Appendix G

Opiate Maintenance

G.1 METHADONE CONTROL PROGRAM OF THE GOVERNMENT OF CANADA

Early in 1972 the Government of Canada decided to subject the use of methadone to special controls. Physicians would require special authorization from the Minister of National Health and Welfare to prescribe or administer methadone. This decision resulted from concern over the dangers of an unregulated use of methadone, and it was influenced by the recommendations of a Special Joint Committee on Methadone of the Food and Drug Directorate of the Department of National Health and Welfare and the Canadian Medical Association, as well as by the recommendations of the Commission in its *Treatment Report.*

The Special Joint Committee identified certain abuses in the use of methadone in the following terms:

> Reports of misuse and abuse of methadone have already come to the attention of the Department of National Health and Welfare. These include prescribing excessive and sometimes escalating doses of methadone for individual patients and issuing prescriptions for large quantities at one time; treatment of large groups of addicts by individual physicians without the facilities for proper diagnosis, management and follow-up; 'on-and-off' prescription of methadone; inappropriate use of injectable solution; simultaneous prescription of methadone and other narcotics; use of methadone by non-addicted persons and multiple drug users; addicts obtaining prescriptions simultaneously from different sources; and diversion of methadone to the illicit drug market. Several deaths have occurred, due either to methadone over-dosage in non-dependent casual users, or to potentiation of the effects of other depressive drugs, especially barbiturates.[1]

The Commission's *Treatment Report,* submitted in January 1972, spoke of abuses in the following terms:

> Unquestionably, the greatest illicit use occurs in the prescription of methadone by private physicians who have no facilities for laboratory moni-

> toring or social follow-up, who prescribe more than two days' supply for self-medication and for 'self-withdrawal' . . . and who cannot be certain that they are the sole source of supply for individual patients.
>
> Study of prescriptions across Canada shows evidence of serious abuse of this method of obtaining methadone: private physicians carrying large caseloads of methadone patients and individual patients receiving continuing supply from many physicians. We have had other evidence of some physicians being extremely careless in determining the indication for the prescribing of methadone. It is highly probable that under these conditions much of the privately prescribed methadone reaches the illegal market and is contributing to a growing population of primary methadone addicts.[2]

From its field survey in May 1972 the Commission derived the distinct impression that the availability of illicit methadone had played a significant role in the increase of opiate use. In Montreal, Halifax and other areas, indiscriminate prescribing created a unique opiate dependency phenomenon and a natural bridge to heroin.

Imports of methadone had been rising markedly in recent years, as indicated by the following figures: 1966 – 2.7 kg; 1967 – 5.1 kg; 1968 – 9.3 kg; 1969 – 11.7 kg; 1970 – 27.1 kg; 1971 – 40.6 kg.[3]

The Special Joint Committee of the Food and Drug Directorate and the Canadian Medical Association made the following observation concerning the reason for the increase in imports:

> Only about one third of this increase can be accounted for by use in controlled clinics such as the Narcotic Addiction Foundation of British Columbia and the Addiction Research Foundation of Ontario. The remainder results from increased prescribing of methadone by practising physicians.[4]

The estimated *consumption* of methadone for the years 1961 to 1971 (stated in pure drug figures) was as follows: 1961 – 5.562 kg; 1962 – 3.324 kg; 1963 – 3.571 kg; 1964 – 4.115 kg; 1965 – 4.175 kg; 1966 – 4.353 kg; 1967 – 6.216 kg; 1968 – 9.417 kg; 1969 – 13.053 kg; 1970 – 20.967 kg; 1971 – 40.158 kg.[5]

In recent years there had been an increase in "prescription shopping" or "double doctoring" involving methadone. This practice, in which the patient obtains the drug or a prescription from more than one doctor, is prohibited by section 3(3) of the *Narcotic Control Regulations*. In 1970 there were four convictions for this offence involving methadone, and in 1971 there were 43. For the first half of 1972 there were 29, suggesting a further increase for the year as a whole. Almost all of these convictions were in British Columbia and Quebec. There had also been a marked increase in the total number of other offences involving methadone (simple possession, trafficking, and possession for the purpose of trafficking), as indicated by the following figures: 1970 – 10; 1971 – 40; first half of 1972 – 20.[6]

The essential emphasis in the report of the Special Joint Committee is contained in the following passages:

> To minimize this risk and the likelihood of ineffective care, methadone maintenance should preferably be undertaken, for the present, in structured programs such as those offered by the Narcotic Addiction Foundation of British Columbia and the Addiction Research Foundation of Ontario....
>
> The Committee believes that individual practitioners who are not well versed in methadone maintenance techniques and have no access to the necessary laboratory and other control facilities and rehabilitation services, should not attempt to take on the responsibility of treating narcotic addicts. Whenever possible, narcotic addicts seeking medical treatment should be referred to clinics that are equipped for this type of treatment. The physician can of course assist in the treatment of narcotic addicts by cooperating or affiliating with established methadone maintenance programs.

The Committee outlined certain guiding principles for the case where it is necesary to treat a narcotic addict with methadone outside an established methadone maintenance program. These include consultation with experienced colleagues, care in determining that there is a true and long-standing case of opiate dependence before methadone therapy is initiated, the administration of methadone in oral form and ingestion under the supervision of the physician, nurse or pharmacist, and the keeping of proper records. The report also suggested certain other principles of good medical practice for the use of methadone in withdrawal and maintenance. In effect, the Committee expressed a very definite preference for confining the use of methadone maintenance as much as possible to organized programs in properly equipped clinics, but it recognized that it would probably be necessary for private physicians to engage in this form of treatment, and it sought to assist them by guidelines on good medical practice.

The Commission, in its recommendations, was somewhat more insistent on the necessity of having methadone maintenance controlled through properly equipped clinics. It also recognized that it might be necessary for private physicians and even paramedical personnel to be authorized to engage in methadone maintenance in certain areas, but it considered that they should only be permitted to do so under the supervision of a recognized clinic. In effect, the Commission recommended that the right to engage in methadone maintenance be confined to specialized clinics and to medical personnel affiliated with them and acting under their general responsibility and supervision. The Commission's recommendations on this point are contained in the following passages:

> Methadone maintenance programs should be developed only—and methadone be available only—in specialized clinics, preferably hospital-based, as part of an overall maintenance program serving an area. The prescription of methadone by private physicians should be terminated except where there is a special arrangement with the clinic, and then under continuing close supervision by the clinic. This exception should be permitted

only where auxiliary facilities, including counselling services, laboratory monitoring, and careful control including monitoring by the Food and Drug Directorate may be ensured.

In special cases where the patient cannot reasonably have regular access to a specialized clinic or authorized physician because of geographical location, private physicians, pharmacists, public health nurses or other suitably qualified persons may be authorized to administer methadone. In such cases, however, the person specially authorized to administer methadone should perform the necessary counselling and monitoring services and should make regular reports to the specialized clinic which has assumed and retained overall responsibility for the patient's maintenance program. Alteration of the dose of methadone should be subject to prior approval by the specialized clinic. This exceptional procedure of administration should be authorized only after the patient's adaptation to methadone has been clearly established.[7]

In February 1972 the Honourable John Munro, Minister of National Health and Welfare, announced a new policy of methadone control. The Minister said:

During the last year, staff of my department have received many reports of misuse and abuse of methadone. As a result of concern over misuse of this drug, the former Food and Drug Directorate of my department and the Canadian Medical Association established a joint committee in 1970, to investigate the proper place of methadone in the care of the narcotic addicts. Concern about the abuse of methadone also was raised by the Le Dain Commission in its final report on Treatment, which was submitted to the Government a few weeks ago.

As a result of the recommendations of the joint FDD-CMA Committee and of the Le Dain Commission, I have decided to restrict the availability of methadone in the following way: Physicians will be permitted to prescribe methadone only after they are authorized to do so by the Minister of National Health and Welfare. Those so authorized will be considered to be qualified by reason of expertise and the availability of necessary facilities and ancillary services to utilize methadone effectively in the treatment of heroin abuse.

In line with the recommendations of the Le Dain Commission, authorized physicians will be required to be associated with a specialized clinic. Requests for authorization will be considered by an expert advisory committee to be appointed by me in cooperation with the medical profession.[8]

By letter dated April 19, 1972 the Health Protection Branch of the Department of National Health and Welfare advised all physicians registered to practise medicine in Canada that regulations were being prepared to implement the new policy of methadone control effective June 1, 1972, and that practitioners wishing to use methadone should apply for authorization. To facilitate such application the letter enclosed a document entitled "Methadone Control Program—Guidelines for Establishing Affiliation with Specialized Treatment Units and Applying for Authorization to Use Methadone".

The Guidelines reaffirmed that as a result of the recommendations of the Special Joint Committee and of the Commission the Minister had decided to restrict the use of methadone to "authorized physicians, associated with a specialized clinic or treatment unit, who are considered to be qualified by reason of expertise and the availability of the necessary facilities and ancillary services to utilize the drug effectively and safely in the care of heroin addicts".[9] Requests for authorization to use methadone would be considered by an expert advisory committee appointed by the Minister in cooperation with the medical profession. Physicians would be granted temporary authorizations to give them sufficient time to establish an affiliation with an accredited specialized treatment unit.

The Guidelines indicated the kind of information that should be furnished with an application for authorization. Three kinds of application were contemplated: an application for accreditation by a specialized clinic or treatment unit; an application for authorization by a physician affiliated with such an accredited clinic or treatment unit; and an application for temporary authorization by a physician who had not yet established such affiliation. To be accredited, a specialized clinic or treatment unit was to submit certain information, including its treatment protocol. Affiliated physicians (of whom there were to be two classes—Clinic Associates and Regional Associates) would be required to undertake to conform to the protocol of the clinic or treatment unit.

The Guidelines indicated the following basic requirements for an accredited clinic or treatment unit:

(1) Qualified and experienced medical, psychiatric and social services and necessary support staff;

(2) Adequate facilities for supervised collection, and regular testing of urine for detection of narcotics and other drugs of abuse;

(3) Well established controls for dispensing methadone and supervising its use in order to prevent diversion to illegal channels and misuse of the drug;

(4) Established policies for diagnosis, selection of patients, treatment, follow-up and rehabilitation, including the keeping of appropriate records and evaluation of program results.[10]

The new *Narcotic Control Regulations* with respect to methadone were adopted on May 16, 1972, to take effect on June 1, 1972.[11] They provide that no practitioner shall administer, prescribe, give, sell or furnish methadone to any person or animal unless he has been authorized to do so by the Minister.[12] Neither a licensed dealer nor a pharmacist may supply methadone to a physician who has not been so authorized nor may they supply it to a hospital upon the order of an unauthorized physician.[13] A pharmacist may not fill a prescription for methadone unless it has been issued by a physician who has been authorized by the Minister.[14]

To permit physicians to obtain supplies of methadone and prescribe it after June 1, 1972, full implementation of the methadone control program guidelines was postponed until November 1, 1972. On June 1, 1972 any physician who had prescribed methadone in the past was authorized to continue to use it on a temporary basis until October 31, 1972, unless records kept by the Bureau of Dangerous Drugs revealed a prior misuse of the drug by a practitioner. The Health Protection Branch came to a decision on an application for authorization after consulting the Canadian Medical Directory, the Bureau of Dangerous Drugs for record of possible prescribing abuse, and, in most cases, advice was also sought from one or more relevant provincial bodies, such as Colleges of Physicians and Surgeons, provincial authorities involved in the drug abuse field, or recognized established treatment clinics. There were six classes of temporary authorization: an authorization to use methadone in the treatment of narcotic dependence in both maintenance and withdrawal therapy; an authorization to use methadone solely in the management of narcotic withdrawal; an authorization for the use of methadone solely as an analgesic agent in non-addicted persons; authorization for the use of methadone solely as an antitussive agent in non-addicted persons; an authorization for the use of methadone by dentists as an analgesic agent; and an authorization for the use of methadone by veterinarians.

The practitioner, dentist or veterinarian was temporarily authorized to "prescribe, administer, give, sell or furnish methadone" for the purpose indicated and upon certain conditions. In the case of authorization to use it in the general treatment of narcotic dependence or in withdrawal therapy only, the temporary authorization required monthly reporting on the particulars of the use of methadone, as well as a summary progress report on all patients who had received methadone or for whom the drug had been prescribed during the interim summer period.

As of August 28, 1972 there were 657 physicians in Canada with general authorization to use methadone in the management of narcotic dependence (that is, in withdrawal and in maintenance) and 65 physicians authorized to use it in the management of withdrawal symptoms only.[15] An additional 85 were authorized to use methadone under the other categories as medical practitioners (analgesic and antitussive), dentists (analgesic) or veterinarians. The number of physicians having a general authorization to use methadone in the management of narcotic dependence or an authorization to use it in the management of withdrawal only were distributed by province as of August 28, 1972 as follows: British Columbia—383; Alberta—33; Saskatchewan—7; Manitoba—20; Ontario—168; Quebec—75; New Brunswick—1; Nova Scotia—33; Yukon and Northwest Territories—2; Newfoundland and Prince Edward Island—0. Between August 28, 1972 and October 31, 1972 some authorizations had been withdrawn by mutual agreement between the Health Protection Branch and the practitioner and some new authorizations had been granted.

Authorizations to use methadone expired on October 31, 1972. Any practitioner wishing to use methadone after that date was required to apply for authorization or for renewal of authorization. Applications for authorization or renewal of authorization to use methadone after October 31, 1972 were considered by the Health Protection Branch with the assistance of a Methadone Advisory Committee.[16] Two general categories of authorization were issued for the use of methadone in the treatment of narcotic dependence effective November 1st, 1972: authorization to practitioners affiliated with a methadone treatment program or unit; and a temporary authorization to private practitioners without such an affiliation. A temporary authorization expires at the end of October 1973, at which time the physician's authority to use methadone will be reviewed.

The requirements for authorization of physicians who are affiliated with a methadone treatment unit or program are as follows. The methadone treatment unit or program must file its proposed protocol or protocols with the Department. The general protocol is "a detailed statement of the policies, standards and procedures" that will be used in the proposed methadone treatment program, with reference to the following matters: objectives, criteria for diagnosis and selection of patients, admission evaluation, methadone treatment procedures and rehabilitation program (including the methods used for dispensing, prescribing and supervising the administration and use of methadone "in order to minimize its misuse and abuse"), and evaluation of program results. Special protocols must be submitted by methadone treatment programs "wishing to use methadone either in patients less than 18 years of age or under special conditions requiring more elaborate cautions than those that might be provided in a General Protocol". Such protocols must describe "in detail the plan for using the drug under restricted conditions and maintaining appropriate safeguards". A statement of affiliation and an application for authorization to use methadone must be filed by the physician. In the statement of affiliation the physician agrees to conform to the policy guidelines and protocol(s) filed by the methadone treatment unit program and acknowledges that his authorization to use methadone will cease to be effective upon termination of his affiliation with the program.

The precise criteria for determining whether the protocols of methadone treatment units or programs are acceptable are not too clear. The matters to which the Department attaches importance are suggested by the information required in the application for filing protocols, but the Department does not appear to have laid down clearly defined minimum requirements for approval. It has called for certain information on which to base the decision as to approval. It is not clear what role, if any, as a basis for decision, is to be played by the "Guidelines for Establishing Affiliation with Specialized Treatment Units and Applying for Authorization to Use Methadone", which were circulated to physicians in the spring of 1972. These were mainly concerned with indicating the kind of information that must be furnished, but they did contain certain statements of general

principle which suggested criteria for decision. For example, the application for filing protocols, for purposes of authorization after October 31, 1972, calls for an indication of "the laboratory facilities in which urinalysis will be performed". A reasonable implication of this requirement is that satisfactory facilities of this kind will be a condition of approval, but this is not explicit. The "Guidelines" lay it down as a basic requirement of specialized clinics or treatment units, for purposes of affiliation, that they have "adequate facilities for supervised collection, and regular testing of urine for detection of narcotics and other drugs of abuse".[17] Under the heading of "Admission Evaluation", in the information required in treatment unit protocols, the "Guidelines" state: "The evaluation should include an assessment of the degree of dependence and a determination of the drug or drugs of abuse. The protocol should provide for laboratory confirmation by checking and maintaining surveillance of the presence of drugs of abuse in urine sample."[18] Thus the "Guidelines" clearly indicate the requirement of adequate laboratory facilities for urinalysis to confirm dependence as an essential condition of admission to methadone maintenance and to monitor the patient's use of illicit drugs. As we shall see, however, the Department appears to have abandoned this requirement, at least with respect to the authorization of physicians who are not affiliated with an approved program.

Both the Special Joint Committee and the Commission emphasized the importance of care in determining that there is a true case of opiate dependence before a patient is introduced to methadone maintenance. The Special Joint Committee insisted on urinalysis: "The diagnosis of narcotic dependence should be confirmed by the repeated presence of a narcotic drug in supervised samples of urine analysed by thin layer chromatography. The presence of heroin and other drugs should be checked regularly by supervising the collection of urine samples, in order to detect the patient's use of illicit drugs and orient his treatment."[19] And again, the Committee said: *"Confirmation of the diagnosis of addiction by several daily consecutive, positive, urine determinations, is an essential requirement."*[20] The same concern for adequate "laboratory monitoring" was one of the factors that lay behind the Commission's recommendation that methadone maintenance be placed under the supervision of specialized clinics. The assumption was that as a general rule only physicians who were affiliated with an organized methadone program would have access to the necessary laboratory facilities.

The application for temporary authorization of a physician who is not affiliated with a treatment unit or program calls for information on the qualfications, scientific training and experience of the physician in the management of narcotic addiction (as in the case of the physician who is affiliated to a treatment unit), a description of "the facilities available for treatment and of the laboratory services that will be used for determination of drugs of abuse in the urine", and a description of the principles that will be adhered to in selecting patients for treatment, ascertaining the diagnosis,

supervising the administration of methadone, allowing take-home privileges, and maintaining the clinical and laboratory surveillance of the patient's progress.

In a letter to the Commission concerning the criteria to be applied to these applications, Dr. A. B. Morrison, Assistant Deputy Minister, Health Protection Branch, said: "The applications from private practitioners without affiliation will be judged on their own merits and on the basis of the available evidence concerning our monitoring of the use of methadone by the individual practitioner."[21]

As of November 29, 1972, there were 455 practitioners authorized by the Minister to use methadone under the new regulations. Of these, 340 medical practitioners were authorized to use it for the treatment of narcotic addiction, 103 practitioners were authorized to use it as an analgesic agent only, four were authorized to use it as an antitussive agent only, and eight veterinaries were authorized to use it. Of the total number of physicians authorized to use methadone in the treatment of narcotic addiction, 118, or approximately 35 per cent, were affiliated with an approved methadone treatment program. Physicians affiliated with an approved program are restricted in the use of methadone to the treatment regime ("methadone maintenance and withdrawal" or "methadone withdrawal only") specified in the program's treatment protocol.[22] Of the 118 physicians affiliated with approved programs, 102 were affiliated with programs authorized to use methadone in maintenance and withdrawal, and 16 were affiliated with programs authorized to use it in withdrawal only. Of the 222 physicians authorized to use methadone in the treatment of narcotic addiction but who were *not* affiliated with an approved program (see Table G.1 on page 978), 156 were authorized to use it in maintenance and withdrawal, and 66 were authorized to use it in withdrawal only. Thus, of the 340 physicians authorized to use methadone in the treatment of narcotic addiction, 258 were authorized to use it in maintenance and withdrawal, and 82 were authorized to use it in withdrawal only. In all, 23 treatment programs had been approved in 28 treatment locations.[23] When the federal control program was introduced early in 1972 there were only four fully operational methadone treatment units in Canada: the Narcotic Addiction Foundation of British Columbia, the Methadone Program operated in Edmonton by the Alcoholism and Drug Abuse Commission of Alberta, the Addiction Research Foundation of Ontario, and the Jewish General Hospital in Montreal, Quebec.

The distribution of authorized physicians by province is shown in Table G.1, and the approved treatment programs in Table G.2. It will be noted that at the end of November 1972, British Columbia, Ontario and Quebec had the greatest number of authorized physicians and approved programs for the use of methadone in the treatment of narcotic addiction, as follows: British Columbia—115 physicians and 11 approved treatment programs; Ontario—93 physicians and five approved treatment programs;

Quebec—59 authorized physicians and six approved treatment programs. After them ranked Alberta, with 29 authorized physicians and two approved treatment programs; Manitoba, with 19 authorized physicians and two approved treatment programs; and Nova Scotia, with 18 authorized physicians and two approved treatment programs. At that date there were physicians authorized to use methadone in the treatment of narcotic addiction in all provinces except Prince Edward Island and an approved treatment program for such purpose in all provinces except Saskatchewan, New Brunswick, Prince Edward Island and Newfoundland.

TABLE G.1

PHYSICIANS AND VETERINARIES AUTHORIZED TO USE METHADONE IN CANADA AS OF NOVEMBER 1972

—	*Physicians*					*Veterinaries*	TOTALS
	Affiliated with a Treatment Program	Not Affiliated with a Treatment Program (Nov. 1, 1972 to Oct. 31, 1973)					
		Withdrawal and Maintenance	Withdrawal only	Analgesia only	Antitussive only		
Province							
British Columbia	34	63	18	15	—	—	130
Alberta	13	6	10	9	—	—	38
Saskatchewan	—	5	—	1	—	1	7
Manitoba	16	—	3	6	—	2	27
Ontario	27	39	27	60	4	4	161
Quebec	23	31	5	9	—	—	68
New Brunswick	—	—	1	—	—	—	1
Nova Scotia	5	11	2	3	—	—	21
Prince Edward Island	—	—	—	—	—	1	1
Newfoundland	—	1	—	—	—	—	1
TOTALS	118	156	66	103	4	8	455

Source: Data from the Drug Advisory Bureau, Health Protection Branch, Department of National Health and Welfare, November 1972.

