects of drunkenness in certain populations, even with this increased financial burden alcohol is likely to be one of the last goods to be sacrificed by the dependent user. In certain low income families with an alcoholic member, an increase in the cost of alcohol would likely result in an even greater diversion of very limited funds away from food and other essential commodities to the purchase of the drug. Further deterioration in child nutrition might be a more probable result than a significant reduction in alcoholic adult drinking under such conditions. Moreover, if the cost of licit alcohol were raised substantially, there would likely be a significant increase in the illicit manufacture and distribution of alcohol, which, as indicated in Appendix B, is already extensive in certain parts of Canada. Finally, it seems unlikely that the general public would support the level of taxation and law enforcement which would be required to bring about a substantial change in heavy alcohol consumption.¹

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Not only is the excessive use of alcohol serious in itself, but it also figures prominently in various patterns of multiple drug use. Indeed, alcohol plays a significant background role in most dependent drug use, including the use of the opiate narcotics. It also frequently becomes the alternative or substitute for other forms of harmful drug use. For example, in many of the cases in which there is an apparent cure of opiate dependence, the user turns to the excessive use of alcohol sometimes with even more deleterious consequences. Alcohol also plays a serious role in producing harmful effects in combination with other drugs, such as the barbiturates and other sedatives. In our *Cannabis Report* we commented on certain additive effects of alcohol and cannabis.

The use of tobacco continues to be a very serious public health problem and is one of the leading contributing factors in disease and premature death in Canada. Tobacco use, itself, does not generally lead to injury to third persons, as in the case of alcohol, nor does it cause psychological damage, but it creates a serious risk of physical harm and substantially increased mortality rates in heavy users. It also creates strong psychological dependence which makes it difficult for users to break the tobacco habit despite its dangers to health and, frequently, its offensiveness to others. Indirectly, tobacco smoking is often a significant factor in property damage, personal injury and death caused by urban and forest fires. Today about 40 per cent of Canadians over the age of 15 smoke tobacco regularly. There has apparently been some slight reduction in recent years in the total proportion of the population engaged in the use of tobacco, but there has been little change, or perhaps some increase in the number of heavy users. As well, there are indications of increasing use among young people—particularly teenage girls. There is no reason to believe that there has been a decrease in the incidence of harmful effects of this drug. The use of tobacco continues to play a significant role in multiple drug use as indicated by its close associations with the use of alcohol, cannabis and other drugs. The general presence of inadequately attended cigarette dispensing machines and lax sales practices of many vendors make tobacco easily available to all, including the very young. Increasing concern is being expressed over the right of non-smokers to breathe uncontaminated air in public places often dominated by heavy smokers.

In addition to alcohol, there has been an apparent increase in the non-medical use of other sedative drugs, in particular, barbiturates and related sedative-hypnotics and minor tranquilizers. These drugs have close affinities with alcohol. Indeed, many complications arise from their use in combination with alcohol. It is impossible to estimate the full extent of the non-medical use of these drugs, particularly by adults, because the supply for such use often originates under prescription which is not routinely monitored. But there has been increasing evidence of an illicit market in certain of these drugs and clear indications of an increase in their use by young people. The extent of the non-medical use of barbiturates and related drugs in Canada is not comparable to that in the United States, however. As part of the general increase in the use of drugs with sedative action—sometimes referred to as

'downers'—there apparently has been a continuing increase in the use of cannabis, which is sometimes taken for its tranquilizing effect.

Among the sedative drugs, the most evident increase is in the use of certain non-barbiturate sedatives and minor tranquilizers, which in recent years have tended to replace the barbiturates in many medical applications. The rapid increase in the non-medical use of methaqualone (e.g., Mandrax®) is particularly noteworthy. There have been a number of reports of the use of these drugs simultaneously with alcohol by adolescents to achieve very intense intoxication.

We believe that because of the widespread adult reliance on these drugs with sedative-like action from supply originating under medical prescription and the stressful conditions of modern life for which they appear to offer relief, it is reasonable to expect a continuing increase in their non-medical use in all groups of the drug-using population. These drugs vary considerably in their potential for harm, but all have the capacity to produce dependence, and certain of them have significant potential for physical toxicity and death by overdose, either alone or in combination with other drugs. Barbiturates are the drugs most frequently involved in fatal self-poisoning or suicide, perhaps because they have been prescribed for the last half century, while most of the other non-barbiturate sedative-hypnotics have only been developed during the last 10 or 15 years, and consequently are less known to the medical profession and the public. Even the less potent of the sedative drugs can have serious effects when used, as they often are, with other drugs such as alcohol. One of the most insidious aspects of this general category of drugs is the tendency of those who are attracted by them to use them in combination.

There continues to be an extensive non-medical use of stimulants. The desire for stimulant effects is, of course, reflected in the heavy consumption of caffeine in the form of coffee, tea and cola drinks. There is also widespread non-medical use of amphetamines and amphetamine-like drugs. Although most of the non-medical use of amphetamines in the general population apparently involves oral use of relatively moderate quantities, much concern has developed over the high-dose intravenous use of methamphetamine or 'speed' by certain groups. The total number of persons involved in the intravenous use of amphetamines appears to be fairly stable, and may even have declined somewhat in recent years. It would appear that many who drop out of the 'speeder' population after a few years, because of the severe strain which the 'speed' life style imposes, are more or less balanced by the initiation of new users. It is our impression, however, that the non-medical use of oral amphetamine and amphetamine-like drugs, such as Dexedrine® and Preludin®, often supplied from an illicit market, has increased in recent years, particularly among young people. The medical use of amphetamines has decreased in the past few years, and may be expected to decrease still further as a result of the restrictions imposed by the Federal Government at the beginning of 1973 on the purposes for which such drugs may be used in

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medical treatment. But it is likely that the non-medical use of such drugs, supplied by an illicit market, will continue to increase. As well, many persons who have been obtaining amphetamines on prescription will likely continue to receive from legitimate sources other amphetamine-like prescription drugs which are not subject to the above restrictions. Taken occasionally and in moderate doses, amphetamine and amphetamine-like drugs are not particularly harmful, but tolerance develops with frequent use and they have a significant capacity for producing strong psychological dependence in certain users. At higher doses, they can produce serious psychological and physiological disorders. Additional problems are frequently caused in 'speeders' by the use of unsterile injections and insoluble contaminants in illicit drugs. The reliance which many people place on these drugs for additional energy and confidence to meet the demands of modern life creates a serious health hazard. In recent years there has been an increase in the non-medical use of the stimulant cocaine, although it has not yet become very extensive.