Although the total number of physicians authorized to use methadone in the treatment of narcotic addiction as of November 30, 1972 is only about 63 per cent of the number who had temporary authorizations for such purpose at the end of August, this decrease was not the result of rejection by the Department but rather of self-selection. The Department did not in fact turn down any application for authorization on or after November 1st, although there were a few cases in which it decided to send cautionary letters because of some concern over the physician's performance. There had been some withdrawals of authorization in the summer of 1972 by mutual agreement between the physician and the Drug Advisory Bureau.

TABLE G.2

APPROVED METHADONE TREATMENT PROGRAMS IN CANADA AS OF NOVEMBER 1972

Province	Name and Location	Type of Treatment Program
British Columbia	1. Lower Mainland Regional Correctional Center, Burnaby, B.C.	Withdrawal Therapy
	2. South Okanagan Methadone Program, Kelowna, B.C.	Maintenance and Withdrawal Therapy
	3. Penticton Methadone Maintenance Clinic, Penticton, B.C.	Maintenance and Withdrawal Therapy
	4. Powell River General Hospital, Powell River, B.C.	Maintenance and Withdrawal Therapy
	5. Narcotic Addiction Foundation, Vancouver, B.C. (Principal Unit).	All Foundation Units: Maintenance and Withdrawal Therapy
	6. Narcotic Addiction Foundation, Trail, B.C. (Regional Unit).	
	7. Narcotic Addiction Foundation, Prince George, B.C. (Regional Unit).	
	8. Narcotic Addiction Foundation, Coquitlam, B.C. (Regional Unit).	
	9. Narcotic Addiction Foundation, Victoria, B.C. (Regional Unit).	
	10. Narcotic Addiction Foundation, Nanaimo, B.C. (Regional Unit).	
	11. Riverview Hospital, Essondale, B.C.	Withdrawal Therapy
Alberta	1. Edmonton Methadone Evaluation Committee, Methadone Clinic, Edmonton, Alberta.	Maintenance and Withdrawal Therapy
	2. Foothills Hospital, Calgary, Alberta.	Maintenance and Withdrawal Therapy
Saskatchewan	No approved programs.	
Manitoba	1. Brandon Hospital for Mental Diseases, Brandon, Manitoba.	Maintenance and Withdrawal Therapy
	2. St. Boniface Hospital Drug Rehabilitation Program, St. Boniface, Manitoba.	Maintenance and Withdrawal Therapy

TABLE G.2—*Continued*

APPROVED METHADONE TREATMENT PROGRAMS IN CANADA AS OF NOVEMBER 1972

Province	Name and Location	Type of Treatment Program
Ontario	1. Narcotic Dependence Program Clinical Institute, Addiction Research Foundation, Toronto, Ontario.	Maintenance and Withdrawal Therapy
	2. Charlton Project, Hamilton, Ontario.	Maintenance and Withdrawal Therapy
	3. IODE Hospital Methadone Clinic, Windsor, Ontario.	Maintenance and Withdrawal Therapy
	4. St. Catherines Methadone Clinic, St. Catherines, Ontario.	Maintenance and Withdrawal Therapy
	5. Ottawa General Hospital, Ottawa, Ontario.	Maintenance and Withdrawal Therapy
Quebec	1. Royal Victoria Hospital, Montreal, Quebec.	Maintenance and Withdrawal Therapy
	2. Jewish General Hospital, Institute of Community and Family Psychiatry, Montreal, Quebec.	Maintenance and Withdrawal Therapy
	3. Département de réadaptation pour alcooliques et autres toxicomanes, Hôpital St. Charles de Joliette, Joliette, Quebec.	Maintenance and Withdrawal Therapy
	4. Programme d'entretien à la méthadone (deuxième ligne), Montréal, Quebec.	Maintenance and Withdrawal Therapy
	5. Unité d'alcoolisme et de toxicomanie de l'Hôpital St-Michel Archange, Mastal, Quebec.	Withdrawal Therapy
	6. Clinique de réadaptation pour toxicomanes du centre hospitalier universitaire de Sherbrooke, Sherbrooke, Quebec.	Withdrawal Therapy
New Brunswick	No approved programs.	
Nova Scotia	1. Nova Scotia Hospital, Dartmouth, Nova Scotia.	Withdrawal Therapy
	2. Victoria General Hospital, Halifax, Nova Scotia.	Maintenance and Withdrawal Therapy
Prince Edward Island	No approved programs.	
Newfoundland	No approved programs.	

Source: Data from Treatment Program Protocols submitted to the Drug Advisory Bureau, Health Protection Branch, Department of National Health and Welfare, November 1972.

It is not known what proportion of physicians authorized to use methadone without affiliation with an accepted clinic have access to laboratory facilities for the purpose of confirming dependence and monitoring illicit drug use. The authorization to use methadone after October 31, 1972 does not make urinalysis to confirm dependence and to monitor illicit drug use an explicit condition. At the time of the preparation of this report, all approved methadone clinics had access to urinalysis facilities, and authorized practitioners affiliated with these clinics were required to adhere to urinalysis procedures outlined in the clinics' treatment protocols. It is understood that in many cases the application for authorization received from physicians not affiliated with specialized treatment units did not make it clear whether such access to urinalysis would be available. The reasons given by the Health Protection Branch for not making access to urinalysis facilities a condition of authorization to use methadone are: first, that because of lack of the necessary facilities insistence on this requirement would severely reduce the availability of methadone for the treatment of narcotic dependence; secondly, there is some conflict of expert opinion as to the necessity or desirability of urinalysis; and thirdly, there is some opposition by individual physicians to the use of urinalysis because of its alleged effect on the physician-patient relationship and the patient's attitude towards treatment.

It should be noted further, that the authorizations to use methadone, whether the physician is affiliated or not, contemplate the possibility of self-administration on prescription and do not insist upon administration under direct supervision of the physician in all cases. The condition with respect to administration is in the following terms:

> Administration or prescription of methadone for narcotic addicts shall be only in a liquid dosage form that does not lend itself to mainlining, such as methadone dissolved in a constant volume of approximately 100 mg of 'Tang'.
>
> The drug shall be administered to addicts under direct supervision, or supplied or dispensed in oral liquid dosage form in limited quantities, when a cooperative relationship has been established between the patient and the practitioner.

The Special Joint Committee, in referring to the principles which should be followed in the use of methadone by a physician working outside an established methadone maintenance program, laid down the following rule concerning administration: "Arrangements should be made for direct administration to the patient of oral methadone, preferably in liquid form, which should be ingested always under the supervision of the physician, nurse or pharmacist. *Written prescriptions for methadone should never be given to narcotic-dependent patients.*"[24] The Commission was less explicit on this point. It spoke of the "administration" rather than the prescription of methadone, but it did not expressly rule out the possibility of prescription.

The Commission's concern about the dangers of prescription is clearly reflected, however, in the following passage in the *Treatment Report*:

> Unquestionably, the greatest illicit use occurs in the prescription of methadone by private physicians who have no facilities for laboratory monitoring or social follow-up, who prescribe more than two days' supply for self-medication and for 'self-withdrawal' ... and who cannot be certain that they are the sole source of supply for individual patients.[25]

Prescription or self-administration is permitted under the so-called "British system" of heroin and methadone maintenance, and it is permitted in varying degrees in methadone programs on this continent.

On this point the *Treatment Report* contained the following passage:

> *Dispensing* is most commonly done by administering methadone dissolved in Tang under supervision. Daily visits to the clinic are almost universal during the first part of the program, with gradual spacing of visits made possible by issuing doses for self-administration as the clinic develops trust in the individual patient. The maximum released at any clinic is a one-week supply.[26]

G.2 SOME ASPECTS OF THE "BRITISH SYSTEM"[1]

Although the history of opiate dependence and the present conditions in Great Britain are quite different from those on this continent, two remarkable facts remain: the population of known addicts appears to have been fairly stable in recent years, and while there is certainly an illicit market in narcotics there is still no evidence that it is an organized or even a very significant one.

The law enforcement task with respect to the opiate narcotics is much easier in Great Britain than it is on this continent, although it is important to keep in mind that the clinic "system" does not dispense with the need of law enforcement to suppress an illicit market. In 1970, there were 281 persons convicted of offences involving heroin in Great Britain. Of these, 157 were convicted of possession (which included possession for personal use as well as possession with intent to sell).[2]

The number of "active" addicts (those using drugs) known to the Home Office in recent years is as follows: 1969 – 1,456; 1970 – 1,430; 1971 – 1,555.[3] It is estimated that the total number of addicts who are not using but are at risk of relapse is 3,000.[4] It is on the basis of these figures and other indications that the authorities express the opinion that the heroin problem is being "contained".[5]

There may be other factors peculiar to Great Britain which explain this enviable situation and which make the British experience more or less irrelevant to conditions on this continent. The British do not make particular claims for the "success" of their approach. Characteristically, they are quite

matter-of-fact about it and adopt a pragmatic approach, watching to see how it turns out. There is no serious body of opinion, however, in treatment or in law enforcement that advocates abandoning the present approach. Certainly, the results appear to justify the general conclusion that the approach is a reasonably successful one.

The British have been gradually shifting their emphasis from heroin to methadone, although it must be observed that a high proportion of the methadone administration in Great Britain is still in intravenous form. The total quantities of heroin and methadone used in the clinics in recent years are as follows:

Year	*Heroin (grams)*	*Methadone*
1969	18,393	3,341
1970	17,387	14,833
1971	14,201	15,691

Source: Department of Health and Social Security.

For purposes of rough comparison, doses of heroin and methadone may be treated as equivalent. Heroin and methadone are used interchangeably on a weight for weight basis.[6]

The proportion of oral methadone in 1971 was only about 24 per cent of the total methadone used. Difficulty is experienced in persuading patients to accept oral methadone. British experts have attributed this to the long-established practice of prescribing narcotics for intravenous administration and to the difficulty of weaning addicts from the needle fixation. As one expert put it, "It is often as hard to break the needle habit as it is to break the drug habit."[7] There has been fear that too great an insistence on oral methadone would drive patients away or encourage the development of a black market in heroin.[8] It is felt that it is easier to wean a patient from intravenous methadone to oral methadone than from heroin to oral methadone.[9] The general approach with a "needle using heroin addict" has been described as follows:

(i) try to get him off intravenous heroin and onto intravenous methadone;

(ii) try to reduce the dose of intravenous methadone;

(iii) try to transfer the patient from intravenous methadone to oral methadone;

(iv) try to get him off drugs altogether.[10]

There are other important differences in the British and North American approaches to opiate maintenance. The British do not use blocking doses of methadone, but rather maintenance therapy on reducing doses.[11] The reason for this is presumably that heroin can also be prescribed so that it is not

essential to prescribe a dose of methadone that will completely block the action of heroin. Secondly, instead of supervised administration on the premises, which is the general rule for organized methadone treatment programs in Canada, the general rule in Great Britain is that addicts pick up their drug supply on prescription from pharmacists. They are required to pick up their supply daily, except on Saturdays, when they can take a two-day supply. Many clinics supply addicts with sterile disposable syringes for intravenous administration.[12] One reason for favouring injectable methadone over heroin is that methadone can be supplied in solution in ampoules. This avoids the unsterile practices involved in dissolving tablets of heroin which are the cause of serious complications.[13]

The British clinics vary considerably in the extent to which they provide ancillary services for social adjustment. In the fall of 1972 a group of 70 patients at the Charing Cross Clinic who had been abstinent for periods of up to three years, were being visited monthly by social workers, their functioning in the community was assessed, their arms were inspected for injection marks, and specimens of their urine were taken for analysis.[14] The clinic uses social workers, volunteers for counselling and vocational guidance as needed, but no group therapy.[15]

Generally speaking, the approach to treatment in Great Britain has been described as a "multi-pronged" one that incorporates all the available services, including social workers, visiting nurses, vocational guidance and training counselling, psychiatric care and housing facilities. Individual clinics and clinicians have the freedom of choosing which facilities they will use generally and for individual patients. Some clinics use a great deal, others less, depending upon perceived needs. Some patients may require only maintenance therapy; others may require psychiatric help. Most need purely social help, such as obtaining employment and housing. A senior medical officer in the Department of Health and Social Security expressed the importance of ancillary services as follows:

> I think that treatment and rehabilitation cannot be separated from one another. In a report on the Rehabilitation of Drug Addicts, the Advisory Committee on Drug Dependence recommended that rehabilitation begins with the contact with the addict. This is usually at the Drug Dependence Clinic. Out-patient treatment and rehabilitation programmes have not been running long enough for us to have evaluated their contribution to the successful treatment of the drug addicts. My own observations are that one needs a variety of facilities and professional and voluntary workers to cover the variety of problems presented by drug addicts. The mere withdrawal of the drug from the addict is most unlikely to succeed if there is no substitution of the drug culture by a social life which is satisfying and if there is no skilled help with the emotional and personality problems which will help the addicts to abandon the former culture and accept the latter. The successful outcome of treatment appears to be related to a multi-disciplinary approach to the problem with a backing up of a number of treatment and rehabilitation facilities, e.g. social work support, various types of hostels, day centres and etc.[16]

NOTES

G.1 *Methadone Control Program of the Government of Canada*

1. Methadone and the Care of the Narcotic Addict: Report of A Special Joint Committee of the Canadian Medical Association and the Department of National Health and Welfare Food and Drug Directorate, p. 6.
2. *Treatment Report*, pp. 27–28.
3. These figures, furnished to the Commission by the Bureau of Dangerous Drugs, are pure drug figures representing the pure anhydrous base content of the total substance imported; in the case of methadone, this amounts to about 90% of the total quantity of methadone compounds imported each year.
4. Note 1, *supra*, p. 6. The figures for imports cited by the Joint Committee, which were apparently not in pure drugs terms and were therefore somewhat higher than those furnished by the Bureau of Dangerous Drugs, were as follows: 1966 – 3.29 kg; 1967 – 5.71 kg; 1968 – 10.4 kg; 1969 – 13.4 kg; 1970 – 30.19 kg; first half of 1971 – 30 kg.
5. These figures are furnished by the Bureau of Dangerous Drugs to the International Narcotics Control Board. For this purpose estimates of consumption of the main narcotics, including methadone, are stated in pure drug figures and are based upon a formula which reflects changes in the inventory of drug manufacturers and distributors in Canada from the last day of the preceding year to the last day of the current year, plus imports and minus exports of the substances during the year. The result is that the narcotic is estimated to be consumed when it is supplied by the drug manufacturer or distributor to the hospital, pharmacy or physician.
6. Source for the figures in this paragraph: Bureau of Dangerous Drugs, Health Protection Branch, Department of National Health and Welfare, Statements of Convictions Involving Methadone for the Calendar Years 1970 and 1971 and for the Period Jan. 1—June 30, 1972, as recorded to July 21, 1972.
7. *Treatment Report*, p. 31.
8. *Debates*, House of Commons, Canada, February 24, 1972, p. 197.
9. Canada, Health Protection Branch, Department of National Health and Welfare, "Guidelines for Establishing Affiliation with Specialized Treatment Units and Applying for Authorization to use Methadone," 1972, p. 1.
10. These requirements were adopted verbatim from the Report of the Special Joint Committee of the Food and Drug Directorate and the Canadian Medical Association.
11. Order in Council P.C. 1972-1033, 16 May 1972, SOR/72-155.
12. *Narcotic Control Regulations*, section 38(3). The physician must be named in an authorization issued by the Minister under section 47(1) of the

Narcotic Control Regulations, which, as amended on August 24, 1972 (P.C. 1972-1795, 24 August 1972, SOR/72-337), reads in part as follows:

> Where he deems it to be in the public interest, or in the interests of science, the Minister may in writing, authorize... (d) any practitioner to administer, prescribe, give, sell or furnish methadone to a person or animal who is a patient under his professional treatment.

13. *Narcotic Control Regulations,* sections 20(3), 24(3)(d).
14. *Ibid.,* section 20(2)(e).
15. These figures were compiled by Commission research staff from the records of the Drug Advisory Bureau and the Bureau of Dangerous Drugs.
16. This Committee, consisting of Dr. T. Da Silva, Head, Central Nervous System Section, Drug Advisory Bureau, Health Protection Branch, Department of National Health and Welfare; Dr. C. J. Schwartz, University of British Columbia; Dr. Ramsey W. Gunton, Department of Medicine, University of Western Ontario; Dr. Jean-M. Bordeleau, University of Montreal; Dr. Marcel A. Baltzan, Saskatoon (Dr. John Bennett of the Canadian Medical Association has substituted for Dr. Baltzan at past meetings of the Committee), met on October 10, 11 and 12, 1972.
17. Note 9, *supra,* p. 3.
18. *Ibid.,* p. 5.
19. Note 1, *supra,* p. 9.
20. *Ibid.,* p. 12. Italics are those of the Committee.
21. Personal communication to the Commission, October 20, 1972.
22. T. Da Silva, M.D., Head, Central Nervous System Section, Drug Advisory Bureau, Health Protection Branch, Department of National Health and Welfare, personal communication to the Commission, February 2, 1973.
23. The Narcotic Addiction Foundation of British Columbia has six clinic locations.
24. Note 1, *supra,* p. 9. Italics are those of the Committee.
25. *Treatment Report,* pp. 27–28.
26. *Ibid.,* p. 25.

G.2 *Some Aspects of the "British System"*

1. This brief discussion of certain aspects of the British approach to the treatment of opiate dependents is an attempt to bring our general perspective up to date on the basis of correspondence and telephone conversations with government officials and treatment personnel in the fall of 1972. In the course of its inquiry the Commission had access to other sources of information and evaluation concerning the British system. In addition to a review of the literature, a member of the Commission visited a number of treatment clinics and spoke to public officials and clinic directors in England, the Commission consulted frequently with leading treatment experts, and it held a symposium on treatment at which British experience and expertise were represented.
2. H. B. Spear (Home Office, London, England), personal communication to the Commission, September 26, 1972.

3. D. A. Cahal, Senior Principal Medical Officer (Department of Health and Social Security, London, England), personal communication to the Commission, September 5, 1972. (These figures are the number of opiate-dependent persons who are known to be using drugs at the end of the calendar year. The total number of opiate-dependent persons seen by the clinics in the course of the year is slightly under 3,000, and this figure is also often stated for the number of known addicts. But Dr. Cahal expressed the opinion to the Commission that the lower figure was the more reliable for purposes of estimating the actual number who were still using drugs at a particular time.)
4. Ibid.
5. Cahal, personal communication to the Commission, October 18, 1972.
6. Dr. T. H. Bewley, Consultant Psychiatrist (Tooting Bec Hospital, London, England), personal communication to the Commission, October 18, 1972.
7. Cahal, personal communication to the Commission, September 5, 1972.
8. Dr. Gerry Stimson, Medical Sociology Research Centre (Swansea, Glam., Wales), personal communication to the Commission, September 28, 1972.
9. Dr. G. B. Oppenheim, Consultant Psychiatrist (Charing Cross Hospital, London, England), personal communication to the Commission, October 25, 1972.
10. Cahal, personal communication to the Commission, September 5, 1972.
11. Ibid.
12. Ibid.
13. Cahal, personal communication to the Commission, September 5, 1972 and Dr. A. Sippert, Senior Medical Officer (Department of Health and Social Security, London, England), personal communication to the Commission, September 22, 1972.
14. Oppenheim, personal communication to the Commission, October 25, 1972.
15. Ibid.
16. Dr. A. Sippert, Senior Medical Officer (Department of Health and Social Security, London, England), personal communication to the Commission, October 20, 1972.

Appendix H

Treatment Capacity in the Provinces

Introduction

The first concern of treatment insofar as opiate dependence is concerned must be the extent of the treatment facilities in British Columbia, where the major problem of opiate use and dependence exists. It is doubtful if the province has adequate treatment capacity for an opiate-dependent population that may number as many as 10,000.

British Columbia

Methadone maintenance. In British Columbia at the end of November 1972, there were 11 approved treatment units for methadone maintenance, six of them operated by the Narcotic Addiction Foundation. The Foundation's main unit is in Vancouver, and it has regional units at Trail, Prince George, Coquitlam, Victoria, and Nanaimo. Other approved treatment programs in the province are the Lower Mainland Regional Correctional Centre at Burnaby, the South Okanagan Methadone Program at Kelowna, the Penticton Methadone Maintenance Clinic at Penticton, the Powell River General Hospital, and the Riverview Hospital, Essondale.

In November 1972 there were 115 physicians in British Columbia authorized to administer or prescribe methadone to opiate-dependent persons, 34 of them affiliated with approved treatment programs, and 81 not affiliated. Of the latter, 63 were authorized to use methadone in maintenance, as well as withdrawal, and 18 in withdrawal only. In the protocol which it submitted for approval to the Drug Advisory Bureau of the Department of National Health and Welfare during the summer of 1972, the Narcotic Addiction Foundation estimated the caseload of its Vancouver unit at 400 patients and the caseload of three of its four regional units at 50 patients each. There was no estimate for the fourth. The other approved programs estimated very small caseloads.

According to the records of the Bureau of Dangerous Drugs, 454 persons received methadone from the Narcotic Addiction Foundation in June 1972 and 493 in July. During the same two-month period, 346 persons received methadone from other sources in British Columbia. The Vancouver unit of the Foundation sees approximately 1,000 people a year, but its average daily caseload is about 350 to 400 patients. On the basis of the information that we have been able to gather we would estimate that there are not more than 650 to 800 persons regularly in methadone maintenance in the province. It is fairly safe to assume that the total is not more than ten per cent of the probable total population of opiate dependents in British Columbia. If we take the assumption made in the United States that methadone maintenance could be made to reach at least 40 per cent of the opiate-dependent population,[1] then present delivery of this form of treatment or management is well below potential. This situation may, of course, reflect lack of awareness of demand as well as insufficient capacity.

The effective reach of methadone maintenance is even less because it is estimated by treatment personnel of the Foundation that not more than 20 or 25% of the persons who come for treatment at the Foundation remain in it for any length of time, and that only about 10% of these are benefited by it in the long run.[2]

What is lacking in methadone maintenance programs is sufficient trained personnel for adequate follow-up and assistance with adjustment in the community. It is the same lack that we encounter in probation and parole. There are not enough people to give opiate dependents the close attention they require. Moreover, there is a need for smaller caseloads.

In the Vancouver methadone maintenance unit of the Foundation there are two full-time medical practitioners, two full-time pharmacists, lab technicians and pharmacy technicians, and four full-time social workers, each with a caseload of 80 or 90 patients. The regional units at Victoria, Nanaimo, Prince George, Trail, and Coquitlam are each staffed with one medical practitioner on half-time, two counsellors and a receptionist. All clinical laboratory analysis is done at the Vancouver unit. Samples are mailed in from the regional units.

A major drawback of the treatment program at the Foundation is that it is not sufficiently comprehensive and it lacks an effective research and evaluative component. The present approach is almost exclusively pharmacological. The Foundation is funded by seven different government agencies, federal and provincial, and the frame of reference for funding purposes is the medical model. What is required is a much more comprehensive or multi-modal approach to treatment which, in addition to methadone maintenance, would include residential treatment in therapeutic communities, detoxification in a highly supportive setting, a wide range of adjunctive services—workshops, recreational activities, and the like—and a research and evaluation component. The lack of such a component is seen by Foundation

staff to be a major weakness of their program at the present time. Without such a component there can be little hope of development of treatment efficacy.

The Foundation has operated some other therapeutic or rehabilitative facilities. *The House* was organized as a drop-in centre for persons with problems with drugs other than opiate narcotics. As it became apparent that one could not separate types of drug use in this way, *The House* became a crisis intervention centre for all types of drug use. It has three crisis beds, but it is not a residential centre. There is no follow-up in the community, with the result that once an individual leaves the premises he may have no further contact with *The House*.

In Touch, the outreach component of *The House* and the clinic, was a one-year experimental project funded by matched contributions from a philanthropist and the federal and provincial governments. It was closed, for lack of further financial support, towards the end of 1972.

Facilities for urinalysis. The Foundation would appear to have adequate equipment and staff for urinalysis. It carries out approximately 6,000 urinalyses a month. The Foundation has been using thin-layer chromatography (TLC), which permits qualitative but not quantitative analysis. In the fall of 1972 it received a provincial government grant to permit it to establish a clinical laboratory, with gas liquid chromatography equipment (which permits quantitative analysis), for the analysis of street drugs.

Equipment for qualitative TLC tests costs about three hundred to four hundred dollars and has been installed at the Royal Jubilee Hospital in Victoria, the Royal Columbia Hospital in New Westminster, and in Vancouver at the Biomedical Laboratory, the Provincial Medical Laboratory, the Vancouver General Hospital, the Children's Hospital, the Federal Food and Drug Laboratory, and the Narcotic Addiction Foundation treatment unit. The quantitative GLC testing equipment costs about ten thousand dollars, and facilities for this exist at the Royal Jubilee Hospital in Victoria, the Royal Columbia Hospital in New Westminster, and in Vancouver at the Vancouver General Hospital and the University of British Columbia, as well as the Foundation.

There is a concensus of opinion in British Columbia that adequate facilities now exist to handle qualitative analysis for the entire opiate-dependent population in the province, and that with the expansion of the Foundation's laboratory there will be adequate facilities for quantitative analysis as well.

Therapeutic communities and other residential treatment units. The total capacity of residential treatment programs in British Columbia is relatively small. X-Kalay Foundation Society, one of the oldest and largest therapeutic communities in Canada, has a capacity in its various facilities

in British Columbia of about 65. X-Kalay's facilities are not exclusively reserved for opiate dependents. X-Kalay's capacity may increase to approximately 125 upon execution of a proposed expansion to a farm location in Langley, British Columbia. (A survey conducted by the Commission to determine the residential capacity of therapeutic communities in Canada is described in detail, and the results of the survey presented in tabular form, in the Annex to this Appendix on pages 1000 to 1003.)

In Vancouver X-Kalay maintains a variety of premises—a residence which is a former private hospital and accommodates a maximum of 40 persons, an office and two private homes. In the fall of 1972 there were about 30 persons in residence in X-Kalay in Vancouver. Operating expenses were running at about $10,000 per month, or about $4,000 per resident per year.

X-Kalay rents a small hotel and five cabins on Salt Spring Island, which accommodate approximately 25 persons. The Foundation operates a dining room and a coffee shop in the hotel. The facilities are used primarily by X-Kalay therapy groups, and are occasionally loaned or rented to other community organizations and associations. During the winter, Salt Spring Island is managed by a skeleton staff of three to four people. It is used to a greater extent during the summer.

By the fall of 1972 plans for the X-Kalay mini-village had been revised to locate the facility on a six-acre farm near Langley, British Columbia, with a capacity of about 60 residents. The estimated cost was $700,000, and negotiations for financial assistance were being conducted at both levels of government. The new building would reduce operating expenses to about $9,000 per month, or about $1,800 per resident per year if the facilities were operated at full capacity.

The three businesses which X-Kalay operated (a service station, a beauty salon, and an advertising service industry) were closed in the spring of 1972, primarily because their operation interfered with treatment. David M. Berner, Executive Director of X-Kalay, is now of the opinion that it is not advisable to operate a commercial enterprise for therapeutic purposes, and that some kind of sheltered industry should be established instead.

The Director provided the Commission with the following percentages of persons treated at X-Kalay during the period January 1969 to June 1972 for various problems (classified as "drugs", "alcohol" and "other") who remained drug-free and gainfully employed, which are the essential criteria of "success" in the program:

Problem	Male	Female	Average
Drugs	42.1%	36.8%	39.3%
Alcohol	46.8%	33.3%	43.6%
Other	11.1%	29.9%	20.5%

Although the number of residents in the Vancouver facility of X-Kalay remains fairly constant at about 30 persons, the population is fluid. The Director estimates that about three persons enter or leave the community each week. Of the 30 persons at X-Kalay in the fall of 1972, about half had been there a considerable time, and about eight to ten for several months. In talking with the Commission, the Director spoke of the same "split rate" phenomenon described by American authors who have commented on the experience of therapeutic communities: the greatest number of persons leave the first day; the next largest number leave after about three weeks; those who remain longer than three weeks generally remain for three to six months; if they remain at the end of that period, they will likely remain one and one-half years, which the Director estimates to be the optimum treatment period. In the *Treatment Report* we stated that X-Kalay does not aim to return its people to society, (p. 87). The Director states that this is not the case: that residents do enter the community at large after a period of treatment in X-Kalay, and that X-Kalay encourages them to do so.

The Director has expressed the opinion that between 200 and 300 residents is the optimum number for a therapeutic community like X-Kalay, and that several such communities could be established if there were sufficient funds available, administrative staff was supplied, and some agency would contract to fund a training program of approximately six months for therapeutic community leaders.

There is one other therapeutic community in British Columbia, a residence operated by Teen Challenge (a Christian organization) in Richmond. The total number of opiate dependents accommodated by this program is comparatively small.

Alberta

Early in 1972 Calgary experimented with a program of withdrawal for opiate dependents. It proved to be unsuccessful. Few presented themselves for detoxification, and of those who did, few completed the five-day withdrawal program. Later in the year interested physicians were urging the establishment of a methadone maintenance clinic, and a proposal was being considered by the Methadone Evaluation Committee of the Alcoholism and Drug Abuse Commission. A protocol was approved by the Department of National Health and Welfare for the Foothills Hospital in Calgary to carry on a limited withdrawal inpatient facility and a limited methadone maintenance program. At the time of approval the program was still in an "embryonic" state and was looking for financial support.

A methadone clinic began operation in Edmonton in January 1972 under the direction of a joint committee of the Alberta Medical Association

and the Alcoholism and Drug Abuse Commission. As of June 30th the clinic had seen approximately 190 patients. In October there were 79 patients in methadone maintenance. Of these, 52 received methadone at the clinic and 27 obtained it on prescription at pharmacies in Edmonton.[3] The protocol of the Edmonton Methadone Clinic has been approved by the Department of National Health and Welfare.

As of November 1972, 13 physicians affiliated with approved treatment programs had been authorized to use methadone maintenance in the treatment of opiate dependence in Alberta, and 16 physicians were authorized who were not affiliated with a program. Of these, six were authorized to use methadone in maintenance, as well as withdrawal, and ten in withdrawal only.

It is estimated that there were about 750 opiate dependents in Alberta in the fall of 1972, with about 120 in methadone treatment.

There are currently three therapeutic communities operating in Alberta with a combined residential capacity of 50. As one of these programs has only recently begun, the overall capacity of therapeutic communities in the Province can be expected to increase in the near future.

Saskatchewan

On October 20, 1972 there were 12 persons being maintained on methadone at the Alcoholism Rehabilitation Centre in Regina. During the previous two months there had been an average of 18–20 methadone patients at the Centre. At that time, methadone was being employed by physicians at the Centre in the following ways: (1) high dose administration (85–120 mg) decreased after six to eight weeks; (2) medium dose (80 mg) maintenance for an indefinite period—particularly for patients between the ages of 25 and 30; and (3) high dose (85–120 mg) maintenance for patients 40 years and older.[4]

As of November 1972 there were no methadone programs in Saskatchewan formally approved by the Department of National Health and Welfare; and hence, no physicians were authorized to use methadone on a permanent basis through affiliation with an approved program. However, five unaffiliated physicians in Saskatchewan were authorized by the Department to use methadone in both withdrawal and maintenance therapy.

On the basis of a survey of methadone prescriptions in Saskatchewan, the Bureau of Dangerous Drugs recorded 53 individuals who had received methadone in the Province during the period May 1st to July 31, 1972. The opiate-dependent population in Saskatchewan was estimated at 125 in the fall of 1972.

MANITOBA

In Manitoba there are two approved methadone programs: the St. Boniface Hospital Drug Rehabilitation Program and the program at the Brandon Hospital for Mental Diseases. In October 1972, there were approximately 60 opiate dependents in the St. Boniface program: 5 were "medical addicts"; the remaining 55 were all regular heroin users of whom 33 were being maintained on methadone, some were being detoxified with methadone, and some were being treated without the aid of any drug. Six of the methadone maintenance patients were permitted to take home daily supplies; the remainder were obliged to consume their medication at the clinic and to present a urine sample each day. The five "medical addicts" were given weekly supplies of the drug. Of the 60 patients at the clinic 40 were either employed, going to school or housewives with children.[5]

As of November 1972, 16 physicians who were affiliated with an approved treatment program had been authorized to use methadone and three who were not affiliated had been authorized. The latter were authorized to use it in withdrawal only.

It is estimated that there were about 450 opiate dependents in Manitoba in the fall of 1972, of whom 70 were receiving methadone treatment.

X-Kalay Foundation Society operates a therapeutic community at St. Norbert, Manitoba, in which 51 drug-dependent persons are in residence. This community, located on a farm, has a maximum capacity of 80. An urban-based group called Kiazam operates a residential facility for opiate dependents in Winnipeg with a capacity of ten.

ONTARIO

As of November 1972 there were five approved methadone treatment programs in Ontario: the Narcotic Dependence Program Clinical Institute of the Addiction Research Foundation, in Toronto; the Charlton Project, Hamilton; the IODE Hospital Methadone Clinic, Windsor; the St. Catherines Methadone Clinic, St. Catherines; and the Ottawa General Hospital, Ottawa. Twenty-seven physicians who were affiliated with approved programs were authorized to use methadone in treatment and 66 who were not affiliated. Of the latter, 39 were authorized to use methadone in maintenance, as well as withdrawal, and 27 in withdrawal only.

The prescription records of the Bureau of Dangerous Drugs indicate that 230 persons received methadone in Ontario during June and July 1972. The active caseload of patients on methadone at the Addiction Research Foundation is between 100 and 110 at any one time. The Director of the Foundation's program indicated to the Commission that in the past three years there were close to 500 applicants for methadone maintenance of

whom about 260 were accepted.[6] How many of the remainder were suitable candidates for methadone maintenance but could not be handled because of the Foundation's limited facilities is not clear. It is clear, however, that the Foundation has deliberately limited its caseload to about 100, as the optimum number which it feels it can manage effectively with its limited staff and the follow-up that is required. Thus its capacity is severely limited in relation to the probable potential for methadone maintenance in the Toronto area.

The Foundation operates an outpatient clinic for addicts on Yonge Street and a 100-bed clinical institute on Russell Streets, in Toronto. The Foundation operates three types of methadone programs: short-term withdrawal, prolonged withdrawal and methadone maintenance therapy. The protocol submitted by the Foundation to the Drug Advisory Bureau of the Department of National Health and Welfare states that short-term withdrawal is used as a last resort for long-term addicts when no other course is feasible. It is also the primary course to be used for neophyte users and persons under 18 years. The short-term withdrawal program takes about 18 days. The protocol states that the prolonged withdrawal program is used primarily where longer therapeutic endeavour is indicated but commitment to methadone maintenance is lacking, patients display some degree of motivation to achieve a drug-free state, their addiction history does not indicate a long-term involvement with heroin, and unsuccessful withdrawal attempts have been carried out. The prolonged withdrawal program is aimed at achieving a drug-free state within four to six months.

An evaluation of the Foundation's methadone maintenance program indicated a drop-out rate of 56.7% (51 out of 90) within one year.[7]

Ontario has the largest number of therapeutic communities for drug-dependent persons in Canada, although the residential capacities of these communities is comparatively small. Thirteen residential programs had a combined total of 136 residents in February 1973, with a maximum capacity of about 200. Only a few of these programs were exclusively concerned with opiate or amphetamine dependence. The Twin Valley program in London, Ontario, is planning to develop an 800-acre rural community to accommodate several hundred drug-dependent persons.

Quebec

There are six approved methadone programs in Quebec: Royal Victoria Hospital, Montreal; the Jewish General Hospital, Montreal; Département de réadaptation pour alcooliques et autres toxicomanes, Hôpital St. Charles de Joliette, Joliette; Programme d'entretien à la méthadone (Deuxième Ligne), Montréal; Unité d'alcoolisme et de toxicomanie de l'Hôpital St. Michel Archange, Mastaï; Clinique de réadaptation pour toxicomanes au Centre hospitalier universitaire de Sherbrooke, Sherbrooke.

As of November 1972, 23 physicians who were affiliated with approved treatment programs were authorized to use methadone, and 36 who were not affiliated. Of the latter, 31 were authorized to use methadone in maintenance, as well as withdrawal, and five in withdrawal only.

In the fall of 1972 the Royal Victoria Hospital had about 25 patients in its methadone program. The protocol which it submitted to the Federal Government stated that a maximum of 150 patients will be accepted in the program.

In the fall of 1972 there were six patients on methadone maintenance in the program of the Jewish General Hospital. The Commission was informed that because of limitations of staff and funds a limit of 12 patients had been set for this program.[8] In the protocol submitted to the Federal Government it was stated that between June and September 1972, 53 patients had contacted the clinic and that it was "likely that as the program develops and expands this rate will increase significantly".

In the fall of 1972 there were 15 patients in the methadone program of Deuxième Ligne, in Montreal. The program has applied for government financial support to permit it to accommodate as many as 150 patients.[9]

As of February 1973 there were three therapeutic communities in Quebec caring for 65 drug-dependent persons. At the time of the Commission's survey (see the Annex on page 1000) two additional therapeutic communities were in advanced planning stages. The overall capacity of therapeutic communities in Quebec is likely to increase with the proposed expansion of the "Portage" program, which may eventually accommodate as many as 100 drug-dependent persons.

Maritime Provinces

There have been two methadone programs approved for Nova Scotia; the Nova Scotia Hospital at Dartmouth, and the Victoria General Hospital at Halifax. As of November 1972, five physicians who were affiliated with approved treatment programs had been authorized to use methadone and 13 physicians who were not affiliated. Of the latter, 11 were authorized to use methadone in maintenance, as well as withdrawal, and two in withdrawal only. The Nova Scotia Hospital at Dartmouth uses methadone for withdrawal therapy only. In November 1972, it had one patient in treatment.

Therapeutic communities in the Maritimes have an overall capacity of approximately 50. These programs include two residences in Halifax, Nova Scotia, which have been seeing problems associated primarily with amphetamine and multi-drug use, a community located on a farm near St. John, New Brunswick, and a residence in Charlottetown, Prince Edward Island.

Appendix H

Hospital Facilities in Canada

On the suggestion of the Department of National Health and Welfare and the Canadian Hospital Association, Statistics Canada incorporated into its Quarterly Hospital Information System for the fourth quarter of 1971 a questionnaire to identify "those hospitals that considered they were making some provision for the treatment of persons having problems with 'alcohol' and/or 'drugs' on an ambulatory or inpatient basis."[10] Since the terms "provision" and "treatment" as employed in this questionnaire were purposely not defined, the responses to the survey served only to determine "the universe of general and allied special hospitals that, in their opinion, are providing some kind of hospital service to patients on an ambulatory or impatient basis. Obviously, the scope and quality of the services provided by the responding hospitals would vary greatly."[11]

As of December 31, 1971, there were 1,234 general and allied special hospitals in operation in Canada, all of which received the above-mentioned questionnaire from Statistics Canada. One thousand and forty-five, or almost 85%, of these hospitals returned completed questionnaires.

In an analysis of the data contained in these completed questionnaires, the Health Economics and Statistics Directorate, Health Program Branch, Department of National Health and Welfare, noted a further qualification of the results of this hospital survey in the following words:

> . . . as 'alcohol' and 'drugs' are not necessarily exclusive categories there is likely to be some overlapping in the reporting by hospitals. Also, because of the prevalence of multiple drug problems, treatment of addiction may be integrated in a single program.[12]

Statistics Canada's survey indicated that on the whole the provision in hospitals in Canada for the treatment of persons having problems associated with "drugs" is less common than the provision for the treatment in hospitals of persons experiencing problems with alcohol. (See Table H.1.) Of the 1,045 reporting hospitals, 309 (29.6%) provided inpatient treatment and 313 (29.9%) provided outpatient treatment for persons experiencing problems with "drugs" as of December 31, 1971.

The number and proportion of reporting hospitals providing inpatient and outpatient treatment for persons having problems with "drugs" and alcohol are presented by province in Table H.1. While the results of this survey are limited for the reasons mentioned above, they do, however, suggest that there may not be sufficient capacity for ambulatory and inpatient treatment of problems primarily associated with non-medical drug use in hospial facilities in Canada generally.

TABLE H.1

HOSPITALS REPORTING TREATMENT SERVICES FOR DRUG AND ALCOHOL PROBLEMS BY TYPE OF SERVICE AND BY PROVINCE, DECEMBER 31, 1971

Province	No. of Hospitals Surveyed	Hospitals Reporting		Drugs				Alcohol			
				In-Pt.		Out-Pt.		In-Pt.		Out-Pt.	
		No.	%	No.	%	No.	%	No.	%	No.	%
Nfld.	47	34	72.3	7	20.6	7	20.6	9	26.5	8	23.5
P.E.I.	9	4	44.4	1	25.0	1	25.0	2	50.0	—	—
N.S.	50	49	98.0	11	22.4	11	22.4	12	24.5	10	20.4
N.B.	40	34	85.0	6	17.6	7	20.6	8	23.5	8	23.5
Que.	256	220	85.9	61	27.6	74	33.5	73	33.0	82	37.1
Ont.	273	232	85.0	89	38.4	94	40.5	91	39.2	91	39.2
Man.	103	91	88.3	19	20.9	18	19.8	26	28.6	20	22.0
Sask.	143	111	77.6	30	27.0	25	22.5	34	30.6	27	24.3
Alta.	153	132	86.3	41	31.1	37	28.0	47	35.6	36	27.3
B.C.	116	108	93.1	33	30.6	31	28.7	36	33.3	33	30.5
Yukon	6	5	83.3	3	60.0	2	40.0	3	60.0	2	40.0
N.W.T.	38	25	65.8	8	32.0	6	24.0	9	36.0	7	28.0
Canada	1,234	1,045	84.6	309	29.6	313	29.9	350	33.5	324	31.0

Source: This table was prepared by the Health Economics and Statistics Directorate, Health Programs Branch, Department of National Health and Welfare, on October 5, 1972 from the Institutions Section, Health and Welfare Division of Statistics Canada, Summary Tables for *Canada 1971*, and each province and territory based on listing of responses by individual hospitals to questionnaire survey, December, 1971.