There has been a marked increase in recent years in the non-medical use of the opiate narcotics, particularly heroin and methadone, and an apparent increase in the proportion of young people engaged in such use. In 1972, the records of the Bureau of Dangerous Drugs showed approximately 9,000 "habitual" users of illicit opiate narcotics (formerly called street addicts). There is reason to believe that the total number of opiate dependents shown on the records of the Bureau at any particular time is considerably below the total number actually in the country at that time, but it is not known by how much it falls short. It is felt that sooner or later most of the opiate-dependent persons will come to the attention of the police, the treatment agencies or private physicians, who are the main sources of the information on which the Bureau bases its records, but there is a considerable timelag and other gaps in information channels which probably leave a significant proportion unknown to the Bureau at a particular time. There has also been a greater dispersal of opiate narcotic use in recent years and a marked increase in experimental or occasional use, so that the total number of persons in the process of becoming dependent is likely to be less exposed to law enforcement and treatment personnel than it formerly was. Our own estimates of the probable number of opiate dependents in 1972, based on field studies and other Commission research as well as estimates by the R.C.M. Police made about the same time, suggest that the actual number is probably somewhere between 12,000 and 15,000. In order to avoid any danger of underestimation we are prepared to accept the figure of approximately 15,000 as a reasonable estimate of the number of daily users of opiate narcotics in Canada at the present time. We certainly feel that this is a safe estimate, and that there is little likelihood that the total number exceeds this figure. There is reason to believe, however, that there are also tens of thousands of persons experimenting with the use of opiate narcotics, an unknown proportion of whom are probably at serious risk of becoming dependent. Thus the situation with respect to the use of opiate narcotics is a

dynamic one, with a definite tendency to increase in numbers and to spread geographically. At the present time, such use is still very heavily concentrated in British Columbia—and to that extent the use of opiate narcotics can be regarded as still very largely a regional problem—but there has been a significant increase in use and dependence in recent years in certain parts of the prairie provinces, particularly Alberta, and in certain parts of eastern Canada, especially in Toronto and other cities in southern Ontario. In some areas, there are reports of youthful “primary methadone addicts” who have not been significantly involved in the use of heroin.

The chief danger from the use of opiate narcotics is, of course, the great difficulty in curing a typical case of opiate dependence. Where the drug must be obtained in an illicit market the consequences of such dependence are likely to be very serious both for the individual and the society in the form of drug-related crime. There is also the general effect of such a style of life on the health of the dependent person, and the ever present danger of death or serious injury from various causes including suicide, accidents, drug toxic reactions or overdose, and numerous diseases and other effects of unsterile intravenous injection. Even where the drug may be obtained legally, as in the case of methadone maintenance, such dependence is a serious qualification of the individual's freedom and a pharmacological necessity which renders him increasingly vulnerable to the will of others. The increase in the experimental use of opiate narcotics, and in the extent of opiate dependence in Canada in recent years is undoubtedly a serious problem requiring determined efforts by government and community resources of various kinds. It is impossible to estimate how it may develop in the future. It may well not take the course it has followed in the United States. There are number of circumstances that are different in the two societies, including the absence in Canada of the urban ghetto phenomenon on a comparable scale. At the same time, there is no ground for confidence that opiate narcotic use is about to level off or decline in Canada. It requires continuing vigilance.

In recent years there has been an apparent levelling off, and possibly even a decrease, in the total number of persons using LSD, although there is still a relatively heavy concentration of such use among high school and university students and certain other populations. At the same time, there has been a marked increase in the use of MDA, a physically more toxic hallucinogen with certain amphetamine-like properties. There has also been an increased use of PCP. In spite of persistent rumours of exotic psychedelic drugs in North America, there is little indication of significant use of hallucinogenic drugs other than cannabis, LSD, MDA and PCP in Canada. The use of the stronger hallucinogens remains for the most part an occasional one. Heavy dependent use of these drugs is uncommon. Few of the psychedelic ideological connotations of the mid-1960s are associated with current drug use. Typically, hallucinogens are now among a wide variety of drugs involved in a general multiple drug-using pattern of behaviour.

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The use of volatile solvents appears to be concentrated in certain parts of the country, of which Manitoba is one. It is our impression that while such use may have increased locally from time to time it has, on the whole, levelled off or perhaps even declined slightly in recent years. There have been changes in the form of the substances most frequently used; in particular, nail polish remover has tended to replace glue, although the same volatile solvents are generally involved. While a few solvent-related deaths (primarily involving plastic bag suffocation) have been given considerable attention, serious adverse reactions from volatile solvents do not appear to constitute a significant public health problem at the present time.

As indicated in preceding sections, the dominant pattern of non-medical drug use is one of multiple use. The individual about whom there is major cause for concern is the youthful chronic multi-drug user who is indiscriminate in his choice of drugs. He is sometimes referred to in the drug culture as a "garbage head". The hazards of drug use increase with indiscriminate experimentation and the mixing of drugs which have additive or potentiating effect. It is impossible to estimate the size of the hard core chronic multi-drug-using population—there are certainly several thousand—but this group likely has a potential for stimulating the spread of harmful drug use out of proportion to its size.