ANNEX

Capacity of Drug-Oriented Therapeutic Communities in Canada (as Recorded to February 9, 1973)

On the basis of information gathered in the course of its previous studies of innovative services in Canada (see Appendix M *Innovative Services*) and from discussions with the headquarters and five regional offices of the Non-Medical Use of Drugs Directorate, Health Protection Branch, Department of National Health and Welfare, the Commission conducted a telephone survey in February 1973 to determine the capacity of drug-oriented therapeutic communities in Canada. For the purpose of this survey, *therapeutic community* was defined as a residential treatment program offering voluntary commitment to various individual and group therapy processes, within a drug-free milieu, to treat persons dependent on opiate narcotics, amphetamines and/or multiple non-medical drug use. So defined, these programs are distinguishable from a variety of other residential programs in Canada dealing with such programs as adolescent emotional and family disturbances and delinquency, on the one hand, and from methadone maintenance and other outpatient programs for the treatment of drug dependence, on the other. Only those residential programs with a stated policy of providing treatment for drug dependence within a drug-free setting are included in the listing of therapeutic communities in Table H.2 on page 1002. In cases where program emphasis was uncertain, programs were included only upon a finding that at least one-third of their residents were coping with a drug problem.

There appears from this survey to be a growing tendency among therapeutic communities and other residential programs to deal with a drug-related problem, other than long-term opiate narcotic dependence, as part of a broad spectrum of personal and social problems and, as such, a problem amenable to therapeutic methods not specifically drug-related through practised in a drug-free setting. Only a few of the programs listed in Table H.2, among them, "X-Kalay", "Portage", "414", "Spera" and "Narcanon", are almost exclusively concerned with drug rehabilitation.

It was determined from this survey that a total of 28 drug-oriented therapeutic communities were operating in Canada as of February 9, 1973. It should be noted that these therapeutic communities are greatly outnumbered by non-residential programs for drug users, such as outpatient counselling programs, workshops and cooperatives, communal living projects and methadone maintenance programs.

When considering the residential capacity of therapeutic communities in Canada at any one time, it is important to bear in mind that at the present

time most therapeutic community programs are in part, or wholly, dependent on one or more (usually federal) short-term grants. Until such time as long-term funding arrangements are worked out with these programs, the overall treatment capacity of therapeutic communities in Canada will be subject to rapid fluctuation.

This survey revealed that within the 28 therapeutic communities operating in Canada as of February 1973 there were 178 salaried staff, 379 residents and a maximum residential capacity (given present staff and facilities) of 634. (See Table H.2 on the following page.)

Appendix H

TABLE H.2

RESIDENTIAL THERAPEUTIC COMMUNITIES IN CANADA
(As Recorded to February 1973)

Region/ Province	Name of Program	Location	Current Staff*	Current Residents	Maximum Residential Capacity†	Average Duration of Residential Stay‡	Drug Problems Dealt With
Maritime Provinces	1. Dirnan House	Halifax, N.S.	5	9	9	1 month	M§
	2. New Options	Halifax, N.S.	8	13	20	3 months	O/A‖
	3. Aware House	St. John, N.B.	4	12	12	6 months	M
	4. Christian Challenge Home	Charlottetown, P.E.I.	8	4	10	2 months	M/A#
TOTAL			25	38	51		
Quebec	5. Spera Foundation	Rawdon	10	25	30	9 months	M/A O/A
	6. Portage	Montreal	13	10	100	12 months	O/A
	7. La Terre	Wotton	6	30	35	3 months	M/A
TOTAL			29	65	165		
Ontario	8. "GYATE" (Get Your Act Together Enterprises)	Ottawa	9	5	10	3 months	M/A
	9. Stonehenge	Guelph	5	11	13	3 months	O/A
	10. Oolagen House	Toronto	7	6	6	5 months	M
	11. Western Ontario Therapeutic Comm. Hostel	London	10	23	30	4 months	M
	12. "414" Dufferin	London	5	6	30	12 months	O/A
	13. 56 Colbourne	Oshawa	6	5	7	4 months	M/A
	14. Crossroads Farm	Windsor	6	14	14	4 months	O/A
	15. Friendship House	London	3	15	15	3 months	M/A
	16. Delisle House	Toronto	6	8	8	6 months	M/A
	17. Spera Niagara	Welland	3	7	14	9 months	O/A
	18. Twin Valley	London	6	22	36	—	M
	19. Narcanon	Toronto	4	8	16	3 months	O/A
	20. Oasis	Sudbury	6	6	6	3 months	M
TOTAL			76	136	205		

TABLE H.2 — (Continued)

Region/ Province	Name of Program	Location	Current Staff	Current Residents	Maximum Residential Capacity	Average Duration of Residential Stay	Drug Problems Dealt With
Prairie Provinces	21. X-Kalay	St. Norbert, Man.	10	51	80	6 months	O/A
	22. Kiazam	Winnipeg, Man.	6	8	10	2 months	O/A
	23. Point III	Edmonton, Alta.	8	20	24	2 months	O/A
	24. Help House	Calgary, Alta.	6	8	14	6 months	O/A
	25. ADAPT	Lamont, Alta.	3	3	12	—	M
TOTAL			33	90	140		
British Columbia	26. X-Kalay	Vancouver	7	30	40	12 months	O/A
	27. X-Kalay	Salt Spring	4	15	25	3 months	O/A
	28. Richmond Residence (Teen Challenge)	Richmond	4	5	8	4 months	O/A
TOTAL			15	50	73		
GRAND TOTAL			178	379	634		

* *Staff* refers to salaried positions only, including both those who work directly with residents and the administrative and support staff. (In practice, these distinctions tend to blur, with the same person often filling roles in each group.) In programs where residents "graduate" to positions of junior staff or assistants, such persons are not counted as staff unless salaried.

† *Maximum Capacity* refers to residential capacity only, based on current staff and physical plant. Many of the organizations listed here provide outpatient service (including post-resident, follow-up counselling) to as many or more persons as those in residence.

‡ *Duration of Stay* refers to a rough average only, not to a statistically weighted one. Most people who leave these programs do so within the first few weeks, while a very few stay on for the maximum allowable time—usually around 12 to 18 months. A minority of therapeutic communities have fixed lengths of stay which are contracted by the residents.

§ M – multiple youthful problems, including drug dependence.

|| O/A – opiates/amphetamines.

M/A – multiple drug use/amphetamines.

NOTES

1. W. H. McGlothlin, U. C. Tabbush, C. D. Chambers and K. Jamison, "Alternative Approaches to Opiate Addiction Control: Costs, Benefits and Potential," Paper prepared for the U.S. Department of Justice, Bureau of Narcotics and Dangerous Drugs, February 1972, mimeographed, p. 21.
2. E. Milligan (Director of Treatment and Rehabilitation, Narcotic Addiction Foundation of British Columbia), Personal communication to the Commission August 27, 1972.
3. Z. Thompson (Medical Officer, Edmonton Methadone Evaluation Committee, Methadone Clinic), Personal communication to the Commission, October 10, 1972.
4. S. Cohen (Alcoholism Rehabilitation Centre, Regina, Saskatchewan), Personal communication to the Commission, October 20, 1972.
5. J. Matas (Director, St. Boniface Hospital Drug Rehabilitation Program), Personal communication to the Commission, October 12, 1972.
6. A. Eversen (Director, Narcotic Dependence Program, Clinical Institute, Addiction Research Foundation of Ontario), Personal communication to the Commission, November 14, 1972.
7. M. Krakowski and R. G. Smart, "Report on the Evaluation of the Narcotic Addiction Unit's Methadone Maintenance Treatment Program," Unpublished manuscript, Project C 214, Substudy No. 492, Addiction Research Foundation, Toronto, 1972, p. 4.
8. P. R. Beck (Methadone Program, Jewish General Hospital, Institute of Community and Family Psychiatry), Personal communication to the Commission, October 19, 1972.
9. J. Huot (Director, Deuxième Ligne), Personal communication to the Commission, October 23, 1972.
10. Canada, Health Economics and Statistics Directorate, Health Programs Branch, Department of National Health and Welfare, "The Role of the General Hospital in Treatment of Alcoholism and Other Drug Addictions," mimeographed, October 6, 1972, p. 1.
11. Ibid., p. 2.
12. Ibid.

Appendix I

Treatment of Opiate Dependents in Federal Penitentiaries in Canada

Canadian experience with a special treatment program in a prison setting in which drug addicts are segregated from other offenders has not been very encouraging. The Fauteux Report on Remissions in 1955 recommended specialized institutions for the treatment of narcotic addiction. In accordance with this recommendation the Federal Government constructed Matsqui Institution, a medium security penitentiary, at Abbotsford, about 45 miles from Vancouver, British Columbia. It opened in March 1966. It was designed to accommodate 312 male and 128 female inmates. The planning called for a staff of 333.

A special treatment experiment with a research and evaluation component was begun at Matsqui in January 1967. Its object was to evaluate the effectiveness of an experimental treatment program developed in the Pilot Treatment Unit (PTU), a special treatment-research unit at Matsqui.[1] The effectiveness of the PTU treatment program was to be determined by comparing it with a Limited Control (LC) group which underwent the treatment program in the main institution.[2] The PTU treatment was more intensive and more enriched than LC treatment: it involved living together in small dormitories rather than in individual cells, as in the LC treatment, a more intensive, and presumably more effective use of group therapy than in the LC program, and a greater participation in educational courses.

The experimental program consisted of treatment periods of seven months followed by release on parole. The relative effectiveness of the PTU and LC programs was judged on the basis of a comparison of the offenders' behaviour during the two years prior to incarceration with their behaviour during the period of one and a half years following release on parole, with reference to the following matters: per cent of time legally employed; per cent of time illegally employed; and mean monthly frequency of opiate use.[3]

It is important to note that the comparison was between two treatment programs at Matsqui Institution, and not between prison with a treatment program and prison without one.

Brian C. Murphy, Research Officer who reported on the treatment experiment, summarized the results as follows:

1. Neither PTU nor LC treatment was significantly more effective than the other in increasing percent of time legally employed or $value of legal earnings.
2. LC treatment was significantly more effective than PTU treatment in decreasing percent of time illegally employed and $value of illegal earnings.
3. LC treatment was significantly more effective than PTU treatment in decreasing monthly frequency of opiate use. When opiate use was broken down into its two components, prescription opiate use and non-prescription opiate use, LC treatment was found to be significantly more effective than PTU treatment in decreasing non-prescription opiate use. However, neither PTU nor LC treatment was significantly more effective than the other in decreasing prescription opiate use.[4]

It is not clear why inmates who went through the more intensive PTU treatment had a more unsatisfactory record on release, with respect to illegal earnings and illegal opiate use, than those who went through the general or LC treatment. The results are attributed to the treatment in the institution rather than the parole supervision, which is assumed to have been more or less the same for all parolees. Murphy suggested the following hypothesis: that inmates in the more intensive PTU program acquired, as a result of the better program of group therapy and academic training, "superior applied communication and applied academic abilities"[5] which made them more effective in illegal activity. The research officer concluded that they applied these new skills to illegal activity because they "did not have the skill, experience, and social contacts necessary to compete effectively with 'square johns' for scarce legal employment opportunities or scarce 'straight' recreational and social opportunities".[6]

A comparison of the behaviour of PTU and LC inmates before and after incarceration suggests a measure of improvement among both groups. The percentage of time legally employed increased for the LC group from 42.5% before incarceration (as compared to 33.6% for the PTU) to 61.4% after incarceration (as compared to 67.1% for the PTU). The percentage of time illegally employed dropped for the LC group from 43.7% before incarceration (as compared to 47.1% for the PTU) to 5.3% after incarceration (as compared to 22.9% for the PTU). With the LC group, the mean frequency of opiate use per month dropped from 62.3 times before incarceration (as compared to 61.9 for the PTU group) to 12.6 times after incarceration (as compared to 41.6 for the PTU).[7]

While these comparisons suggest a measure of improvement in the behaviour of the PTU and LC groups, they cannot be regarded as significant, nor the experimental treatment program as successful, in light of the number of these inmates who were returned to custody following their release on parole. The Research Officer at Matsqui informed the Commission that of

36 delinquent opiate addicts treated at Matsqui (including the 26 inmates who comprised the PTU and LC groups discussed above), 31 or 86% were returned to custody within a five-year period after their release on parole. Of the five who were not returned to custody, two were deceased due to accidents within one year of their release on parole, so that the rate of recidivism approached 100%.[8]

As mentioned above, the parole supervision was assumed by the treatment-research team at Matsqui to have been more or less the same for all parolees. The experimental treatment program was not designed to evaluate the effects of parole and other post-release treatment,[9] nor was the Special (Parole) Narcotic Addiction Project, which involved these PTU and LC inmates, designed with an evaluative component. (See Appendix K *Parole of Heroin Dependents in Canada.*) Consequently, there is no way of determining how far the results of this treatment experiment should be attributed to the treatment program in the institution and how far to the parole supervision. Brian C. Murphy, Research Officer at Matsqui, suggested that much more could have been done to assist inmates with the process of social rehabilitation and reintegration during the parole period. He emphasized this point as follows:

> If institutional training had been followed by a carefully engineered, well staffed, active programme of intervention, immediately upon release and continuing for some months thereafter, to make non-delinquent, non-addict vocational, recreational, and social opportunities readily available to parolees (including the restructuring of friendship circles around 'square johns'), the PTU subjects would probably have earned more legally, earned less illegally, and used non-prescription opiates less frequently than the LC subjects. A series of formal treatment experiments, with that kind of carefully engineered post-release intervention, would appear to be a most worthwhile enterprise.[10]

It should be noted that the "specialized caseload approach" to the parole of opiate dependents, which was applied throughout the treatment research programs conducted at Matsqui and was intended to provide the kind of active post-incarceration follow-up envisaged by Murphy, was discontinued without evaluation by the National Parole Service early in 1972. (See Appendix K *Parole of Heroin Dependents in Canada.*)

Although a number of the inmates in the PTU and LC groups received regular doses of methadone following their release from Matsqui on parole, the goal of the program and the criteria of success were essentially those of a drug-free program. From the data available to the researchers it was found that ". . . illegal employment is strongly, positively and significantly associated with consumption of illicit opiates, but illegal employment is not significantly associated with consumption of legally prescribed opiates."[11] This finding led Murphy to hypothesize that:

1. Most economic crime committed by addicts is committed mainly because the supply of satisfactory opiates is restricted to high priced bootleg supplies.
2. If opiates were made readily and cheaply available to addicts, the amount of economic crime committed by them would be sharply reduced.[12]

Not having tested these hypotheses, the Matsqui treatment experiment does not demonstrate the results that could be obtained using an institutional program and methadone as a stabilizing and transitional factor during a controlled post-release period. To date, neither the Penitentiary Service nor the National Parole Service has tested the effectiveness of a methadone maintenance program for former opiate dependents released from penitentiary. However, the Penitentiary Service is currently developing a multi-modal treatment program (described in more detail below) which may include a methadone maintenance component as suited to inmates being considered for release on temporary absence or parole; and, as we point out in Appendix K, a number of parolees are currently in methadone maintenance programs in Canada, who either entered voluntarily or were presented with the alternative of entering a methadone program or being returned to custody.

Matsqui continues as a medium security institution for opiate-dependent offenders and as a treatment unit; but its inmate population is now composed of non-addicts as well as addicts, and the experimental evaluation of its treatment programs is being done under the auspices of the regional research unit at New Westminster, British Columbia. In the fall of 1972 Matsqui had 330 inmates (or virtually 98% of its capacity),[13] of whom approximately 100 were "addicts".[14] It continues to employ group therapy, but this is now on a voluntary basis. There has been an increasing emphasis on short-term release into the community in the form of day parole (see Appendix K *Parole of Heroin Dependents in Canada*) or temporary absence,[15] but there has been a reduction in the amount of such releases in accordance with a departmental re-examination of policy on this matter. To date, there has not been an evaluation of these programs as forms of correctional treatment of delinquent opiate dependents.

The majority of federal penitentiaries in Canada use the services of community-based self-help programs which employ counselling and individual and group therapy techniques to bring about a change in the life style of delinquent opiate dependents. Among the self-help programs operating in penitentiaries in Canada are: the "Centre Group" in Kingston, Ontario; the "Circle Group", an organization of 15 former drug dependents incarcerated in Collins Bay Institution, Kingston, Ontario; the Alcoholism and Drug Foundation of Manitoba working with inmates in Stony Mountain Institution near Winnipeg; "ADCON", an organization working with inmates in the Saskatchewan Institution in Prince Albert; and "Transcendental Meditation" and the "Seven Step Movement", both groups working in British Columbia Penitentiary at New Westminster.

At the present time at least one physician in each federal penitentiary is authorized by the Minister of National Health and Welfare to administer methadone as an aid in withdrawal of inmates dependent on an opiate narcotic at the time of their admission to a penitentiary.

The Canadian Penitentiary Service is currently developing a multi-modal program for the treatment of delinquent opiate dependents incarcerated in the Regional Medical Centre at Abbotsford, British Columbia—a 138-bed, maximum security penitentiary adjacent to Matsqui Institution. This program, a developmental project to include individual and group therapy and possibly a methadone and opiate antagonist maintenance component as suited to individual inmates being considered for release on temporary absence or parole, will be developed in consultation with the Department of National Health and Welfare. It is expected that the program will be operational by the fall of 1973. It should be noted, however, that the Regional Medical Centre is primarily concerned with the treatment of acute psychiatric problems of adjustment to the custodial setting, and that as a result, only a small number of incarcerated drug dependents will be affected by this program.

Appendix I

NOTES

1. B. C. Murphy, *A Quantitative Test of the Effeciveness of an Experimental Treatment Programme for Delinquent Opiate Addicts*, Department of the Solicitor General of Canada, Research Centre Report 4 (Ottawa: Information Canada, 1972), p. 1.
2. *Ibid.*, p. 16.
3. *Ibid.*, p. 17.
4. *Ibid.*, p. 25.
5. *Ibid.*, p. 31.
6. *Ibid.*, p. 29.
7. *Ibid.*, p. 22 (Table 6).
8. B. C. Murphy, personal communication to the Commission, December 22, 1972.
9. Murphy, *A Quantitative Test*, p. 16.
10. *Ibid.*, p. 31.
11. *Ibid.*, p. 34.
12. *Ibid.*
13. J. R. G. Suprenant (Chief, Secretariat, Canadian Penitentiary Service), personal communication to the Commission, October 10, 1972.
14. D. Craigen (Director, Medical Services, Canadian Penitentiary Service), personal communication to the Commission, August 30, 1972.
15. Temporary absence is provided for inmates of federal penitentiaries in section 26 of the *Penitentiary Act*, R.S.C. 1970, c. P-6 as follows:

    Where, in the opinion of the Commissioner [of Penitentiaries] or the officer in charge of a penitentiary, it is necessary or desirable that an inmate should be absent, with or without escort, for medical or humanitarian reasons or to assist in the rehabilitation of the inmate, the absence may be authorized from time to time

    (a) by the Commissioner, for an unlimited period for medical reasons and for a period not exceeding fifteen days for humanitarian reasons or to assist in the rehabilitation of the inmate, or

    (b) by the officer in charge, for a period not exceeding fifteen days for medical reasons and for a period not exceeding three days for humanitarian reasons or to assist in the rehabilitation of the inmate.

    Temporary absence for inmates of provincial penal institutions is provided for in section 36 of the *Prisons and Reformatories Act*, R.S.C. 1970, c. P-21 as follows:

    Where, in the opinion of an official designated by the Lieutenant Governor [in Council] of the province in which a prisoner is confined in a place other than a penitentiary, it is necessary or desirable that the prisoner should be absent, with or without escort, for medical or humanitarian reasons or to assist in the rehabilitation of the prisoner at any time during his period of imprisonment, the absence of the prisoner may be authorized from time to time by such official for an unlimited period for medical reasons and for a period not exceeding fifteen days for humanitarian reasons or to assist in the rehabilitation of the prisoner.

Appendix J

Probation for Heroin Dependents in Canada

The Law and Administration with Respect to Probation

Probation is provided for in the *Criminal Code* of Canada,[1] but it is administered by provincial probation services.[2] Unlike the case of parole, there is no federal probation service.

The Canadian Committee on Corrections

The Canadian Committee on Corrections spoke strongly in favour of probation, which it defined as follows:

> ...a disposition of the court, whereby an offender is released to the community on a tentative basis, subject to specified conditions, under the supervision of a probation officer (or someone serving as a probation officer) and liable to recall by the court for alternative disposition if he does not abide by the conditions of his probation.[3]

"The use of probation", said the Committee, "should be expanded as widely as possible."[4] The Committee noted, however, that "there is a serious shortage of qualified officers in probation."[5]

Provisions of the Criminal Code

Probation is provided for in section 663 of the *Criminal Code* as follows:

> 663. (1) Where an accused is convicted of an offence the court may, having regard to the age and character of the accused, the nature of the offence and the circumstances surrounding its commission,
>
> (a) in the case of an offence other than one for which a minimum punishment is prescribed by law, suspend the passing of sentence and direct that the accused be released upon the conditions prescribed in a probation order;

(b) in addition to fining the accused or sentencing him to imprisonment whether in default of payment of a fine or otherwise, for a term not exceeding two years, direct that the accused comply with the conditions prescribed in a probation order, or

(c) where it imposes a sentence of imprisonment on the accused that does not exceed ninety days, order that the sentence be served intermittently at such times as are specified in the order and direct that the accused, at all times when he is not in confinement pursuant to such order, comply with the conditions prescribed in a probation order.

The conditions which are deemed to be included in a probation order, and those which may be included, in the discretion of the court, are provided for in subsection 2 of section 663 as follows:

(2) The following conditions shall be deemed to be prescribed in a probation order, namely, that the accused shall keep the peace and be of good behaviour and shall appear before the court when required to do so by the court, and, in addition, the court may prescribe as conditions in a probation order that the accused shall do any one or more of the following things specified in the order, namely,

(a) report to and be under the supervision of a probation officer or other person designated by the court;

(b) provide for the support of his spouse or any other dependents who he is liable to support;

(c) abstain from the consumption of alcohol either absolutely or on such terms as the court may specify;

(d) abstain from owning, possessing or carrying a weapon;

(e) make restitution or reparation to any person aggrieved or injured by the commission of the offence for the actual loss or damage sustained by that person as a result thereof;

(f) remain within the jurisdiction of the court and notify the court or the probation officer or other person designated under paragraph (a) of any change in his address or his employment or occupation;

(g) make reasonable efforts to find and maintain suitable employment; and

(h) comply with such other reasonable conditions as the court considers desirable for securing the good conduct of the accused and for preventing a repetition by him of the same offence or the commission of other offences.

Treatment as a Condition of Probation

It is to be noted that paragraph (c) above refers to alcohol but not to other drugs, and that the subsection does not explicitly contemplate submission to medical treatment as a condition of a probation order. A condition to abstain from the use of other drugs, including submission to regular testing for the presence of such drugs in the body, would appear to fall within the general terms of paragraph (h). It could also be argued that attendance

at a treatment facility and submission to some treatment of choice would be a reasonable condition for securing the good conduct of the accused and preventing a repetition by him of the same offence or the commission of other offences. There may be some question as to whether a condition calling for submission to a specific form of treatment, such as methadone maintenance, without the consent of the accused, could be considered reasonable within the meaning of paragraph (h), since it involves the very serious decision to persist with and confirm the dependence on an opiate narcotic.

The extent to which treatment may be validly imposed as a condition of a probation order raises the question of how far the Parliament of Canada may provide for medical treatment as an incident of its criminal law jurisdiction. This issue is considered to some extent in Appendix F.1 *The Constitutional Framework*. The discussion there is directed particularly to the implications of the sentence to custody for treatment for an indefinite period which is provided for by Part II of the *Narcotic Control Act*, but which has never been put into force. A question is raised as to whether these provisions are sufficiently related to the issue of criminal responsibility to be a valid criminal law disposition of a case. The indeterminate nature of the sentence, which, in a case of simple possession (the offence most closely related to "addiction"), could end up being considerably longer than the maximum which could have been imposed for the offence under Part I, is clearly not directed to the nature of the particular offence of which the accused has been convicted, nor to his rehabilitation qua criminal offender, but rather to the cure of the medical condition of "addiction". Nor do the provisions for compulsory treatment suggest any necessary relationship between the "addiction" and the crime of which the accused is convicted. The "addiction" could be to the use of a kind of drug different from the one involved in the offence of which the accused was convicted. An attempt might be made to justify the provision for sentence to custody for treatment for an indeterminate period as a kind of preventive detention, but in fact Part II makes special provision for preventive detention where there has been a *prior* conviction for an offence of trafficking or importation. Part II clearly indicates that it does not consider preventive detention to be appropriate for the offence of simple possession, much less a first offence of this kind. There is also doubt, despite the close connection between "addiction" and crime, that Parliament's power to legislate for the prevention of crime would give it power to provide for compulsory treatment of "addiction". This would amount to a general power to provide for compulsory treatment, independent of the existence of a criminal offence. The implications of such a power are very far reaching and would logically extend to compulsory treatment for certain kinds of mental disorder.

Many of these points may simply be peculiarities of the provisions in Part II of the *Narcotic Control Act* which render them particularly vulnerable. There can be no doubt that Parliament may validly provide for the

kinds of treatment to which the inmates of federal penitentiaries may be subjected. If an offender is sentenced to imprisonment he can be validly subjected to a therapeutic regime such as that applied in the Matsqui Institution (see Appendix I). This is clearly a form of compulsory treatment within the jurisdiction of Parliament. The offender is sentenced to a term of imprisonment which is considered appropriate in the particular case, and in the exercise of its jurisdiction with respect to penitentiaries, the Federal Government determines the particular regime which he shall undergo. In the course of imprisonment for a particular offence the correctional authorities attempt to deal with a condition that is related to the offender's criminal behaviour. That condition, however, is not the basis of the sentence, and the total possible length of the sentence is not determined by the possibility of success in treating that particular condition. It is not the notion of "treatment" as such that raises questions about Parliament's jurisdiction. Clearly, Parliament has jurisdiction to provide for medical treatment in federal penitentiaries and in certain other specific areas of federal jurisdiction, such as the armed forces and immigration. Moreover, all correctional disposition can be considered to be "treatment" in a broad sense. Imprisonment can be considered to be a form of "treatment". (See *Treatment Report*, p. 10.) The real issue is whether the object that is sought by the disposition is a valid criminal law object, or at least one that is properly incidental to the criminal law jurisdiction, or whether it is an object that falls outside federal jurisdiction. Obviously, a strong case can be made for the argument that the treatment of the offender's addiction is a necessary part of his rehabilitation qua criminal offender. We merely say there are some legitimate doubts as to how far this may be pressed so as to justify what could amount to a life sentence for a crime for which the ordinary maximum is seven years. Sentence must be appropriate not only to the offence but also to the offender. This is what justifies taking the previous record and other aspects of the offender's character and circumstances into account. At the same time, the fact that a person has been convicted of a criminal offence does not give Parliament the right to deal with any aspect of his condition to any extent it chooses.

If probation for a certain limited period is considered to be appropriate in a certain case, having regard to the nature of the offence and the character of the offender, there would appear to be no reason why a court should not be able to attach the condition that the offender shall submit to some treatment in an attempt to cure his dependence.

In any event, one should not stress too much the compulsory character of such a condition, since in practice the offender should be asked to agree to follow a course of treatment as a condition of being placed on probation. In the opinion of treatment experts such agreement is essential if there is to be the proper motivation. The alternative of imprisonment undoubtedly exerts a certain compulsion, but the willing cooperation of the offender must be enlisted as much as possible.

The Canadian Committee on Corrections, which spoke of the probation "contract", stressed the importance of obtaining the offender's consent to probation in the following terms:

> There is some disagreement among correctional officials as to whether the consent of the offender should be required before a probation order is made. Offenders are not given a choice in relation to other dispositions by the court. It may be that some offenders who refuse probation would learn to accept it if it were imposed without their consent. However, the Committee is of the opinion that probation can be most effective if the offender understands and accepts what is involved. When he signs the order he commits himself to cooperation.
>
> *The Committee recommends that before issuing a probation order the judge or magistrate explain the implications and conditions of the order to the offender; that a copy of the probation order signed by the judge or magistrate be served on the offender; and that the offender be asked to endorse the original order to the effect that a copy has been served on him, that he understands its terms and conditions, and that he agrees to abide by them.*[6]

Sanction for Failure to Comply with a Probation Order

Wilful failure or refusal to comply with a probation order is an offence punishable on summary conviction by imprisonment for not more than six months or by a fine of not more than $500, or by both. If a probationer is convicted of this offence or any other offence, he may in addition to the punishment for such offence, be required to appear before the court that made the probation order, and after hearing, such court may, if the probation order was granted on suspended sentence, revoke the order and impose any sentence that could have been imposed for the original offence, or make such changes in the probation order as are deemed desirable or extend the period for which the order is to remain.[7]

Canadian Experience with Opiate Dependents on Probation

The following review is based on a study by the Commission of the effectiveness of a methadone maintenance program for probationed heroin users and discussions with correctional and treatment personnel in Canadian cities with a relatively high concentration of heroin use.

British Columbia

Probation, accompanied by urinalysis to monitor illicit drug use or methadone maintenance, has been experimented with to some extent in Vancouver in cooperation with the Narcotic Addiction Foundation. Impressions of the results have varied considerably.

In a submission to the Commission in April 1971, Mrs. Miriam Bent, Senior Probation Officer in Vancouver, spoke very favourably of the use of

probation to encourage opiate-dependent offenders to accept treatment.[8] She described the change in thinking in the late 1960s which influenced certain judges to try probation with treatment conditions as an alternative to a sentence to penitentiary so that the offender could be placed in the Matsqui Institution. (See Appendix I.) In many cases young offenders had been given sentences of two years or more so that they could be placed in Matsqui. Judges in Vancouver were pursuaded to consider the alternative of making use, on probation, of the local treatment facilities of the Narcotic Addiction Foundation.

Mrs. Bent pointed out that the Foundation was at first reluctant to be involved in a cooperative relationship with law enforcement for two reasons: they feared that voluntary patients might cease to come to them if they were known to be cooperating with law enforcement agencies, and, secondly, as a treatment facility, they did not like the idea of having to play a role in the enforcement of the conditions of probation that might lead to criminal law sanctions against patients.

The experiment consisted of placing certain offenders on probation on condition that they would report to the Foundation for urinalysis or accept treatment in the form of methadone maintenance. Mrs. Bent gave her impression of the success of the experiment as follows:

> ... Apparently the "success rate" (remaining heroin-free) has been better with those individuals who are under Court order than the general population attending the Narcotic Foundation.
>
> The reasons for greater success amongst individuals attending the Foundation as a result of a Court directive appear to this writer as follows: Without any doubt the threat of Court action (incarceration) plays a role in the person's initial adherence to the treatment program. Second, the fact that there is a concerned but authoritarian individual counselling the person (in this case a probation officer) seems to be valuable. The Narcotic Foundation has its counsellors, and these counsellors seem to be quite well accepted by the persons attending the Foundation, but the counsellors tend to be more lenient and less demanding of absolute adherence to the program than do the probation officers. The outcome of this type of controlled attendance at the Narcotic Foundation seems to either be immediate failure by the individual or success that is initially demanded from external bodies (Court, probation officer, Narcotic Foundation) but later internalized as the individual sees himself succeeding in the program plus having positive results in other aspects of his life (employment, marital situation, etc.).[9]

Mrs. Bent estimated that the program was successful "with easily 80% of the individuals tried on it".

The manner in which offenders were referred to treatment was as follows. If the accused was before the court on a charge involving heroin, or if the judge learned that the accused was a heroin dependent, he would often advise the accused that he or she should go to the Narcotic Addiction Foundation immediately and refer the case to the Probation Service for a presentence report. In other cases probation officers would often suggest to the

accused that it would be to his advantage to go to the Foundation, become admitted to their program, and show the court he was serious in his intention to come to grips with his heroin dependence by becoming heroin-free before his next court appearance. During the remand for pre-sentence report the accused would be able to show some attempt at rehabilitation. If some progress were indicated the courts would often adjourn the case for three or four weeks to allow the accused to show a positive pattern of compliance with the program. If the offender was able to become heroin-free during this remand, most courts would suspend sentence and place the accused on probation.[10] The probation order usually contained the condition: "Submit to urinalysis at such times as required by your probation officer, a positive test to constitute a violation of the probation order."

The Commission made a study of the records of 75 heroin users placed on probation and referred to the Narcotic Addiction Foundation in this manner in Vancouver between September 4, 1968 and July 15, 1971.[11] Of the total of 75, 23 had probation orders for a term of one year or less; 31 had orders for two years, and 21 had orders for three years.

Conditions for termination of probation were as follows: commission of a new offence; numerous positive urinalyses (showing illicit drug use); and breach of one of the other conditions of the probation order. For probationers whose probation was terminated because of "numerous positive urinalyses" the mean number of positive urinalyses for the males was 4.73 and for the females 5.06. As of August 1971, four of the 75 probationers had successfully completed their probation period. Probation had been terminated for 11 of the probationers because they had committed a new offence. On three occasions probation had been terminated because the probationer had breached one of the other conditions of probation. On six occasions probation had been terminated solely on the basis of the probationer showing numerous positive urinalysis results. Finally, in six cases probation was terminated because the probationer had shown numerous positive urinalyses as well as violating one of the other conditions of probation.

The Commission's research staff drew the following conclusions from this study:

1. We cannot conclude without further study that certain types of addicts are better disposed to the program or that they should be selected on the basis of certain criteria. We can say, however, that probationers who can be classified as "skilled" have a better chance for success with methadone treatment than those probationers who are "unskilled".
2. It appears from our data that a probation order for a two-year period is the optimum duration for success on the program. The nature of the analysis and the type of data that was made available to us does not allow us to state why this should be the case but the author believes that this phenomenon is due, to a large extent, to the interaction that occurs between the probationer, the probation officers, and the NAF counsellors.
3. What we can say in terms of overall success of the program is that 51, or 68%, of the addicts are responding successfully and are either con-

tinuing in the program or have successfully completed their probation period. From our data it appears that the "rate of success" is slightly lower than the estimated rate of success as reported by Mrs. Bent of the Vancouver Probation Service. A very significant proportion of the probationers have remained out of jail, and have remained off heroin.

4. It is important to note that both the probation officers of the Vancouver Probation Service and the judges of the Vancouver Provincial Court recognize the futility of incarcerating most heroin offenders. In order to give the methadone program a fair chance the courts have tolerated a substantial amount of "backsliding", allowing the probation officer a degree of discretion in not reporting every positive urinalysis test if other social indicators are satisfactory. In general they believe that the innovative methadone program for heroin users is a successful, if not superior, alternative to incarceration which merely involves the user in the classical "revolving door" situation. The results of our analysis tend to support this view.[12]

Two observations are pertinent here: while 68% of the probationers are said to have been successful, only four of the 75 had successfully completed their probation period; secondly, the success was a reflection in some measure of what Mrs. Bent referred to as a policy of "minimal leniency" towards abstinence as verified by urinalysis. Despite the stipulation in probation orders that one positive test shall constitute a violation, the records of probationers whose probation was terminated because of "numerous positive urinalyses" show a mean of about five positive urinalyses. Thus the view which one takes of the relative success of the program depends upon how strictly one feels the conditions of probation should be enforced.

Other probation officers have expressed a less favourable view of the experience with probationers on treatment at the Foundation. Mr. Larry Hoff, Senior Probation Officer in Vancouver, has expressed the opinion, on the basis of routine analyses of weekly urinalysis reports from the Foundation, that an almost constant 70% "do not respond" to the treatment program at the Foundation. He further expressed the opinion that in the long run an even greater percentage would relapse to heroin use or be apprehended for a subsequent offence. He estimated that at the very best the success rate of probationer addicts would not exceed seven or eight per cent.[13]

It is clear that the correctional officers take a stricter view of positive urinalysis (at least as a measure of failure) than treatment personnel, although they are also obliged to show some leniency and flexibility in using it as a ground for termination of probation or parole. In the study made for the Commission of 75 probationers on methadone maintenance, success was determined by continuation in the treatment program and not by the actual degree of lapse which might justify termination of treatment or probation. It would appear that Mr. Hoff is talking about the percentage who comply strictly with a probation condition that makes one positive urinalysis a ground for termination.

The criteria of success applied by the Probation Service in British Columbia to heroin dependents on probation have been described as follows: "abstention from the use of heroin and any other illegal drug; curtailing of all criminal activity and undesirable associations; favourable progress towards becoming a productive member of society including such areas of responsibility as employment, family, and constructive leasure time activities; and general attitude conducive to rehabilitating oneself, and towards attaining adequate feelings of self-esteem."[14]

Probationers who "fail to respond to treatment" and who are dropped from the Foundation's treatment program will be returned to court on a breach of probation if the conditions of the probation order permit and the necessary proof of a violation can be made, or they will be given a negative rating on the probation records and a reduced priority in the probation officer's caseload (referred to as "deadwood"), with the consequence that if their probation terminates and they appear in court again on another charge the probation officer will give a negative report on them. The likelihood in such cases is that they will be sentenced to a term of imprisonment.

The policy of placing probationers on urinalysis or methadone maintenance at the Foundation has been a source of some dissatisfaction to both the correctional and treatment personnel. The Foundation is prepared to take on all probationers for urinalysis to monitor illicit drug use, but it chooses to be completely independent in the selection of persons for methadone maintenance. It does not wish to be obliged by a court decision to accept a person whom it considers unsuitable for methadone maintenance. On the other hand, probation officers who feel obliged to take a reasonably strict view of a violation of the conditions of probation are concerned not only by the extent of illicit drug use shown by the weekly reports of urinalysis from the Foundation but also by the unwillingness of the Foundation staff to testify in court to support the weekly report of urinalysis as a ground for termination of probation.

The point of view of a treatment professional is expressed in the following statement to the Commission:

> The parole services and the probation services are law enforcement agencies. We are not. This distinction has to be very clearly understood. We ought not to try any kind of law enforcement with the patient in treatment, even though he is a probationer.
>
> A clinical therapist would find himself in conflicting roles if he had the power to return a person to prison at the same time as actually trying to keep him out.... A patient-therapist relationship could go on for years given such conflicting roles without any success.
>
> Even though the courts, or probation services or parole services assign, or make a condition of release that a person attend the Foundation treatment centre, we are under no obligation whatsoever to accept the patient.[15]

As of October 31, 1972 the Vancouver office of the British Columbia Corrections Service was aware of 194 cases of heroin dependence and an

estimated 50 non-dependent experimenters with heroin among its total caseload of 973 probationers. Of the total number of heroin users on probation in Vancouver, 24 were attending the Narcotic Addiction Foundation for methadone maintenance therapy. (Of these, 13 were judged by the Probation Service, on the basis of a weekly urinalysis report, to be responding favourably, and 11 to be not responding favourably—that is, an apparent success rate of 54%.) Of a total of 6,129 persons on probation in British Columbia on October 31, 1972, an estimated 325 were dependent heroin users and an estimated 100 were non-dependent experimenters with heroin.[16]

There has been a steady decrease over the last two years in the number of probationers in Vancouver attending the Narcotic Addiction Foundation for methadone treatment. During 1971 an average of 45 probationers attended the Foundation each day. That average dropped to 35 during the first half of 1972. Between June 1, and October 31, 1972, a total of 54 probationers attended the Foundation, with an average daily attendance of 28. Considered over the full five-month period, 13 of these were judged by the Probation Service, on the basis of weekly urinalysis reports, to have responded favourably and 41 to have responded unfavourably to methadone treatment—an apparent success rate of 24%.[16] During the last three months of 1972 the average daily attendance of probationers at the Foundation was reduced by the Probation Service to 23.

The conclusion that we draw from our discussions concerning this reduction is that the Probation Service would rather have a heroin-dependent probationer on their rolls without methadone maintenance than continuing with a poor record of urinalysis on the rolls of the Foundation. Repeated evidence of illicit drug use in weekly urinalysis reports is an embarrassment to the Probation Service because it invites some action, particularly in view of the condition in probation orders stipulating that a positive urinalysis shall constitute a violation of probation. Probation officers also feel that they have less control over probationers when they come under the jurisdiction of treatment facilities.

In an attempt to resolve this conflict, the Probation Service has recently persuaded a number of courts in Vancouver to require, as a condition of probation, that a probationer surrender himself to the custody of any police officer who has reasonable and probable grounds to believe that he is engaging in illicit drug use contrary to the conditions of the order and to submit to urinalysis testing by the police department. The Probation Service must be notified by the police of a positive analysis. A specimen of a probation order containing this condition, as well as the instructions to the Vancouver City Police appear on pages 1026 and 1027, respectively. This procedure gives the Probation Service a means of monitoring and enforcing compliance with a probation order by urinalysis, the validation of which, for the purpose of enforcement of the condition by the Court, is not dependent on treatment personnel.

Special conditions of probation for persons convicted of simple possession of heroin and placed on probation in Vancouver during 1971 and 1972. The British Columbia Corrections Service provided the Commission with the precise wording of special conditions of probation for 76 persons convicted of simple possession of heroin and placed on probation in Vancouver during 1971 and 1972. A tabular analysis of these special conditions is presented in Annex 3 on page 1028. These 76 probation cases were selected at random from probation officers' files in Vancouver and are considered to be a representative sample.

Forty of these 76 probation orders contained a condition with respect to treatment for drug dependence. In 18 (24%) of these cases, the court required the probationers to participate in, and cooperate with, a specific treatment program; in the remaining 22 cases, the degree of the probationer's participation in a treatment program was left to the discretion of a Probation Officer. In no case was a probationer required by the courts to participate in a methadone maintenance program, per se. This may reflect an assumption on the part of the courts that probationers required to attend the Narcotic Addiction Foundation would be engaged in methadone maintenance therapy; it may reflect the courts' deferral of judgment as to the suitability of individual probationers for methadone maintenance therapy to medical practitioners; or it may reflect doubt by the courts as to their authority to require as a condition of probation that an individual cooperate in a treatment regime involving dependence on an opiate narcotic.

The most common conditions in these 76 probation orders were those requiring probationers to submit to urinalysis testing as directed by their probation officers (42 or 55.7%) and those forbidding probationers from associating with known drug users and sellers (34 or 44.8%). These conditions clearly reflect the courts' desire to control illicit drug use and possible criminal associations among probationed heroin users.

Alberta

In Edmonton the courts have not to date required as a condition of probation that a probationer known or suspected of using heroin submit to urinalysis testing, nor have they required as a condition of probation that a person enter a methadone maintenance program.

In the fall of 1972 there was no special policy in the Edmonton Probation Office for the control and treatment of heroin users on probation. A request had been made, however, for additional staff to constitute a special drug unit that could give closer attention to this problem. Mr. G. D. Fralick, the Chief Probation Officer in Edmonton, had diagnosed the need in the following terms:

> The drug problem offers no easy solution. Generally speaking, people addicted to heroin require a great deal of time and expertise to plan and assist in the treatment program. It becomes obvious that if the Courts con-

> tinue to place drug offenders under our supervision, we must become either directly or indirectly involved in a treatment program....
>
> ...I feel that drug offenders can be very time consuming and if we are to become involved in intensive counselling, it becomes apparent that we must reduce our caseloads and to achieve this it is essential that we increase our staff.
>
> ...I would hope that people assigned to the drug unit, so-called, would become specialists within their field and that we would be in a position to provide them with adequate training.[17]

An increase in staff was granted, and it was contemplated that there would be consultations with the courts to determine on an effective policy for the use of probation in conjunction with local treatment services.