There is reason to believe that as youthful drug users have become more experienced and sophisticated they have been able to reduce the number of acute adverse reactions—"bad trips" or "freakouts"—or have been able to cope with them better. In the last year or so, emergency treatment services have seen a smaller number of such cases than they did in the late 1960s.

Thus, we may sum up by saying that while some forms of non-medical drug use appear to have levelled off, and even in certain cases decreased, non-medical drug use as a whole has continued to increase; alcohol and tobacco remain the major sources of drug-related public health problems; the dominant pattern has become one of multiple drug use, with a hard core of indiscriminate, chronic multi-drug users who encourage the spread of harmful drug use; there has been a marked increase in experimental and dependent use of the opiate narcotics; and there is some evidence that hallucinogen users have become more sophisticated in their ability to avoid acute adverse reactions.

NOTE

1. It should be observed that the proponents of this suggestion think of it as a preventive rather than a curative measure. They concede that it might not have too much effect on the present population of users with alcohol problems, but they contend that by discouraging future use it would reduce the incidence of new cases of harmful use. We remain skeptical. We believe that two factors are likely to defeat the purpose of this measure: the compulsive character of the increasing reliance on alcohol by persons who become problem drinkers and alcoholics, and the relative disposable income of the middle-class who contribute significantly to the total extent of excessive use of alcohol. The size of this middle-class, the extent of its reliance on alcohol and its relative disposable income are factors which were never encountered before in the experience of other countries and other periods on which the proponents of relative price rely. For the others in the population, this proposal, as we suggest above, is more likely to result in a further deterioration in child nutrition and other family neglect and in the development of an illicit market. Further, we place no confidence in the proposals of differential taxation to encourage preference for the so-called "moderate" beverages, such as beer. Both beer and wine may be used to excess, and the excessive use of both are capable of leading to alcoholism and other drug-related problems. We are not convinced by the evidence that the differences in the rate and other conditions under which excessive use of the various alcoholic beverages can lead to alcohol-related problems justifies a public policy of encouraging the use of some rather than others.

Part Two

Legal Controls

The Use of the Criminal Law Against Non-Medical Drug Use

The law is the chief instrument of social policy. It provides the framework for all the others. Whether we should use the law, at all, and if so, to what degree, in attempting to reduce non-medical drug use is first of all a matter of principle, but it is also a pragmatic issue—whether we receive a return or benefit from the use of the law that justifies the cost. This turns on the relative effectiveness of the law in this field—the extent to which it is an effective deterrent of the behaviour involved in non-medical drug use—and also on the price which must be paid for the use of it in terms of various adverse effects on individuals and the society as a whole.

THE ISSUE OF PRINCIPLE

These issues were discussed in considerable detail in both our *Interim Report* and our *Cannabis Report*. For the convenience of the reader a portion of that discussion, dealing with the views of Mill, Hart and Devlin, is reproduced in Appendix F.2 *Whether, in Principle, the Criminal Law Should Be Used in the Field of Non-Medical Drug Use*. The manner in which the issue of principle is usually presented is whether we should attempt to coerce the individual by means of legal sanctions to abstain from behaviour which many claim really only concerns himself. It is said that the law should only be concerned with preventing people from causing harm to others and not with preventing people from causing harm to themselves by freely chosen behaviour. On this view, the law should not attempt to prevent non-medical drug use altogether, but should only be directed against the behavioural manifestations of such use which cause or threaten harm to others.

Others take the view that the state has a right and a duty to use the law to try to prevent people from causing certain kinds of harm to themselves, but in any event they dispute the assumption that non-medical drug use which causes harm to the user does not generally also cause harm to other persons and the society generally. They argue that the drug use which causes

harm to the individual often causes harm to others, including the members of his family and those who depend on him for work or other social contribution. Harmful drug use may cause acute mental suffering to the members of the user's family who may fear for his health, and in some cases, his life. It may have a very deleterious effect on marital relations and relations between parent and child. It may result in inefficiency and absenteeism in work. Finally, there is the additional cost to the society of treatment and welfare for the care and support of the person who engages in excessive drug use and those who are dependent on him. All of this is harm to third persons and the society generally, quite apart from any physical injury or property damage which the user may cause directly to others by such drug-induced or drug-related behaviour as impaired driving or violence of various kinds.

There is also a more subtle effect or harm of excessive non-medical drug use which many people fear, and that is a kind of general demoralization or lowering of the tone and determination required for a healthy society. There is a fear that an increasingly widespread resort to drugs to escape from the challenges of living will by its example encourage a general spirit of escape and passivity that will undermine the moral fibre and vigour of the society. People fear the development of a style of life in which an increasing number of individuals turn from an attempt to grapple in an active and constructive manner with society's problems to seek solace and oblivion in drugs. This anxiety is reflected in the concern with what is called the "amotivational syndrome"—the passivity and lack of goals which certain observers say they have seen in chronic users of hallucinogens and other drugs. People who are particularly concerned about this possible effect of excessive drug use on the general tone of the society often refer to what they feel is the relative lack of initiative, vigour and enterprise in other countries where drug use is understood to be extensive and thought to be in some measure responsible for such characteristics in the population.

Those who are opposed to the use of the law in connection with non-medical drug use dispute the right of the society to expect or demand a certain level of social contribution from the individual, or at least dispute the right of the society to attempt to compel that contribution by legal coercion. They do not deny that excessive drug use may cause considerable inconvenience and hardship to others who must depend on the user in various ways, but they deny that this justifies the application of legal sanctions to the user if the harm he causes or threatens to cause is not physical injury to the person or property of others. The reasoning would be that none of us is perfect and we all fall short in one degree or another of discharging our various responsibilities to others, and we all disappoint the hopes of others to some extent through freely chosen behaviour that reflects our personal weaknesses or defects. People should not be punished for failing to measure up to what other people expect of them in personal relations or work, even if such failure is attributable to weakness of character or self-inflicted injury of some kind. In effect, we would not consider punishing people for neglecting

their health in various ways. In Section II *Some Preliminary Observations*, we referred to some of these forms of ill health which may be considered to be more or less self-inflicted as a result of such behaviour as excessive work, or overeating, and concluded that if they are distinguished from self-indulgence in drugs it must be partly on the basis of a moral judgment. They do not appear to present the same threat to established values. They do not carry the same connotation of escape from challenge or responsibility, although in fact they may be every bit as much a form of escape and may indeed be attributable to psychological factors similar to those which underlie excessive drug use.