At the end of October 1972 the probation office in Edmonton informed the Commission that of a total caseload of about 1,550 probationers convicted of all types of offences, the estimated opiate narcotic involvement was as follows: on methadone maintenance—19; using heroin presently—45; past users of heroin—64; suspected users of heroin—35. It was also noted that of the total number of pre-sentence reports requested by the courts in Edmonton, the proportion of those involving drug-related offences had steadily increased as reflected in the following percentages for a four-month period in 1972: July—11.5%; August—13.1%; September—27.5%; October—32.9%.[18]

Judged in terms of completion of probation without the intervention of a sentence for violation, the probation program in Alberta appears to be a successful one. As of December 31, 1972 there was a total of 4,049 adult probationers under active supervision in Alberta. During 1972, a total of only 181 reported violations of probation were acted upon by the courts.[19] For the reasons indicated above, we do not have a basis for estimating the rate of success with heroin dependents on probation in Edmonton; however, based on the results in other provinces, it is felt that the success with opiate dependents on probation in Edmonton would be much less than the success of the overall probation program in the Province.

A probation officer in Edmonton estimated that 60–80% of officers' time is spent in the preparation of reports, with insufficient time left for innovation and effective casework, including adequate follow-up of probationers in the community.

Manitoba

In October 1972 the Assistant Director of Probation Services, Department of Health and Social Development, Manitoba, reported that of a total caseload of 1,250 adult and juvenile probationers in Winnipeg, only six admitted to regular heroin use, and only twelve to occasional use. Because of the reluctance on the part of some probationers to admit to drug use, he believed that the actual number of users on probation is probably considerably

higher. It is not the practice of the Manitoba Probation Service to monitor suspected drug users by urinalysis. Of the six who admitted to regular use, two were in a federal institution, two were on a regular methadone program, and two were on a somewhat irregular methadone program.[20]

Ontario

At the end of October 1972, the Probation and Aftercare Service of Ontario was aware of 24 regular heroin users and 42 occasional heroin users among its total active caseload of 3,778 probationers in Metropolitan Toronto. Seventeen of the regular users were in a methadone maintenance program, 16 of them at the Addiction Research Foundation of Ontario. Three probationers attended the Foundation for urinalysis at the direction of a probation officer.

The Director of the Narcotic Dependence Program, Clinical Institute, Addiction Research Foundation, estimated that in the past three years there had been approximately 12 to 15 opiate dependents referred to the Foundation by courts in the Toronto area. The probation order in these cases usually requires that the person "attend the Addiction Research Foundation and cooperate with its program".

The Foundation does not routinely report the results of urinalysis to probation officers in Toronto. They do, however, cooperate with the probation office and the courts on behalf of persons whom they feel have benefitted or would benefit from methadone maintenance. They will use urinalysis reports on behalf of dependents in court. The Director could not recall any court referrals to the Foundation for urinalysis alone.

The courts in Metropolitan Toronto do not request a pre-sentence report on as many as 50% of the individuals placed on probation. The vast majority of probationers are ordered to report to their probation officer only once a month, so that a probationer could be using heroin for long periods without detection. The probation service doubted that they knew anything like the full number of opiate dependents or occasional users on their rolls in Toronto.

If heroin use is definitely established in the course of a pre-sentence investigation, a probation officer will bring it to the attention of the court. How the court will respond will depend on the attitude of the particular judge. There is no unanimity among the judges as to how to deal with heroin use. Because heroin use necessarily involves the criminal conduct of simple possession, judges are sometimes reluctant to make a finding of such use or dependence without very clear evidence.

Probation officers in the Toronto area expressed the opinion that most of the police and the courts are not treatment oriented. To their knowledge there had never been a probation order containing a condition that the probationer submit to daily urinalysis. They would not recommend to the courts

a condition of attendance at the Addiction Research Foundation in the absence of an agreement by physicians at the Foundation to accept the individual for treatment. To date, however, there has not been consultation at the official level between the Probation Service and treatment officials to determine the kind of cooperation that can be developed. The Probation Service was able to provide little information on the results with heroin dependents on probation because they have not had specialized caseloads for dealing with such offenders.

Probation officers in Toronto said that they lacked the funds and the staff for a proper use of probation in conjunction with treatment services to deal more effectively with heroin dependence among probationers. They expressed a need for a more intensive diagnosis of individuals at the court level. Pointing out that the Probation Service is not involved until a person has come into contact with the law, and that probation officers ordinarily have two weeks, at most a month, to prepare a pre-sentence report, they felt that if heroin dependence were disclosed during the pre-sentence investigation, ideally that would be the time for bringing the offender into contact with treatment facilities for medical diagnosis. This would require close consultation and collaboration between the court, the Probation Service and the treatment professionals. The pre-sentence report would contain not only the social and criminal background of the individual but, where indicated, a medical diagnosis as well, answering such questions as "Should the offender be hospitalized? Should he be placed on methadone maintenance?"

The terms of the probation order determine the kind of behaviour that can be invoked as a violation of probation. Most offenders who are returned to court for a breach have failed to report to their probation officer as required or have been convicted of another offence. Other grounds are seldom invoked. The probation officers stress that unlike the case of parole, in which suspension or revocation is determined by the National Parole Board without appeal to the courts, a violation of probation must be brought before a court as a formal charge to which the probationer may plead not guilty and submit a defense. As probation officers put it, the procedure is more "legalistic" than it is in the case of parole and requires more care in the choice of grounds and the submission of proof. Of a total of 29,211 probationers under supervision in Ontario during 1971, 2,920 (10%) were reported for a violation of probation. An undetermined proportion of these, believed to be comparatively small, were permitted to conclude their probation without sentence.[21]

Special conditions of probation for persons convicted of simple possession of heroin and placed on probation in Toronto during 1971 and 1972. The Ontario Ministry of Correctional Services provided the Commission with the precise wording of special conditions of probation for 38 persons convicted of simple possession of heroin and placed on probation in Toronto during 1971 and 1972. A tabular presentation of these special conditions

is contained in Annex 3 on page 1028. These 38 probation cases, selected at random from the files of the Probation Service in Metropolitan Toronto, are considered to be a representative sample.

Twenty-eight of the 38 probation orders contained a condition with respect to treatment for drug dependence. In only seven of these orders, however, did the court require attendance at, and cooperation with, a specific treatment program. In 15 of these cases the degree of participation in a treatment program (and in 11 of these, the program itself) was left to the discretion of the probation officer; and in the remaining six cases, neither the treatment program itself nor the expected degree of participation on the part of the probationer was specified by the court.

In sharp contrast to judicial practice in Vancouver, British Columbia, none of these probation orders contained a condition requiring submission to urinalysis testing for illicit drug use.

Quebec

In November 1972, of a total of approximately 700 probationers under supervision of the Adult Probation Service in Montreal, three were known to be using heroin regularly. One of these was attending a treatment clinic once or twice a month. Probationers were not required by the courts or the Probation Service to submit to urinalysis testing.

It is estimated that less than 50 per cent of persons placed on probation have been investigated by the Probation Office in Montreal prior to sentence. At least 80 per cent of the probationers in Montreal are required to report once a month. The remainder report more or less often.[22]

Nova Scotia

In January 1973 the Adult Probation Service in Halifax informed the Commission that of a total caseload of approximately 500 probationers, three were known to have used heroin in the past but were not, to their knowledge, using at that time. The Probation Service could recall only one person being placed on probation following conviction for simple possession of heroin; and although there were no special conditions in his Probation Order, the Court instructed him to take treatment at the Nova Scotia Hospital.[23]

The present policy of the Adult Probation Service with respect to probationers who have drug-related problems (including drug dependence) is to refer them to the Nova Scotia Commission on Drug Dependency. In certain cases, a "case conference" will be held to develop a suitable program of treatment for probationers having a drug-related problem. A case conference will involve a representative of the Commission on Drug Dependency and an officer in the Adult Probation Service, and could also involve a psychiatrist, a family doctor, a member of the police force or a social worker. The first conference of this kind was held in Halifax on January 26, 1973.[24]

ANNEX 1

Specimen Probation Order

Form 44(b)

Information No.

PROVINCIAL COURT OF BRITISH COLUMBIA

PROBATION ORDER

CANADA
PROVINCE OF BRITISH COLUMBIA
CITY OF VANCOUVER

WHEREAS on the day of A.D., 19 , at the City of Vancouver,

hereinafter called the "accused" (pleaded guilty to the charge that)

at the City of Vancouver on the day of March, A.D., 19 , did unlawfully possess a narcotic, to wit, Diacetylmorphine (Heroin), CONTRARY TO THE PROVISIONS OF THE NARCOTIC CONTROL ACT

contrary to the form of the Statute in such case made and provided:

AND WHEREAS on the day of A.D., 19 , the court adjudged that the passing of sentence upon the accused be suspended and that the said accused be released upon the conditions hereinafter prescribed:

NOW therefore the said accused shall, for the period of ..... from the date of this order, comply with the following conditions, namely; THAT the said accused shall keep the peace and be of good behaviour and appear before the court when required to do so by the court, and in addition,

1. Report in person to the probation office at least one a month or in such manner as directed by his probation officer.
2. Notify his probation officer within 24 hours of any change in address or employment.
3. Make reasonable efforts to find and maintain employment or attend a bona fide educational or vocational training program.
4. Attend the Narcotic Addiction Foundation and co-operate with the program.
5. Obey the reasonable and proper orders of probation officer.
6. The probationer will surrender himself into the custody of any peace officer who has *reasonable* and *probable* grounds to believe that he is on drugs and submit a sample of his urine on demand.
7. You do not use any drugs other than those prescribed by a doctor.

DATED this day of A.D., 19 , at the City of Vancouver.

I hereby acknowledge that the above-mentioned order has been read over to me and I understand the terms and conditions and I have received a copy of the above-mentioned order. I have been informed of the provisions of subsection 4 of section 664 and the provisions of section 666 of the Criminal Code.

....
Accused

.....
A Justice of the Peace in and for the Province of British Columbia

His Honour Judge .....

Source: British Columbia Corrections Service.

ANNEX 2

VANCOUVER CITY POLICE INSTRUCTIONS REGARDING URINALYSIS TESTING OF PROBATIONED HEROIN USERS

CONDITIONS OF PROBATION INVOLVING URINALYSIS

Recently the courts have imposed conditions of probation in probation orders that pertain to drug users where urine samples are required as proof of abstinence from the use of heroin.

The order directs that, "The probationer will surrender himself into the custody of any peace officer who has *reasonable* and *probable* grounds to believe that he is on drugs and submit a sample of his urine on demand."

Discretion must be used when enforcing such an order; reasonable and probable grounds would probably involve—immediate needle marks, being on the nod, or habitually in the company of addicts.

Should a probationer qualify for the test, the following procedure will apply:

1. Escort to the Detention Annex area.
2. Obtain sterile container from Matron's office (4th floor).
3. Secure exhibit and release probationer.
4. Deposit exhibit and copy of report in Analyst's Locker in Report Centre.
5. Direct a report to Analyst advising that exhibit was deposited.

The reporting member will be notified by the City Analyst of the result. In all cases of positive results, the member must notify the Provincial Probation Office, 193 E. Hastings Street, 683-6955, between 09:00 and 17:00 hrs. A copy of the Analyst's report plus member's original report to be forwarded to Probation officer.

Failure of a Probationer to Comply: Release him and submit report to probation officer.

Source: British Columbia Corrections Service.
Note: The probation officer deals with any breach of the order.

ANNEX 3

TABLE J.1

SPECIAL CONDITIONS OF PROBATION FOR PERSONS CONVICTED OF SIMPLE POSSESSION OF HEROIN AND PLACED ON PROBATION IN VANCOUVER AND TORONTO DURING 1971 AND 1972

Special Conditions	Vancouver Total—76		Toronto Total—38	
	No.	%	No.	%
Attend the Narcotic Addiction Foundation (Vancouver) or the Addiction Research Foundation (Toronto) and cooperate with the program	14	18.4	7	18.4
Submit to urinalysis testing as directed by Probation Officer; a positive test constitutes a violation of Probation Order	42	55.7	0	0
Do not associate with drug users or sellers	34	44.8	12	31.6
Restricted from being in a specific geographical area of the city	6	7.9	0	0
Attend the Narcotic Addiction Foundation (Vancouver) or the Addition Research Foundation (Toronto) as directed by your Probation Officer	18	23.7	3	7.9
Do not use illegal (narcotic, restricted or controlled) drugs without a prescription	14	18.4	14	36.8
Take psychiatric therapy as directed by your Probation Officer	4	5.3	4	10.5
Reside at X-Kalay or other therapeutic community and obey its rules and regulations	1	1.3	0	0
Take treatment from a named physician	2	2.6	0	0
Reside at the Elizabeth Fry Society	1	1.3	0	0
The probationer will surrender himself into the custody of any peace officer who has *reasonable* and *probable* grounds to believe that he is on drugs and submit a sample of his urine on demand	1	1.3	0	0
Attend psychiatric hospital for addiction	0	0	1	2.6
Keep in contact with Salvation Army	0	0	1	2.6
Attend "Narcanon" and any further treatment as directed by Probation Officer	0	0	1	2.6
Involve yourself in Narcotic Rehabilitation Program as approved by Probation Officer	0	0	7	18.4
Attend clinic for drug addiction	0	0	1	2.6
Attend as an outpatient a clinic for treatment of drug addiction	0	0	1	2.6
Attend drug addiction centre	0	0	1	2.6
Continue medical treatment in relation to his drug problem	0	0	1	2.6
Attend as an outpatient at a clinic for the reclamation of drug addicts	0	0	1	2.6

NOTES

1. *Criminal Code*, section 662 and following.
2. The administration of probation falls under provincial jurisdiction as an aspect of the "Administration of Justice in the Province" in section 92(14) of the *British North America Act (BNAA)*.
3. Canada, Canadian Committee on Corrections, *Toward unity: Criminal justice and corrections* (Ottawa: Queen's Printer, 1969) (The 'Ouimet Report'), p. 293.
4. The 'Ouimet Report', p. 304.
5. *Ibid.*, p. 305.
6. *Ibid.*, p. 299.
7. *Criminal Code*, section 666.1(1).
8. Miriam H. Bent, Senior Probation Officer (Vancouver, British Columbia), "Community Treatment of Heroin Addicts", private submission to the Commission, 1971.
9. *Ibid.*, pp. 2–3.
10. *Ibid.*, pp. 3–4.
11. Gerald S. Fields, "An Assessment of a Methadone Maintenance Program for Probationed Heroin Users", unpublished Commission research paper, October 1971.
12. *Ibid.*, pp. 47–48.
13. L. M. Hoff, Senior Probation Officer (Vancouver, British Columbia), personal communication to the Commission, June 30, 1972.
14. Hoff, personal communication to the Commission, December 20, 1972.
15. E. Milligan, Director of Treatment and Rehabilitation, Narcotic Addiction Foundation of British Columbia, personal communication to the Commission, June 26, 1972.
16. Hoff, personal communication, December 20, 1972.
17. Memorandum from G. D. Fralick to Superintendent, Adult Probation Branch, Edmonton, Alberta, regarding "Request for Additional Staff", dated September 20, 1972, pp. 2–3.
18. R. H. Bricker, Probation Officer, Drug Unit (Edmonton), Adult Probation Branch, Department of the Attorney General of Alberta, personal communication to the Commission, October 30, 1972.
19. Alberta, Department of the Attorney General, Adult Probation Branch, personal communication to the Commission, February 13, 1973.
20. B. A. Bieber, Assistant Director of Probation Services (Winnipeg), Manitoba Department of Health and Social Development, personal communication to the Commission, October 30, 1972.

21. Ontario, Department of Justice, *Ontario Provincial Probation Services comparative statistical report: Report on the work of Provincial Probation Officers for the years 1970-1971*, p. *ii*.
22. P.-A. Rivard, Director of Adult Probation Services (Montreal), personal communication to the Commission, November 15, 1972.
23. A. Wagner, Chief Probation Officer, Adult Probation Branch (Halifax), personal communication to the Commission, January 11, 1973.
24. *Ibid.*, personal communication, February 1, 1973.

Parole of Heroin Dependents in Canada

The Meaning of "Parole"

As defined in the *Parole Act* of Canada, "parole" means the authority granted to an inmate to be at large during his or her term of imprisonment.[1] The Government of Canada has vested the power to grant this authority in a National Parole Board[2] as well as a provincial parole board in Ontario and British Columbia.[3]

Parole is understood to have two fundamental purposes, described by the National Parole Board as follows:

> The dual purpose of parole is the reformation and rehabilitation of the inmate, and the protection of society.
>
> Offenders who have made good use of their time in custody and who have shown a desire to lead a law abiding life in the future are given the opportunity of living in their community, under supervision.
>
> This supervision and counselling assists them in becoming useful, law-abiding citizens while at the same time ensuring they do not misbehave or return to crime.[4]

Jurisdiction with Respect to Parole

The National Parole Board, a nine-member administrative body, makes decisions regarding the parole of all adult offenders who have been sentenced to a definite term of imprisonment for offences under federal law, whether the offender is imprisoned in a federal penitentiary or a provincial penal institution. The provincial parole boards in Ontario and British Columbia make decisions concerning the parole of offenders who have been sentenced to an indeterminate period of imprisonment as provided for in the *Prisons and Reformatories Act*.[5]

National Parole Board decisions are ordinarily taken by two-member panels sitting at the correctional institutions throughout the country. The

decisions of the Board, and of persons designated by it to act on its behalf in certain matters, are not subject to appeal, either to administrative authority or to the courts. The Board is presumably subject, however, like other federal administrative bodies, to judicial review to assure that it does not exceed its jurisdiction or act irregularly.

The balance of this appendix deals only with persons subject to the authority of the National Parole Board.

Eligibility for Parole

Under the federal *Parole Regulations,* the following are the minimum terms which inmates must serve before they can be eligible for parole by the National Parole Board: on a sentence of less than two years (which must be served in a provincial institution)—one-third of the sentence; on a sentence of two years or more (all sentences of two years or more must be served in a federal penitentiary) but less than three years—nine months; on a sentence of three years or more—one-third of the sentence or four years, whichever comes first (although it has recently been proposed that the *Parole Regulations* be amended so that the term to be served in this case would be one-third of the sentence or seven years, whichever is the lesser); on a life sentence—seven years, except on a life sentence for non-capital murder or a commuted death sentence, in which case the minimum to be served before being considered for parole is ten years less time spent in custody before the term of imprisonment. In the latter cases parole must be approved by the Governor in Council—in other words, the federal cabinet. The National Parole Board may, under exceptional circumstances, grant parole before the expiry of these minimum terms. The case of an inmate who is serving a sentence of two years or more is automatically reviewed within six months of his admission to an institution, and a date for his parole eligibility is set. Unless the National Parole Board is informed in writing that an inmate does not wish to be paroled, his case is automatically reviewed every two years until parole is granted or his sentence is terminated.

The Effect of Parole

Release from custody on parole does not shorten an inmate's sentence; it is meant to shorten the period of imprisonment which he would otherwise have to serve. The National Parole Board does have the power to discharge an offender before the expiration of his sentence, but this power is seldom exercised, and then usually only in the case of very long sentences. As a general rule, parole lasts, in the form of supervision in the community, for the full unexpired portion of the sentence (unless, of course, there is prior parole suspension, forfeiture or revocation—described in detail in the following section), including the period of remission, statutory or earned, with which the inmate was credited while in prison.[6] Formerly an inmate

who was not paroled would have his sentence reduced by the period of statutory and earned remission, and this sometimes led inmates to decline the opportunity for parole. However, there is now a period of *mandatory supervision* in the community following release for prisoners who have not been paroled but have at least sixty days of statutory and earned remission to their credit at the time of release. The period of mandatory supervision is for the length of such remission.[7]

Parole Suspension, Revocation and Forfeiture

Any member of the National Parole Board or any person designated by it may suspend any parole and authorize the apprehension of a paroled inmate,

> ... whenever he is satisfied that the arrest of the inmate is necessary or desirable in order to prevent a breach of any term or condition of the parole or for the rehabilitation of the inmate or the protection of society.[8]

In practice, the District Representatives and their Assistants in the National Parole Service have been designated to suspend parole and authorize the apprehension of a paroled inmate. The paroled inmate must be brought, as soon as is conveniently possible, before a magistrate who must remand him in custody until the suspension of his parole is cancelled or his parole is revoked or forfeited. Within 14 days of such remand the person who ordered the suspension, or some other person designated by the Board for that purpose, must review the order and either cancel the suspension or refer the case to the Board. Upon such referral, the Board reviews the case, and after such investigation as it considers necessary, either cancels the suspension or revokes the parole. An inmate who is in custody as a result of parole suspension is deemed to be serving his or her sentence.

The National Parole Board has absolute discretion to assign "any terms or conditions it considers desirable" to a grant of parole and to revoke a person's parole and require his reincarceration on its determination that it is "necessary or desirable in order to prevent a breach of any term or condition of the parole, or for the rehabilitation of the inmate or the protection of society."[9]

Parole is automatically forfeited when a paroled inmate is convicted of an indictable offence which was committed after the grant of parole and which is punishable by imprisonment for two years or more. If the paroled inmate is sentenced for this new offence, he will be sentenced to a term to be served in addition to the unexpired portion of his original sentence; the courts have no discretion to require that these terms be served concurrently.[10] By virtue of a policy adopted by the National Parole Board in the fall of 1970, a paroled inmate whose parole is forfeited is now eligible for "re-parole".[11]

The effect of recommitment resulting from revocation or forfeiture of parole is that the period spent on parole does not count towards the paroled inmate's sentence; he must serve in custody the entire portion of his sentence that was unexpired at the time he was granted parole (assuming that re-parole is not granted in the case of parole forfeiture), including any period of statutory or earned remission which stood to his credit.[12] The parolee whose parole is revoked or forfeited may spend a longer period in prison than he would have spent had he not been paroled.[13] For example: an offender who is given a three-year sentence, is paroled after serving one year in custody, and is recommited for revocation or forfeiture one year after his release on parole, will be returned to prison to serve the full two years of his original sentence that remained unexpired at the time his parole was granted. His statutory and earned remission for this two-year "remanent" sentence will be calculated from the time of his recommitment. Assuming that he was entitled to the maximum statutory and earned remission during this remanent sentence (approximately one-third of the sentence, or eight months in this example), he would be released after serving an additional one year and four months in confinement. Thus, as a result of his loss of parole he would have served a total of two years and four months in confinement, comprised of the one year prior to the grant of parole and the one year and four months following revocation or forfeiture of parole. Had the same offender not been paroled and had he been entitled to the maximum statutory and earned remission he would have been released upon maximum expiration of this three-year sentence after serving only two years in confinement. (With the institution of mandatory supervision, however, the offender who was not paroled in this example would today be subject to the authority of the National Parole Board for the one-year period of his earned and statutory remission. During the period of mandatory supervision he would be subject to suspension, revocation and forfeiture as though he had been granted parole by the National Parole Board, regardless of whether or not he had applied for parole prior to his release from custody.[14])

The impact of parole revocation and forfeiture on the overall amount of imprisonment of persons who have lost their parole in these ways is not known. One of the questions in this regard is the extent to which the parole of inmates, in view of the effect of parole revocation and forfeiture, actually reduces the amount of time they will spend in prison below that contemplated in their original sentence. A researcher at the University of Toronto Centre of Criminology determined from his study of 399 penitentiary parole applicants in whose cases the Parole Board took a final decision during the period 1962–1964 that there was a net reduction of 10% (or 36 days a year per inmate) of the time that would have been spent in prison had parole not been granted.[15] We are not aware of a more recent study of this kind in Canada.

The additive effect of parole revocation and forfeiture on the overall amount of imprisonment of parolees has very serious implications for the former heroin dependent who is granted parole considering, as we indicate below, that a limited number of such persons have successfully completed parole in Canada.

Table K.2 on page 1047 presents parole statistics compiled by the National Parole Board from its first year of operation in 1959 to 1972.

The "Specialized Caseload Approach" to the Parole of Heroin Dependents in Canada: 1962–1972

Until 1953 it was the unwritten policy of the Remission Service in the Federal Department of Justice not to grant parole, or ticket of leave as it was then called, to inmates with a history of opiate narcotic dependence. During the period 1953 to 1958 the Remission Service, under the direction of Mr. A. J. MacLeod, granted perhaps five or six tickets of leave to opiate dependents found by the courts to be "habitual criminals" and placed under preventive detention for indeterminate periods.[16]

The National Parole Board and the Canadian Penitentiary Service set up a Special Narcotic Addiction Project (commonly referred to as "SNAP") in 1961. Throughout SNAP, which was carried out in British Columbia, the National Parole Service applied the so-called "specialized caseload approach" to the parole of inmates who had a history of opiate dependence prior to their incarceration. This approach involved intensive supervision of smaller than usual caseloads of opiate dependents by Parole Service Officers in the Vancouver and Abbotsford offices of the National Parole Service who were specially trained in techniques of treatment and supervision of narcotic dependents. (The first major parole experiment in North America employing this approach was the Special Narcotic Project conducted by the New York State Division of Parole between November 1, 1956 and October 31, 1959.[17]) The "specialized caseload approach" to the parole of opiate dependents was discontinued by the National Parole Service in January 1972.[18] The following description of the Canadian experiment with this approach is based on SNAP reports by the National Parole Service and discussions with the Parole Service Officers involved in these projects.

The first phase of the Special Narcotic Addiction Project (SNAP I) began with the parole, between June 8 and December 5, 1962, of 16 inmates from the British Columbia Penitentiary who had a history of opiate dependence prior to their incarceration. A "treatment team", consisting of a National Parole Service Officer, a part-time penitentiary consultant psychiatrist and a full-time penitentiary social worker, was appointed to work with these parolees during the period of their parole. The 16 parolees were

described by the Parole Officer on the treatment team in an interim report on this project as follows:

> Fourteen of them were aged between 30 and 40, all with very extensive criminal backgrounds, whilst the other two were aged 23 and 25 respectively. All members of the group were drug addicts of many years standing, none had any skills to offer, a few had never worked at all in their lives, and the majority of them had been returned again and again to the Penitentiary after very short periods on the street, during which time they quickly became addicted again.[19]

(Specialists in the parole field, given these characteristics, would describe SNAP I parolees as "bad risks".) The program of treatment and supervision was described in the following passage in the final report on the project:

> Upon release [the parolees] attended weekly group therapy and individual case work sessions within the parole framework. They were periodically subjected to surprise Lorfan (narcotic detection) testing. There were special police agreements to report any suspicious associations or circumstances at once. Parolees were required to abstain from narcotics but remained in Vancouver which contains Canada's largest addict community.[20]

The status of SNAP I parolees at the end of January 1964 (that is, between one and one and one-half years after their release on parole) was reported to be as follows:

(a) Parole completed	2
(b) Active parolees	4
(c) Returned to prison for technical violations related to drugs	5
(d) Returned to prison for technical violations related to alcohol	1
(e) Returned to prison for drug offences	1
(f) Returned to prison for theft	3

Of the ten SNAP I parolees who had been returned to prison by January 1966, two had had their paroles suspended, five had had their paroles revoked, and three had lost their paroles through forfeiture.[21] (See Annex 2 on page 1048.)

The major problems among SNAP I parolees were described as follows: gaining employment and restoring confidence that the men could find a place in normal society. The major long-range problem was that of establishing meaningful relationships in the normal society and thus providing a narcotic substitute.[22] Drug use by the parolees was described as follows:

> Thirteen of the sixteen men posed major drinking problems while at least eight also used barbiturates. Seven men had major narcotic relapses (requiring Methadone withdrawal) while two of these had partial relapses and five more are known to have had isolated injections. Two men abstained.[23]

The second phase of the Special Narcotic Addiction Project (SNAP II) involved the parole, between June 1964 and January 1966, of 29 inmates with a history of opiate dependence. The "treatment team" during this project consisted of a National Parole Service Officer and a psychiatrist in the Canadian Penitentiary Service. The objectives of SNAP II were reported in an interim report on the project to be the same as those in SNAP I.

> As it was not possible to set up a control group, this project was to be considered essentially experimental again as opposed to research.
>
> The aims continue to be staff training and experience and to learn as much as possible about the major problems presented in the treatment and rehabilitation of criminal addicts so as to be able to make further recommendations as to staff, technique, facilities and other supportive measures necessary to work with success in the future anticipated large scale treatment program of narcotic addicts in the parole setting.[24]

(The large-scale parole program referred to in this report was that which was to take place following the release on parole of former opiate-dependent inmates who would be confined at Matsqui Institution in Abbotsford, British Columbia. See Appendix I *Treatment of Opiate Dependents in Federal Penitentiaries in Canada.*)

Each of the 29 parolees in SNAP II was required to sign the standard Parole Agreement which contained essentially the following conditions:

1. To remain until expiration of his sentence under the authority of a Regional Representative of the National Parole Board.
2. To report immediately upon release, and at least once a month thereafter, to a designated Parole Service Officer.
3. To accept the supervision and assistance of his Parole Service Officer.
4. To remain in an area specified by the Parole Board or the Regional Representative of the Board and to obtain permission to leave that area when there was cause to do so.
5. To endeavour to maintain steady employment and to report to the Regional Representative through his parole officer, any change or termination of employment or any other change of circumstance such as accident or illness.
6. To secure advance approval from the Regional Representative, through his parole officer, if at any time he desired to: (a) purchase a motor vehicle; (b) incur debts by borrowing money or instalment buying; (c) assume additional responsibilities, such as marrying; and (d) own or carry fire-arms or other weapons.
7. To abide by all instructions which may have been given by his parole officer or by the Regional Representative through his parole officer, and especially with regard to employment, companions, hours, intoxicants, family responsibilities, and court obligations.

8. To communicate at once with the Regional Representative, through his parole officer, if he were arrested or questioned by peace officers regarding any offence.

9. To obey the law and fulfill all his legal and social responsibilities.

In addition to these standard conditions, the parolees were required to agree to the following special conditions: that they would abstain from the use of "narcotics"; that they would remain within a twenty-mile radius of Greater Vancouver (and that they would stay away from an "out-of-bounds" area in downtown Vancouver); that they would attend weekly interviews with the Project Psychiatrist; that they would keep individual appointments with the Parole Officer; and that they would have no further association with any person known to be an addict or ex-addict, including one another, unless by special permission of the Parole Officer. (Sessions at the Narcotic Addiction Foundation of British Columbia and with the penitentiary psychiatrist were considered exceptions to this last condition.)[25]

The interim report on SNAP II noted that the mental fitness of the SNAP II parolee had been impaired by the dependent state of mind created by prison discipline and routine.

> The maximum security situation where most movements are made by the bell and most decisions are made by the staff... tends to render him incapable of making decisions and ill-prepared to establish self-controls.
>
> The drastic sudden move to the open community leaves him bewildered, lost, fearful and often initially incapable of thinking out even the simplest steps necessary to prepare himself for a work day or to adapt himself to a family routine. The result is that he is highly inclined to seek out the comforting acceptance of people he has known, principally in the criminal addict community, and the old synthetic relief from all stresses, principally alcohol, barbiturates and narcotics.[26]

The most serious problem noted in the interim report of SNAP II was the inability of most of the parolees to break away from associations with the opiate-using community and to establish new relationships in conventional society. This point was made by the National Parole Service Officer who supervised the SNAP II parolees in the following passage of the report (letters have been substituted for the names of the parolees):

> This [inability to socialize] still poses the single main overall problem. Of the twenty-four men, originally released, apparently only A had made long-range plans prior to his release and was able to carry these out. On initial release, many of the rest of the men lived day by day. After approximately six months release, B and C had each settled down with healthy wives but only C was withdrawing from addict thinking and values and the general addict community, and was beginning to make social adjustment in the normal community, and was also formulating some long-range plans. B had returned to a healthy family as far as drugs of delinquency were concerned but he

essentially identified still with the addict community and was living day by day. D, E and F established relationships on the fringe of the underworld, while G, H, B, I, and J have made periodic half-hearted attempts and partial inroads into the normal community but have been essentially unable to find lasting and meaningful relationships there. K, L, M, and N have made practically no progress in normal socialization.[27]

Lorfan testing for the presence of drugs was not used as frequently during SNAP II as it was during SNAP I. The Project Parole Officer relied on a system of trust and admissions by parolees to determine whether they had relapsed to illicit drug use. (Tests were immediately ordered, however, following a report from a police officer that a parolee was suspected of using drugs.) Drug use by SNAP II parolees, to the extent that it could be ascertained in this way, was described as follows:

> ... of all the parolees, a few have abstained, some are unknown, and at least eight are known to have had periodic isolated fixes, some of these having full relapses, and some only partial relapses. However, most of them have come to the Treatment Team for help and have been withdrawn successfully without being returned to prison. Two, however, have been returned to prison after getting into the hands of the police through using narcotics.[28]

When the interim report on SNAP II was written in January 1966, 18 of the 29 parolees released between June 22, 1964 and January 12, 1966 were still on parole. (See Annex 2 on page 1048.) Of these 18 parolees, four had undergone a previous period of confinement as a result of the suspension of their paroles, one had previously received a formal warning from the Parole Board, and one was awaiting the outcome of a pending *Criminal Code* charge. Six of the 29 parolees were in custody as a result of the revocation of their paroles. Three were in custody as a result of their paroles being suspended. One parolee had previously been charged with the commission of an indictable offence and was in custody following forfeiture of his parole. Only one of the 29 parolees had "successfully" completed his parole period.[29]

Speaking generally of the conditions required for the successful parole of opiate dependents, the report stated:

> ... although the addict is a very psychologically and socially sick person with his primary problems dating from early conflicts with authoritatively and punitively oriented people; given:
>
> (a) Reasonable motivation,
>
> (b) A long parole period,
>
> (c) Some healthy family support,
>
> (d) Some personal stability,
>
> (e) Sufficient ability to establish normal relationships;
>
> he can be successfully rehabilitated.

> ... the essential role of the Parole Officer is to give support and guidance and to provide a firm but sympathetic authority figure with which the parolees can personally identify ... the essential role of the Psychiatrist is to provide a secondary outlet by which the parolees can ventilate any hostility towards the Parole Officer and in the process, aid self-examination and examination of their status in life... the essence of treatment is to help guide the parolee towards correct decisions rather than to attempt to apply force.[30]

The National Parole Service Regional Representative in Vancouver reported on the status of SNAP II parolees in August 1967.[31] A comparison of the status of each of these parolees as recorded by the SNAP II Parole Officer in January 1966 and by the Regional Representative in August 1967 is presented in Table K.1.

TABLE K. 1

A Comparison of the Status of SNAP II Parolees as Recorded in January 1966 and August 1967

As of January 1966	As of August 1967
1. In custody (parole revoked)	1. In custody (parole revoked)
2. Parole completed	2. Parole completed
3. In custody (parole suspended)	3. In custody (parole forfeited)
4. Still on parole	4. Parole completed
5. Still on parole	5. In custody (parole forfeited)
6. Still on parole	6. In custody (parole forfeited)
7. Still on parole	7. In custody (parole forfeited)
8. Still on parole	8. In custody (parole forfeited)
9. Still on parole	9. Still on parole
10. Still on parole	10. Parole completed
11. Still on parole	11. In custody (parole forfeited)
12. Still on parole	12. In custody (parole suspended)
13. In custody (parole forfeited)	13. In custody (parole forfeited)
14. Still on parole	14. Still on parole
15. Still on parole	15. Parole completed
16. In custody (parole revoked)	16. In custody (parole revoked)
17. In custody (parole revoked)	17. In custody (parole revoked)
18. Still on parole	18. Parole completed
19. Still on parole	19. Still on parole
20. Still on parole	20. Still on parole
21. Still on parole	21. Still on parole
22. Still on parole	22. Parole completed
23. In custody (parole suspended)	23. In custody (parole revoked)
24. In custody (parole suspended)	24. In custody (parole forfeited)
25. Still on parole	25. Parole completed
26. Still on parole	26. Parole completed
27. In custody (parole revoked)	27. In custody (parole revoked)
28. In custody (parole revoked)	28. In custody (parole revoked)
29. In custody (parole revoked)	29. In custody (parole revoked)

Thus, as of August 1967, five (17%) of the 29 SNAP II parolees were still on parole. Sixteen (55%) had been returned to custody (one following suspension of his parole, seven following revocation of their paroles, and eight following forfeiture of their paroles), and eight (28%) had completed their parole periods.

The third phase of the Special Narcotic Addiction Project (SNAP III) involved the release on parole of ten inmates between November 18, 1966 and December 16, 1966. Each of these inmates had had previous histories of opiate dependence, and each of them had participated in the first Treatment-Research Program (TRP I) at Matsqui Institution during the seven months prior to their release on parole.[32] (See Annex 2.) Eight of these inmates were subject to supervision by the Vancouver Office of the National Parole Service during their parole periods; and two of them were subject to supervision by the Abbotsford Office.

A report by the Project Parole Officer in the Vancouver Office on the status of the eight parolees under his supervision emphasized again the difficulty experienced by the parolees in breaking away from associations with the opiate-using community and establishing new relationships in conventional society. This point was made in the following passage of the report:

> Many things plague the addict, who is attempting to change his ways. In his earlier years, he did not acquire the education or develop the social skills required for a different way of life. Consequently, he is often faced with loneliness, depression and boredom. He really makes limited use of the entertainment media available. For instance, there seems to be a general interest in sports [among addict parolees], but it takes time to develop a taste for other interests and the desirable social contacts that go along with them. In the group, there was almost general concern about how one goes about mixing with non-addicts, and non-criminals.[33]

When this report was written on May 2, 1967, five of the eight parolees were still on parole. One of these five had experienced a previous period of confinement as a result of the suspension of his parole. The remaining three parolees were in custody as a result of their paroles being suspended. Two of the latter were awaiting the outcome of a pending *Criminal Code* charge which could have resulted in the forfeiture of their paroles.[34]

A report on the status of SNAP III parolees in August 1967 by the National Parole Service Regional Representative in Vancouver revealed a change in the status of only one of the eight parolees discussed above. This individual, who was in custody on May 2, 1967 awaiting the outcome of a pending *Criminal Code* charge, was subsequently convicted on this charge, and his parole was thereby automatically forfeited.[35]

In his brief to the Commission the Solicitor General of Canada describes the status as of October 1969 of parolees released during SNAP I, II and III

(see Annex 3 on page 1050). This description appears to have been based in part on a summary prepared by the National Parole Board in October 1969, which also refers to a phase IV, V and VI of the Project (see Annex 4 on page 1052). The National Parole Board permitted a member of the Commission's staff to examine its SNAP files at its headquarters in Ottawa in January 1973. The most recent report on file at that time dealing with the status of SNAP parolees was that prepared by the Vancouver Regional Representative in August 1967 (which describes the status of parolees released during SNAP II and III). The Parole Service Officers who specialized in the supervision of opiate-dependent parolees in Vancouver informed the Commission that they did not prepare a report on a specific group of SNAP parolees after SNAP III.[36] Under these circumstances, there is some doubt concerning the reliability of the Board's summary of the Special Narcotic Addiction Project as of October 1969.

On May 7, 1971 a "Report of Special Narcotic Addiction Project (1970)" was prepared by a Parole Service Officer in Vancouver. This report deals generally with *all* opiate-dependent parolees under supervision of the National Parole Service in Vancouver during 1970; it does not describe any of them as having been released during a specific phase of SNAP, as did the reports discussed above.

With regard to future plans for SNAP, this report stated:

> In the immediate future we look forward to... [t]he development of a research instrument to assist in the collection of data regarding the special narcotic addiction project. Because of the increase in the problem of drug addiction and the necessity for the Vancouver Office to supervise more and more drug addicts on parole, it is most important that we have a complete knowledge of what we have done, what we are doing, and where we plan to go from here.[37]

At the time of writing the present report, such a research instrument had not been developed, and the National Parole Service had not made a further attempt to evaluate the Special Narcotic Addiction Project or the performance of heroin dependents on parole since the discontinuation of the specialized caseload approach in January 1972.[38]

In the absence of a report on the status of SNAP parolees more recent than that prepared in August 1967, we are unable to describe the status of *any* of the SNAP parolees since that time. We do not know how many of them are still on parole; how many of them completed their parole periods and are at liberty in the community; how many of them completed their parole periods and were later sentenced for a subsequent offence; or how many of them are in custody as a result of the suspension, revocation or forfeiture of their paroles or "re-paroles".

The *impression* of the National Parole Board and of the Parole Service Officers who specialized in the supervision of opiate-dependent parolees

is that the Special Narcotic Addiction Project met with very limited success.[39] In addition to an apparent shortage of Parole Service Officers to engage in intensive supervision of opiate-dependent parolees, this overall impression of the success of SNAP very likely influenced the decision of the National Parole Service to abandon the specialized caseload approach in January 1972. At that time, the opiate-dependent parolees who comprised a special caseload were assigned to ordinary caseloads under supervision of the National Parole Service. Unfortunately, the Project was not designed to compare the effectiveness of the specialized caseload approach with the less intensive supervision to which opiate-dependent parolees are now subject on the Parole Service's ordinary caseloads. Studies conducted in the United States, however, suggest that there is no statistically significant difference between the recidivism rates of parolees who undergo intensive supervision on special caseloads and parolees subject to less intensive supervision on ordinary caseloads, although these studies do suggest that the amount of time spent with a parolee does have a bearing on parole outcome.[40]

Based on the SNAP reports of the National Parole Service discussed above, it would appear that few inmates with a history of opiate dependence complete their parole period without experiencing the prior loss of their paroles through suspension, revocation or forfeiture. In view of the additive effect of parole revocation and, in most cases parole forfeiture on the overall amount of imprisonment of inmates who lose their parole in these ways, it would seem possible that, on balance, the former opiate-dependent inmate may spend more time in custody as a result of parole than he would if he were not released on parole. The SNAP projects did not compare the experience of former opiate-dependent inmates released on parole with that of former opiate-dependent inmates not released on parole (that is, those released upon expiration of their sentence before the introduction of mandatory supervision in 1971). We are not aware of any studies of this kind in North America.

The Recent Extent of Heroin Dependence Among Parolees on Selected Caseloads in Canada

An accurate estimate of the extent of heroin dependence among parolees in Canada cannot be made on the basis of existing criminal statistics alone. As a general rule criminal statistics do not identify heroin dependents, as such. In this section we discuss the extent of heroin dependence among parolees in Canadian cities with a high concentration of heroin use based on information provided by National Parole Service Officers in 1972 concerning the number of parolees on their caseloads who were known to be regular users of heroin.