Obviously, there are more than moral values involved. There is concern about the specific physical and mental harm which certain kinds of drug use may cause to the individual, quite apart from consequences to society. There is particular concern about the possible effect of certain kinds of drug use on the mind. The most serious risk of immediate harm is that of toxicity, which sometimes results in severe physical or mental damage and even in some cases, death. This is the danger presented by poison. Any drug can be poisonous if the dose is sufficiently high. Thus drug use raises in the first instance the question of how we should deal, as a matter of public policy, with poison.

Poison constitutes a danger or trap, particularly where children are concerned, that we would like to be able to remove altogether if possible. There are two possible legislative policies in relation to poisonous substances: one is to attempt to prevent exposure to them altogether; the other is to provide people with sufficient warning of their dangers. (A third possible policy in some cases is to provide certain safeguards in the custody of poisons.) The first policy is not available where the substance which is a poison is required for some other purpose. Thus a great variety of substances that are required for industrial, domestic or personal use cannot be prohibited, although they are poisonous if ingested or inhaled. All that the law can do in such cases is to insist that these substances be accompanied by suitable warning of their dangers. This is the situation with respect to certain of the volatile solvents and gases. Although they can be used for purposes of intoxication and are poisonous, they cannot be prohibited because they are necessary or useful in a variety of industrial, domestic or personal applications (and some have important medical uses as well).

Prohibiting the production and distribution of a dangerous substance for which there is no necessary or beneficial use does not appear to give rise to any great philosophic issue. It is somewhat paternalistic and shows a lack of confidence in the good sense and capacity of the individual to avoid harm, but this is not particularly offensive. After all, it is unrealistic to rely, where we are not obliged to do so, on a complete and sufficient dissemination of the information about a dangerous substance which people must have if they are to avoid harm, particularly where children are concerned. But acceptance of the necessity of a complete prohibition of production and

distribution turns on the assumption that the substance does not in fact have any beneficial use which justifies or necessitates exposure of people to the risk of harm. The decision as to whether to prohibit all production and distribution turns on a weighing of the beneficial uses or effects, if any, and the potential for harm.

Official drug control policy, as reflected in international agreements and domestic legislation, does not recognize any beneficial uses or effects, for purposes of such evaluation, other than accepted medical or scientific ones. It does not recognize beneficial uses or effects of a non-medical or non-scientific nature, even when these effects may be essentially indistinguishable from those produced by certain drugs when taken under medical advice. This is a serious bone of contention between drug users and official policy. Many drug users claim that there are beneficial effects to be enjoyed from certain forms of non-medical drug use. They claim that the contribution which certain forms of drug use make to the general sense of well-being and to personal equilibrium by reducing tension, increasing self-knowledge, releasing self-expression and facilitating social relations is a beneficial effect which should be weighed against the potential for harm of such use. Official policy does not agree. Where drugs have been made legally available for non-medical use, as in the case of tobacco and alcohol, it is not because of their alleged benefits but rather because a policy of prohibition is not considered to be feasible. They are made legally available, despite their potential for harm, because so many people want them that it is neither politically possible nor otherwise practicable to attempt to suppress them.

It is not difficult to understand why in the case of non-medical drug use, official policy chooses not to weigh alleged benefits in the scales against potential for harm. The alleged benefits are highly controversial, and there is no clearly established framework or consensus of values to which official policy can refer for purposes of determining what is benefit and what is not. There are conflicting value judgments as to whether the pursuit of particular forms of pleasure is a good thing or not.

A principal reason, however, for the refusal to recognize the alleged benefits of certain kinds of drug use is the difficulty of enjoying the benefits on a regular basis without running the risk of dependence or other serious form of harm. This possibility is so closely related to enjoyment of the benefit that it is difficult to give the benefit an independent value apart from it. Others argue that so long as it is possible to enjoy the benefit by occasional or even regular, moderate use without becoming dependent or suffering other serious harm, the benefit is entitled to have its full value acknowledged. This point of view assumes that it is in fact possible for the majority to make a relatively harmless use of a particular drug. This depends on whether the drug lends itself to a controlled, measured use so as to avoid harm, and whether the majority of people will have the necessary understanding, judgment, skill, self-restraint or other required qualities to make such a controlled, measured use.

The difficulty with a general prohibition against drug use of a certain kind is that it is not directed specifically to acts of use which are likely to cause harm. It is an attempt to prevent such acts by preventing all acts of use. Unfortunately, if the law wishes to intervene in this preventive manner, before harm has occurred or is immediately threatened, it has no choice from a practical point of view but to adopt this broad-gauge approach. It is not practicable for it to attempt to direct itself to use of a certain character since it is extremely difficult to define, detect and prove use of a certain degree of potential dangerousness. It would be obliged to make a certain course or pattern of use, such as chronic, dangerous drug use, a crime and seek to prove this by a variety of circumstances. This would be tantamount to making not specific acts but rather a general condition the basis for the imposition of criminal sanctions.

Whether the interference with the freedom of the majority will be justified will depend on the value which one places on the protection of the minority from the particular risk of harm. This will depend on the nature of the harm and how often it is likely to occur. On the other side of the equation is how important access to the substance is for the majority. To what extent are they likely to be seriously inconvenienced or deprived by its prohibition? Obviously, these judgments cannot be reduced to scientific proportions. They depend on approximate numbers or rough orders of magnitude but they also depend on the quality of the harm on one side and the quality of the deprivation on the other. Numbers, however, undoubtedly play a significant role, particularly where they are very heavily on one side or the other—that is, either on the side of those who desire the substance or on the side of those who are opposed to its use. Most often the issue will arise when a majority are opposed to its use. Then the issue of principle is whether the majority should interfere with the freedom of a significant minority to make a relatively harmless use of a substance (assuming such a use can be made of it) in order to protect a much smaller number from harm. We do not see how there can be any absolute objection in principle to such a policy. It must depend on the circumstances in each case. We recognize that it is not only desirable but necessary to impose a variety of restraints or limitations upon freedom in the interests of order, protection and welfare, and indeed, in the interests of maximizing the total, beneficial freedom of everyone. *Non-medical drug use is not a category of behaviour which has a claim to some special immunity, not even to some special relative immunity, as in the case of freedom of speech. Thus, we conclude that the state has a right in principle to prohibit the production and distribution of dangerous substances, and that whether it is justified in doing so in a particular case depends on the facts—and in particular, on a weighing of the deprivation it is causing against the harm it is preventing.*

The use of the criminal law to prohibit the simple possession or use of drugs for non-medical purposes raises slightly different issues than the prohibition of production and distribution. It is not simply a question of

whether one should attempt to interfere with the freedom of the individual to engage in the non-medical use of drugs, since this is done indirectly by the prohibition against production and distribution. There is the further issue of whether a person should be punished for non-medical drug use. Although drug legislation usually prohibits simple possession rather than use as such, it is really use against which it is directed.

The personal use of drugs involves less apparent or obvious harm to others than their distribution. With distribution one is engaging in an act which is clearly going to have direct consequences for other people. The distribution may not be the direct, immediate cause of the resulting harm—there must be an intervening act of volition by the user, which can be considered the more immediate cause—but the distribution facilitates the harm or offers the occasion without which it could not occur. It is, therefore, considered to be an act which necessarily involves a greater degree of responsibility towards another person than the act of personal use. At the same time, as we have seen, a convincing argument can be made for the view that there is no harm which one causes to oneself that does not indirectly cause some harm or loss to others. Moreover, there is the view that by one's own use one supports an illicit market and contributes to a general community and climate of use that assures that others will be attracted or stimulated into use. This view looks at drug use as a whole as involving several kinds of behaviour—production, distribution, possession, use, proselytization, and so on—and as constituting a culture or pattern of life which, as a whole, exercises an unwholesome attraction. All who participate in this pattern and make some reinforcing contribution to it share some responsibility for it. The user who creates demand is also responsible with the seller for the existence of the illicit market. The seller could not exist without the user. On this view, if one wants to undermine the market one must discourage demand. This was the approach taken by the British Columbia Court of Appeal in the 1960s to justify severe sentences in cases of simple possession. "If use of this drug is not stopped," the Court said, "it is going to be followed by an organized marketing system."¹

A prohibition against simple possession is also said to be related to law enforcement against trafficking from a slightly different point of view. The object of the law against trafficking is to reduce availability or supply as much as possible. Accordingly, it is argued, availability must be attacked as a whole; the law must be concerned with possession of any kind, regardless of quantity, although it may be more severe with possession that raises a presumption of intent to traffic than with possession for personal use. Further, it is argued that it is not always easy to detect traffickers in possession of a quantity that raises a clear presumption of intent to traffic, and that it is of some utility to be able to hold them for simple possession. Assuming that an offence of simple possession makes some contribution to the effectiveness of law enforcement against trafficking, this benefit must be weighed against the

harm which the criminal law prohibition of simple possession causes to the individuals affected.

The application of the criminal law against simple possession or use by one who is dependent on a drug raises a particular issue of principle. Since the user is compelled by his dependence to obtain and use the drug, it is akin to making dependence itself a crime. Where, as in the past, there has been little by way of viable options for the drug-dependent person because of the difficulty of effecting cure, such an application of the criminal law raised a serious moral issue. Where there is an option such as methadone maintenance the issue does not present itself in such an acute form. One may also take the view that the person who wills the acts which lead to drug dependence also wills the acts which are the inevitable consequence, including the further acts of simple possession which may be subject to criminal punishment.

THE EFFECTIVENESS OF THE CRIMINAL LAW

The effective application of the criminal law in the field of non-medical drug use is subject to many difficulties. To begin with, the behaviour against which it is directed is one in which a great many people wish to engage. Moreover, it is not one which encounters strong moral resistances or inhibitions in the individual, like murder, armed robbery, assault and other forms of behaviour which come under severe moral censure, apart from the criminal law. Further, and perhaps most important of all from the point of view of law enforcement efficacy, is the fact that there is very seldom anyone who has the necessary interest or inclination to complain of a violation of the law. While drug use may cause specific harm to the user and general harm to the society, it does not generally cause or threaten specific harm to others of a nature that would lead to complaint. Those who are generally most concerned—the members of the user's family—are not likely to invoke the criminal law process against the user. What this means in practice is that law enforcement officers receive comparatively little help from the ordinary type of complainant in their efforts to detect and prove offences. Finally, the prohibited behaviour is one which can be carried on in private and is easy to conceal. For these reasons the police are obliged to rely very heavily on special methods of law enforcement, including extraordinary powers of search and seizure, the use of force to effect entry and recover evidence, the use of undercover agents and informers, and the encouragement or instigation of offences. These methods were discussed in some detail in our *Interim Report* and our *Cannabis Report*. For the convenience of the reader a portion of the discussion in the *Cannabis Report* is reproduced in Appendix F.6 *Special Methods of Enforcement*. While we expressed concern about these special methods of law enforcement we concluded that they were apparently necessary because of the particular difficulties which the police face in the

field of non-medical drug use, and that they must be considered as a special cost of law enforcement in this field.

Even with these special methods, the rate of success with law enforcement against both distribution and simple possession (or use) is relatively disappointing. The relative effectiveness of law enforcement against trafficking is discussed in the following section on *The Control of Availability*, and is the subject of detailed description and comment in Appendix B *Legal and Illegal Sources and Distribution of Drugs*. It is perhaps sufficient to observe here that police have acknowledged at the international level that under the most efficient conditions of enforcement they cannot hope to intercept more than between five and ten per cent of the illicit traffic in drugs.²

Law enforcement against simple possession (or use) gives rise to even greater problems than law enforcement against distribution. The police can make more cases against users than they can against distributors, but in terms of effectiveness they probably make less relative impact on the total extent of use than they do on the total amount of distribution. The reasons for this are fairly obvious. Simple possession or use can be much more a private or concealed activity than distribution. There are infinitely more users than traffickers so that to create a real or impressive risk of detection of use it would be necessary to assign very large numbers of police—much more than we have at present or could reasonably hope to provide—to the task of law enforcement against use. The best the law can hope to do is to create a sufficient risk of apprehension to act as an effective deterrent. Because, however, of the peculiar nature of drug crimes to which we have referred above—the fact that they usually take place between consenting parties, that there is seldom a “victim” to complain, and that the behaviour is easy to conceal—there are limits to the extent of the initiative which the police can take to increase the incidence of apprehension and thus the apparent risk of use. As we put it in the *Cannabis Report*:

... A real fear of being discovered in the private use of cannabis could only be developed and maintained by using the methods of a police state. It would require very large numbers of police, pressure on vast numbers of people to act as informers and ruthless use of the powers of search. Obviously, the society could not tolerate it. Even in a police state, such methods can only be invoked to suppress activity that can plausibly be presented as threatening the security of the state.³

The effectiveness of law enforcement against use varies somewhat as between the different kinds of drug use, but in the case of cannabis and the strong hallucinogens it would appear that less than one per cent of a reasonable estimate of the total number who have ever used are convicted each year, and the proportion is not much higher in the case of the opiate narcotics. What this means is that the actual risk of apprehension, which is the essential basis of deterrence, is not very great.

The deterrent effect of the law against simple possession or use does not rest entirely on the fear provoked by the actual risk of detection and apprehension. It also rests on the relative severity of the criminal law consequences of such apprehension. This turns on the likelihood of prosecution and conviction, if caught, and the likely severity of sentence or other consequences of conviction, such as effect on future employment. All of this depends very much on how seriously the society regards the particular offence. The stigma which attaches to an offence depends very largely on social attitudes towards it. Such attitudes change from time to time. Certain offences lose their relative importance in the public view. This is particularly true of offences in the field of public morality.

Fear of the stigma and other consequences of criminal law conviction do not alone account for the deterrent effect of the law. Many people obey the law simply because it is the law. With them, the law has moral authority, quite apart from any adverse consequences of violation. They obey the law out of a sense of moral obligation to do so. To inspire this sense of voluntary compliance the law must command moral respect. At least it must not profoundly offend the sense of justice or fitness of things. Most people will obey the law even if they disagree with it, as long as it does not strike them as outrageous. (In some cases, of course, the law may become subject to virtual nullification because of lack of a sufficient majority interest in its enforcement.) In the field of non-medical drug use the majority support the law, although they have varying degrees of enthusiasm about it. But there is a significant minority who do not feel an obligation to obey it, or who are so opposed to certain aspects of it that they feel justified in defying it. These, unfortunately, are the people about whom we are most concerned—who are so determined to engage in certain kinds of drug use that they are willing to run the risk of criminal prosecution and conviction. With such people the law obviously has little deterrent effect. Yet they include the people who are most likely to become involved in chronic, harmful drug use. They are, generally speaking, risk takers, and the risk of running afoul of the law is treated in much the same way as the risk of causing physical or psychological harm to themselves. It is extremely doubtful that people who will run the risks inherent in certain kinds of drug use will be deterred by the criminal law, particularly where the risk of detection is relatively slight. The majority of the people who are likely to be deterred by the criminal law, however slight the risk of detection, are also less likely to make an excessive or harmful use of drugs. They are, generally speaking, more cautious and prudent. While it is probable, therefore, that the law deters a large number of people simply by virtue of its existence, regardless of the actual danger of being caught in a case of violation, these are not for the most part the kind of people who are at particular risk of harmful drug use. Those who are at such risk are much less likely to be deterred for a combination of reasons: their strong opposition and even hostility to the law because it represents what they feel is an unjustified interference with their personal

freedom; the relatively slight danger of being caught; their general readiness to run various kinds of risk; and their strong desire to engage in drug use.

The deterrent effect of the law is also based on the assumption that the individual is in a position to be influenced by rational considerations. In the case of non-medical drug use the individual is often in the grip of a strong desire for pleasure, and in the case of dependence, a virtually irresistible compulsion. It must be obvious that the law can have little deterrent effect with the drug-dependent person. The only case in which it could possibly exercise a deterrent effect is where the individual can change his dependence to a drug which he can legally obtain, as in the case of methadone maintenance. This is by no means a course which all opiate-dependent persons are prepared to accept. At the same time, the law does have in many cases a gradually wearing-down effect. Persons who are dependent on heroin often become so tired of the struggle to maintain their habit in the illicit market that they are finally ready to consider alternatives.

THE COSTS OF THE CRIMINAL LAW

Undoubtedly the prohibition against simple possession has some effect on use. The question is whether the effect which it has justifies the various costs which it entails. These costs were discussed in some detail in the *Cannabis Report*. It is sufficient to make brief reference to them here. They apply, of course, not only to the prohibition against simple possession but also to the prohibition against distribution as well.

For our purposes it is not only necessary to consider the effect which the existing law may have on the extent of non-medical drug use, but also the effect which any proposed change in the law may have on attitudes and behaviour. We must not only weigh the benefit of the existing law against its costs; we must also weigh the benefit of any proposed change in the law against its costs.

The creation of an illicit market. The first and undoubtedly the most serious of the costs of criminal law prohibition is the encouragement and maintenance of an illicit market. When we prohibit something which a lot of people desire and are willing to pay money for we invite people to create an illicit market. In effect, we create a profitable enterprise for criminally inclined elements. Moreover, the more effective our law enforcement against distribution is, the more attractive we make the market for professional criminal elements by forcing the price up and putting a premium on skill and daring. This is an inherent and unavoidable cost of a prohibition of distribution. It may be said that there is nothing inevitable about this result if people will obey the law. Unfortunately, it is inevitable that a significant number will disobey it, particularly where a much desired activity is involved, and thus give the illicit market its basis. A closely related cost is that people who persist in seeking to use the prohibited drug will be obliged to have contact with criminal elements and in the process will be exposed to a variety

of illicit drugs and drug use. Some will be introduced to other kinds of crime and become part of a criminal pattern of life.

Effect on resort to treatment. A second important cost of criminal law prohibition is that by making conduct criminal we may inhibit people from seeking help from other sources, such as medical treatment. The fear of being identified as a drug user, and thereafter being subject to surveillance, may make some people reluctant to approach treatment facilities. The attitude of treatment personnel may also be adversely affected by the characterization of the conduct as criminal. Sometimes treatment authorities are placed in an awkward position in relation to law enforcement authorities, as, for example, where they are expected to furnish evidence of violation of probation or parole.

Effect on drug education. A somewhat related cost is the inhibiting effect which legal prohibition can have on drug education. When a drug is legally prohibited it is necessary to start from that position. It is difficult to talk about the pros and cons of the use of that drug as if there were a legally free choice. Yet the drug is being used and will be used. People must therefore understand not only the legal consequences of its use but the physical and mental consequences as well. In discussing the pros and cons of drug use in this way one is placed in the rather ambivalent moral position of assuming that one's listeners may choose to break the law if there are not other good reasons for not using the drug. Yet it is unrealistic today to assume that they may not do so and merely to observe that there is no point in discussing the pros and cons of the particular drug use so long as the law prohibits it. Of course, the problem can be dealt with under the guise of a critical evaluation of the law—what are the facts about a particular form of drug use and to what extent does the law reasonably reflect the facts? But it is difficult to avoid ambiguity as to whether the law deserves to be obeyed. What all this amounts to is that so long as the law purports to make the decision for us it is difficult to discuss drug use in the context of a wise exercise of freedom of choice. The law has really removed the subject from the domain of personal discretion. To discuss it in terms of personal choice is to appear to act on the assumption, explicit or implicit, that a number of people are going to break the law.

The legal characterization of certain kinds of drug use can affect drug education in other ways. A legal characterization that is at extreme variance with the facts, as has been the case with cannabis, can undermine not only the credibility of the law, but also the credibility of information about other drugs. For example, it has been said that the very misleading impression which the law has conveyed about cannabis, by placing it on the same basis as the opiate narcotics, has led many young people to question the truth of information about more dangerous drugs, including heroin.

Demand on law enforcement resources. A further cost of using the criminal law against the distribution and use of drugs is that it requires a

disproportionate application of law enforcement resources. The numbers involved in drug-related behaviour are such that we would have to employ a very large proportion of the time of police, prosecutors and judges to make a serious, systematic effort to enforce the law. This would inevitably have an adverse effect on other law enforcement priorities. Any crime which involves such a high proportion of the otherwise non-criminally inclined population is bound to produce a very drastic distortion in the application of law enforcement resources if a really serious attempt is made to enforce the law.

In fact, the law can only deal with a very small proportion of the actual number of offenders, and this on a haphazard basis. The effort is at most a token one. It serves to create some risk of apprehension, but probably not a sufficiently serious or credible one to act as a very effective deterrent. Even this token effort requires a considerable application of resources. The result is that for a very substantial expenditure there is really only a modest yield. The purpose of law enforcement in this field is simply to reinforce to some extent the moral injunction of the law. It is to keep the law from becoming a dead letter.

The stigma of criminal conviction. Finally, there is the cost of the criminal law for those who are apprehended and convicted. There is first of all the stigma of exposure to the criminal law process and of a criminal record.⁴ This stigma can have an adverse effect on self-image. It can make the individual feel a criminal and in the end seek to fulfil this opinion of himself. The reaction is: If I am going to be treated as a criminal I shall act like one. This stigma or self-image will often drive a person to seek support and reinforcement in a deviant or criminal subculture. This proceeds from a feeling that one has been rejected or ostracized by society and that the only people who can be turned to for friendship and support are those who have been similarly stigmatized. The process of stigmatization also produces feelings of humiliation and degradation which can cause acute mental suffering. Finally, the stigma affects the attitude of others in the society to whom the offender must eventually turn for help and opportunities of various kinds in the process of rehabilitation or reintegration. These attitudes will affect the ability to obtain satisfactory work and to establish healthy relationships and social involvement. It is only by such means that a new self-image and sense of identity can be shaped.

The effect of imprisonment. In addition to stigma, there is the severity of the other results of conviction and sentence. This is to be seen chiefly in the effects of imprisonment, although one should not overlook the relative deprivation of freedom as well as the uncertainty involved in probation or parole. The adverse effects of imprisonment, including the physical violence to which inmates are exposed, have been described many times. They are well known. Perhaps the chief objection to imprisonment is that it tends to achieve the opposite of the result which it purports to seek. Instead of curing offenders of criminal inclinations it tends to reinforce them. This results from confining offenders together in a closed society in which a

criminal subculture develops. The offender becomes dependent on this subculture in many ways and constantly exposed to the unwholesome influence of criminally oriented individuals instead of law-abiding and socially adjusted individuals who could have a more beneficial influence on him. Status in this subculture depends on skill in crime. The models and leaders to whom the offender is obliged to turn for emulation are leading criminals. Prison is in many ways a finishing school for criminals. There the offender has an opportunity to perfect his criminal knowledge and skills. It is difficult to think of a better way to train people for crime than to bring all the criminal types together in one long live-in seminar on crime. There would be, on the contrary, every interest in trying to keep them away from one another. An awareness of this problem is reflected to some extent in attempts to segregate young offenders from mature offenders, and also in an increased emphasis on serving the sentence in the community rather than in prison. As yet, however, we are only paying lip service to this awareness. We continue to bring the criminal elements of the country together for a kind of continuing education or refresher course.

These adverse effects of imprisonment are particularly reflected in the treatment of drug offenders. Our investigations⁵ suggest that there is considerable circulation of drugs within penal institutions, that offenders are reinforced in their attachment to the drug culture, and that in many cases they are introduced to certain kinds of drug use by prison contacts. Thus imprisonment does not cut off all contact with drugs or the drug subculture, nor does it cut off contact with individual drug users. Actually, it increases exposure to the influence of chronic, harmful drug users.

In the course of our investigations many addicts have testified that it is impossible for them to break the drug habit if they cannot escape from the associations which encourage it. Inmates in a provincial institution with a special treatment program stated that the chief reason for their failure to give up drugs was the inability to break away from the drug environment. The effect of the reinforcing prison subculture in a provincial institution without a special treatment program was described by an observer as follows:

... the heroin users as a group were a well-defined social force in the wing not only organizing the importation and distribution of illicit drugs, but also providing every possible support and justification for use. The users continually discussed all aspects of use, reaffirming the validity of continued use, and criticising those agencies and institutions which try to prevent it. Pictures of needles and mottos extolling the virtues of heroin use covered the walls of some cells. News from the street scene in the city arrived with all speed and regularity. The large amount of spare time and the dull routine made heroin use the most popular topic of discussion among users, by default if not for other reasons. It becomes obvious why a sizeable percentage of heroin users get their first fix in prison itself, or after release, from a friend met in prison. ...

Status among the heroin users was determined by drug experience on the street, the user's status on the street following him into the institution for better or worse. Status was positively related to extent of use, length of habit, involvement in the drug trade, and criminal sophistication. There was a special reverence for the long-time users, as if their mere existence was some type of endorsement for use.

Inmates would brag among themselves about the size of their habits, like drinkers bragging about their ability to hold their liquor. One inmate would tease another by calling him a 'chippy-fixer, hophead or bomber freak'. In this way it seemed that the users' condemnation of the 'lesser' drugs somehow justified use of heroin.*

NOTES

1. *R. v. Hartley and McCallum* (No. 2), [1968] 2 C.C.C. 187 at 189 (B.C.C.A.).
2. *Urgent International Action Against the Abuse of, and the Illicit Traffic In, Narcotic Drugs and Psychotropic Substances*, Report by the Secretary General of the United Nations to the Second Special Session of the Commission on Narcotic Drugs, July 28, 1970, E/CN.7/530, p. 3.
3. *Cannabis Report*, p. 290.
4. Absolute or conditional discharge (see Appendix F.8) avoids a conviction, but there is a plea or a finding of guilt in such a case, and there is a criminal record of it. *The Criminal Records Act*, R.S.C. 1970 (1st Supp.) c.12 as amended by the *Criminal Law Amendment Act*, 1972 (1972 Stat. Can. c. 13, s. 72), provides that a person who has been convicted or given an absolute or conditional discharge may apply after a certain period of time for a pardon and removal of his criminal record. In the case of conviction of an indictable offence, the period is five years after satisfaction of sentence; in the case of summary conviction, two years after satisfaction of sentence; and in the case of absolute and conditional discharge, one year for summary conviction sentences and three years for other offences. The pardon is granted on recommendation of the National Parole Board. The effect of such pardon is to vacate the conviction or discharge, remove any disqualifications resulting from it under federal legislation or regulations and prevent any question being asked concerning the conviction or discharge in connection with service in the armed forces or employment in government or in any enterprise under federal jurisdiction. Thereafter the record of the conviction or discharge may be disclosed only for certain limited purposes with the authorization of the Solicitor General. It is impossible to destroy all record of a criminal case in any real sense once it has entered into the data collection process, but even where it has been removed and put beyond the effective reach of ordinary enquiry, the knowledge which a lot of people invariably possess of a conviction (or a plea or finding of guilt in the case of absolute or conditional discharge) and the knowledge which can be obtained by interested parties through careful investigation cannot be eliminated.
5. The Commission carried out studies of one federal and four provincial correctional institutions in an attempt to evaluate the effect of their programs on drug offenders. The federal institution was Matsqui, which is discussed in Appendix I *Treatment of Opiate Dependents in Federal Penitentiaries in Canada*. The provincial institutions consisted of two with special treatment programs, one of the traditional kind without a special program and a wilderness camp based on the "outward bound" philosophy. Some of this study was carried out by participant observation with investigators living in on a 24-hour basis or during the day. There was some reference to the conclusions of these studies in the *Treatment Report*. Because of differences in the drug offender populations in these institutions (for example, two of the provincial institutions had few, if any, opiate-

dependent inmates) there is really not a basis for comparing the effect of their respective programs. The major generalization to be drawn from these studies is the effect of the prison subculture in encouraging pre-occupation with drugs and some drug use in prison. The notable exception to this general impression was the wilderness camp, in which there was apparently very little drug use during the period of confinement. It should be noted, however, that the population of the wilderness camp did not include any opiate-dependent persons. The studies of these correctional institutions were carried out by L. McDonald, R. Solomon, and A. Caplan under the general direction and supervision of John Hogarth.

6. Solomon, "Study of Traditional Institution," Unpublished Commission Research Paper, 1972 (edited by L. McDonald), pp. 69 and 73-74.