The National Parole Service Office in Vancouver, British Columbia, recorded the number of heroin-dependent parolees under its jurisdiction from April 1971 to March 1972 as follows: April 1971—79; May 1971—80; June

1971—78; July 1971—76; August 1971—73; September 1971—72; October 1971—78; November 1971—79; December 1971—74; January 1972—72; February 1972—67; March 1972—66.[41] As of August 1, 1972 the number of heroin dependents on parole in Vancouver had dropped to 47.[42]

Of the 47 heroin dependents on parole in Vancouver on August 1, 1972 (at which time there were approximately 370 persons on parole in that city), ten were participating in the methadone maintenance program at the Narcotic Addiction Foundation of British Columbia. (Parolees in Vancouver who are discovered to be using heroin may be presented with the alternative of entering a methadone maintenance program or being returned to custody.) Ten others were attending the Foundation each day for urinalysis; and 17 were attending the Foundation on a random basis for urinalysis. The remaining ten parolees were not attending the Foundation for methadone maintenance therapy or for urinalysis; nor were they in any other treatment program at that time.[43]

Following informal discussions with Parole Service Officers in Abbotsford, Prince George and Victoria, British Columbia, the National Parole Service Assistant District Representative in Vancouver recorded the number of regular heroin users on parole in these cities as of August 1, 1972 as follows: Abbotsford—35 (including day parolees[44]); Prince George—3; and Victoria—10.[45]

Parole Service Officers interviewed in Vancouver by a member of the Commission's staff observed that virtually all inmates with a history of heroin dependence had used the drug while on parole.[46] They were also in agreement that a significant number of heroin-dependent parolees had been introduced to the use of the drug during their confinement.[47]

The National Parole Service District Representative in Edmonton, Alberta, informed the Commission on October 11, 1972 (when there were approximately 280 persons on parole in Edmonton) that he could not recall a parolee in that city who had used heroin in the previous five months. A parolee who is discovered to be using heroin in Edmonton will be presented the alternative of abstaining altogether from heroin use, of entering a methadone maintenance program or of being returned to custody.[48]

Following an informal survey of Parole Service Officers in Winnipeg, Manitoba, the National Parole Service District Representative informed the Commission that there were seven regular heroin users on parole in that city as of October 12, 1972. At that time, there were approximately 280 persons on parole in Winnipeg. Two of the parolees who were known to have used heroin were methadone maintenance patients at the Drug Rehabilitation Program at St. Boniface Hospital in Winnipeg. The National Parole Service will direct parolees using heroin to the Counselling Service

of the Provincial Alcoholism Commission, who in turn will refer them to the Drug Rehabilitation Program.[49]

The National Parole Service District Representative in Toronto, Ontario, after discussions with Parole Service Officers in that city, informed the Commission that there were no known heroin users under their jurisdiction on October 25, 1972. There were about 650 persons on parole in Toronto at that time. The Parole Officers recalled that 28 persons then on parole had had histories of heroin dependence but were not presently using heroin to their knowledge.[50] Four persons on parole in Toronto in October 1972 were participating in the methadone maintenance program at the Addiction Research Foundation of Ontario. Their treatment at the Foundation had been arranged by officials at Matsqui Institution in British Columbia.[51]

The National Parole Service District Representative in Montreal, Quebec, informed the Commission that there were no known heroin users on parole in that city on October 19, 1972. Approximately 920 persons were on parole in Montreal at that time. Earlier in 1972, the Parole Service in Montreal had referred three persons experiencing drug problems to the Spera Foundation, a residential therapeutic community in Rawdon, Quebec.[52] (See Table H.2 on page 1002.)

Current Policy of the National Parole Board with Respect to Heroin Dependents

There does not appear to be any clearly defined special policy with respect to the parole of offenders with a background of drug dependence, although there is the following statement in a handbook on parole issued by the National Parole Board:

> Many inmates applying for parole were under the influence of alcohol when they committed their crimes. Some are chronic alcoholics. When alcohol is directly involved in the case, the Board believes it is in the best interest of both society and the inmate that complete abstinence from intoxicants be one of the conditions of parole.
>
> We expect the inmate to recognize his problems and to do something to overcome them. Indeed, we are encouraged by the number of inmates who take advantage of Alcoholics Anonymous programs available within the various institutions and who continue their affiliation with AA upon their release.
>
> Greater care must be taken in the granting of parole to drug addicts because of the serious nature of drug addiction. Their applications demand greater study than usual. However, if it appears the inmate in question sincerely intends to stay away from drugs, the Parole Board does everything in its power to help him do so. Caution being the keynote in these cases, all such parolees are carefully supervised and assisted upon release from an institution. Although there is no known sure cure for drug addiction, many parolees have abstained from the use of drugs; some for periods of several years.[53]

The present policy of the Board is based on the belief that the former heroin dependent, who must eventually be released from custody in any event, can be better treated in the community than in prison and should have an opportunity, like other offenders, to attempt to make an adjustment in the community before the termination of his sentence.[54] When deciding on an application for parole by an inmate who has a record of heroin dependence, the Parole Board will look for some indication that the person intends to change his former drug-using behaviour. This positive indication would be found in the usual course of examining his past performance in the community and in the correctional institution and in his statements of future intentions.[55]

The Parole Board does not require every inmate with a history of opiate dependence to participate in a methadone maintenance program as a condition of parole; however, it does feel that it is necessary in certain cases to present a parolee who is discovered to be using heroin with the alternative of entering a methadone maintenance program or being returned to prison.[56]

In the absence of a systematic evaluation by the National Parole Service of the experience with parole of opiate dependents, there is not a basis for firm conclusions or specific recommendations concerning such parole. Under the circumstances, we recommend that the Parole Service undertake such evaluation, having regard to such matters as: (a) the effectiveness of varying degrees and kinds of supervision; (b) the use of methadone and other forms of opiate maintenance; and (c) the effect of parole suspension and revocation on the rehabilitation of the parolee.

ANNEX 1

TABLE K.2

STATISTICAL TRENDS IN APPLICATIONS, GRANTING AND TERMINATION (FOR VIOLATION) OF NATIONAL PAROLE IN CANADA SINCE ITS INCEPTION, 1959–1972*
(Ordinary Parole)†

	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972
FEDERAL														
Percentage Eligible Applying	—	85%	64%	64%	57%	56%	61%	62%	66%	71%	75%	83%	89%	88%
Number Granted During Year	944	1192	1005	885	663	751	1127	1114	1328	1331	2030	2852	2785	1756
Granted as Percentage of Applicants	44%	34%	35%	32%	26%	29%	37%	41%	47%	42%	62%	64%	61%	44%
PROVINCIAL														
Number Granted During Year	1044	1333	1292	987	1126	1101	1170	1382	1760	2187	3062	3071	3493	1957
Granted as Percentage of Applicants	41%	51%	32%	30%	31%	29%	31%	39%	46%	54%	70%	74%	71%	54%
TOTAL														
Granted During Year	2038	2525	2297	1872	1789	1852	2297	2496	3088	3518	5092	5923	6278	3713
Granted as Percentage of Applicants	42%	41%	33%	31%	29%	29%	34%	40%	46%	49%	66%	69%	66%	49%
TERMINATIONS														
Revocation during year	60	97	115	97	122	111	107	127	141	176	212	365	367	442
Forfeiture during year	58	94	141	114	114	95	85	116	151	206	339	639	1142	1041
Total Revocations and Forfeitures during year‡	118	191	256	211	236	206	192	243	292	382	551	1004	1509	1483

Source: National Parole Board, March 30, 1973.

* The figures in this table represent "decisions" taken by the National Parole Board in a given year. Persons who are granted parole in one year may not actually be released from custody in that year; and persons whose paroles are revoked or forfeited in one year may not be returned to custody in the year in which the revocation or forfeiture was recorded.

† "The decision whereby an inmate of an adult federal or provincial correctional institution, after having served a portion of his sentence, is released conditionally under supervision to carry out the remainder of his sentence in the community," (Canada, Department of the Solicitor General, *National Parole Board: Statistics 1970* [Ottawa, n.d.], in "Glossary of Terminology Used in the Report".)

‡ It is not possible to relate the total number of parole revocations and forfeitures in a given year as a proportion of the total number of paroles granted in the same year, since persons whose paroles are revoked or forfeited in one year may have been released on parole in a previous year.

ANNEX 2

TABLE K.3

THE SPECIAL NARCOTIC ADDICTION PROJECT

National Parole Service Project Designation	Treatment-Research Program (TRP) at Matsqui Institution (M) Male inmates (F) Female inmates	Number of Inmates Paroled in Each Program[5]	Period During Which Paroles Granted (or Month in Which Last Parole Granted in Each Program)[9]	Status of SNAP Parolees as Reported by the National Parole Service					National Parole Service Report Author/Date	Canadian Penitentiary Service (Matsqui Institution) Report Author/Date
				In Custody (Parole Suspended)	In Custody (Parole Revoked)	In Custody (Parole Forfeited)	Parole completed	Still on Parole		
SNAP I		16	June 8-Dec. 5, 1962	2	5	3	2	4	Selkirk (1/64)	
SNAP II		29	June 1964-Jan. 1966	3	6	1	1	18	Selkirk (1/66)	
				1	7	8	8	5	Stevenson (7/67)	
SNAP III	TRP I (M)	10	Nov. 18-Dec. 16, 1966	3				5	Bishop (4/67)[10]	Murphy (6/68)
				2		1		5	Stevenson (7/67)	
	TRP II (M) (14 in PTU[1]) (12 in LC[2])	26	July 15-Aug. 15, 1967						NONE	Craigen, McGregor & Murphy, 1967[11] Murphy, 1972[12]
	TRP III (M) (12 in PTU) (6 in LC) (12 in MC[3])	30	Last parole granted in May 1968						NONE	NONE

	TRP IV (F)[4]	5	Last parole granted in June 1968						NONE	NONE
	TRP V (M) (14 in PTU)	14[6]	Last parole granted in February 1969						NONE	NONE
	TRP VI (F)	5	Last parole granted in April 1969						NONE	NONE
	TRP VII (F)	7[7]	Last parole granted in April 1970						NONE	NONE
	TRP VIII (M) (13 in PTU)	13[8]	Last parole granted in September 1971						NONE	NONE

1. Pilot Treatment Unit at Matsqui Institution. (See Appendix I *Treatment of Opiate Dependents in Federal Penitentiaries in Canada.*)
2. Limited Control group in the main Matsqui Institution.
3. Major Control group in the main Matsqui Institution.
4. All programs involving female inmates took place in the separate Female Unit at Matsqui Institution.
5. Information in this column pertaining to Matsqui Treatment-Research Programs 3–8 was presented to the Commission by B. C. Murphy, Research Officer, Western Region, Canadian Penitentiary Service, on January 16, 1973.
6. This group of inmates included one person who did not have a history of opiate dependence prior to his incarceration at Matsqui. Some inmates in this group were released upon maximum expiration of their sentence and were, therefore, not under parole supervision following their release from the Institution. (Murphy, personal communication, January 16, 1973.)
7. Some of these parolees were in previous Treatment-Research Programs at Matsqui. (Murphy, personal communication, January 16, 1973.)
8. See note 7 above.
9. See note 5 above.
10. The National Parole Service reports on SNAP III describe only eight parolees in the project who were paroled under the supervision of the National Parole Service Vancouver Office.
11. D. Craigen, D. R. McGregor & B. C. Murphy, "The Pilot Treatment Unit: A Preliminary Report of Treatment-Research Program II—An Experimental Treatment Program for the Narcotic Addict," (Mimeographed), Department of the Solicitor General, Canadian Penitentiary Service (1967).
12. This report, an evaluation of the effectiveness of the treatment program at Matsqui Institution in which these 26 inmates participated prior to their release on parole, is discussed in Appendix I *Treatment of Opiate Dependents in Federal Penitentiaries in Canada.*

ANNEX 3

EXCERPT FROM THE BRIEF OF THE SOLICITOR GENERAL OF CANADA TO THE COMMISSION

(December 1969)

SPECIAL NARCOTIC ADDICTION PROJECT

In 1961 the National Parole Board and the Canadian Penitentiary Service set up a Special Narcotic Addiction Project (referred to as SNAP), the first experiment of its kind in Canada. A group of 16 criminal addicts from B.C. Penitentiary were released on parole. Two years after their release, seven of the 16 were still living in the community, nine had their paroles revoked, but only two of these for further offences. A later follow-up revealed that only three had successfully completed their parole period, and one is still under parole supervision.

In a second phase of this experiment, (SNAP II), 30 men were released under intensive supervision between June and December, 1964. As of October, 1969, 13 of these parolees were still living in the community, nine of whom had successfully completed parole. Of the remaining seventeen, nine had forfeited parole (new crime) and eight had their parole either suspended or revoked (breach of parole regulation).

Notwithstanding the initial results obtained from treatment, and in order to seek more effective treatment of narcotic drug addicts, the Government of Canada built the Matsqui Institution in British Columbia for narcotic offenders.

From the very beginning when the Matsqui Institution was opened in 1966, the Canadian Penitentiary Service and the National Parole Board continued to experiment in the treatment of narcotic addicts both within the institution and in the community. The residential part of the Project was named Pilot Treatment Unit and a sequential numbering system is used to identify each program so as to be able to identify each block of patients who undergo treatment as well as to note each program modification resulting from prior experimentation.[1]

The Pilot Treatment Unit is a therapeutic community in which a small group of narcotic addicts who are selected from the general population at British Columbia Penitentiary live together. The inmates (addicts) undergo a special training program, which includes all facilities and services based

on current assumptions about the nature of delinquent addiction. In addition, the patients participate in daily group therapy sessions which last up to two hours.[1]

The first experimental group of ten inmates (PTU I) was treated in the therapeutic community for seven months, beginning on April 25, 1966 and was released on parole (SNAP III) one member at a time between November and December, 1966. Only three were still leading a non-criminal life in the free community after two years; the others had either relapsed or had forfeited their parole. [Pp. 2–3]

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[1] CRAIGEN, D., McGREGOR, D. R., MURPHY, B. C. *The pilot treatment unit, a preliminary report of treatment research—program II, an experimental treatment program for the narcotic addict.* Department of the Solicitor General, Canadian Penitentiary Service, (1967).

ANNEX 4

Special Narcotic Addiction Projects

(SNAP)

[Summary presented to the Deputy Solicitor General of Canada by the National Parole Board on October 27, 1969]

		Released	Suspended and/or Revoked	Forfeited	Successfully Completed	Still Active
SNAP	I (1962)	16	7	5	3	1
	II (1964)	31	8	9	9	4
	III (1966) (PTU1)	10	3	4	2	1
	IV (1967) (PTU2)	26	8	2	4	12
	V (1968) (PTU3)	29	11	2	1	15
	VI (1968) (PTU4) (Females)	5	2	0	2	1
		117	39	23	21	34

SNAP I —was first experiment of its kind in Canada.
PTU —Pilot Treatment Unit.
SNAP III—represents first co-operation with New Matsqui Institution.
SNAP IV—this group included an experimental group of 14 and a control group of 12.

Source: National Parole Board (presented to the Commission on August 29, 1972).

NOTES

1. *Parole Act,* R.S.C. 1970, c. P-2.
2. *Ibid.,* s. 3.
3. *Prisons and Reformatories Act,* R.S.C. 1970, c. P-21, s. 41 (in the case of Ontario), and s. 15 (in the case of British Columbia).
4. Canada, Department of the Solicitor General of Canada, *Parole in Canada* (Ottawa: Queen's Printer, 1970), p. 1.
5. Section 41 in the case of Ontario; section 151 in the case of British Columbia. How this federal and provincial jurisdiction is exercised in practice is discussed in D. Bowie, "Some Aspects of Parole in Canada," *Queen's Law Journal,* 1(2) (November 1971): 167–207. Briefly, by arrangement between the National Parole Board and the British Columbia Board of Parole an inmate in that Province who receives a definite-indefinite sentence (see Appendix F.8 *Sentencing*) and is granted parole by the National Parole Board will be under the jurisdiction of the National Board and subject to the provisions of the national *Parole Act* and *Parole Regulations* during the definite portion of the sentence, and under the jurisdiction of the Provincial Board and subject to parole conditions approved by the Solicitor General of Canada during the indefinite portion. In Ontario, however, an inmate who receives a definite-indefinite sentence and is granted parole by the National Parole Board will remain under the jurisdiction of the National Board and subject to the provisions of the national *Parole Act* and *Parole Regulations* during both the definite and the indefinite portions of the sentence.
6. Statutory remission is provided for in the *Penitentiary Act,* R.S.C. 1970, c. P-6, s. 22 as follows:

   (1) Every person who is sentenced or committed to penitentiary for a fixed term shall, upon being received into a penitentiary, be credited with statutory remission amounting to one-quarter of the period for which he has been sentenced or committed as time off subject to good conduct.

   Earned remission is defined in section 24 of the *Penitentiary Act* as follows:

   (1) Every inmate may be credited with three days remission of his sentence in respect of each calendar month during which he has applied himself industriously, as determined in accordance with any rules made by the Commissioner [of Penitentiaries] in that behalf, to the program of the penitentiary in which he is imprisoned.

   Persons sentenced or committed to imprisonment in a place of confinement other than a penitentiary (that is, a provincial penal institution) are entitled to the same amount of statutory and earned remission as inmates in federal penitentiaries. (*Prisons and Reformatories Act* R.S.C. 1970, c. P-21, sections 17(1) and 18(1).)
7. *Parole Act,* s. 15.
8. *Ibid.,* s. 16(1).
9. *Ibid.*

10. *R. v. Markwart* [1969] 1 C.C.C. 167 (Sask. C.A.).

11. *Re-Parole Granted* is "The decision of the Board whereby a parolee who has automatically forfeited his parole due to the commission of an indictable offence while on parole is subject to further parole by issuance of a new Certificate of Parole.... The parolee is subject to a further parole because his chances of rehabilitation are still considered acceptable." (Canada, Department of the Solicitor General, *National Parole Board: Statistics 1970* [Ottawa, n.d.], in "Glossary of Terminology Used in the Report".) Preliminary parole statistics compiled by the Statistical Information Centre, Department of the Solicitor General of Canada for 1971 indicate that a total of 209 re-paroles were granted by the National Parole Board in that year. It has recently been proposed that the *Parole Regulations* be amended so that a person who forfeits his parole would have to serve one-half of his new term of imprisonment or seven years, whichever is the lesser, before being again considered for parole.

12. *Parole Act*, ss. 20 and 21. The Canadian Committee on Corrections, recognizing that the person who lost his parole through revocation or forfeiture was not credited with the period of time successfully served in the community on parole, recommended that:

> *... when parole is forfeited or revoked the parolee be credited with the period of time which he has already successfully served in the community but that he be not credited with the period of time which is equivalent to the 25 per cent statutory remission or with any earned remission that he might have had to his credit before he was paroled.* [*Toward Unity: Criminal Justice and Corrections* (The 'Ouimet Report'), (Ottawa: Queen's Printer, 1969), p. 350.]

13. P. McNaughton-Smith, "Permission to Be Slightly Free: A Study of the Granting, Refusing and Withdrawing of Parole in Canadian Penitentiaries," Unpublished manuscript (mimeographed), n.d., pp. 6/4–6/5. See also Bowie, "Some Aspects of Parole in Canada," p. 199.

14. *Parole Act*, s. 15(2).

15. McNaughton-Smith, "Permission to Be Slightly Free," p. 6/10. The 399 male penitentiary inmates in McNaughton-Smith's sample were expected, if not paroled, to spend a total of 330,992 man-days in prison, or an average of 830 days per man.

> [Two hundred and sixty-three] of them were refused parole. For them there was no saving by the Parole Board of time spent in prison. [Thirty-seven] men were granted parole and later lost it, and they... actually spent more time in prison than if parole had not existed. In this way they lost an estimated 6124 man-days, or an average 166 days each. The remaining 99 men were granted and kept their parole. Before release they spent between them 67,204 man-days in prison, or an average 679 days each. If not paroled they would have spent in prison 106,401 man-days, or 1075 days each. Thus the net saving to our sample... was 33,073 man-days, or almost exactly 10 per cent of what they would have spent if there had been no parole system. [P. 6/10]

16. F. P. Miller (former Member of the National Parole Board and Executive Director of the National Parole Service), personal communication to the Commission, January 1973.

17. This parole program is described in "An Experiment in the Supervision of Paroled Offenders Addicted to Narcotic Drugs: Final Report of the Special Narcotic Project," New York State Division of Parole, New York, 1960.

18. D. Dryden (Parole Service Officer, National Parole Service, Vancouver, British Columbia), personal communication to the Commission, December 22, 1972.
19. J. F. D. Selkirk (Parole Service Officer, National Parole Service, Vancouver, British Columbia), "National Parole Board Experimental Release of Drug Addicts," *The Canadian Journal of Corrections*, 6(1) (January 1964): 32.
20. J. F. D. Selkirk, "The Special Narcotic Addiction Project (SNAP I): Final Report," (Mimeographed), January 7, 1964, Addendum (n.d.), p. 1.
21. *Ibid.*
22. *Ibid.*
23. *Ibid.*, p. 2.
24. J. F. D. Selkirk, "Special Narcotic Addiction Project No. II: A Pilot Project for the Parole of Drug Addicts from the B.C. Penitentiary," (Mimeographed), n.d., p. 1.
25. *Ibid.*, pp. 3–4.
26. *Ibid.*, p. 51.
27. *Ibid.*, p. 52.
28. *Ibid.*, p. 54.
29. *Ibid.*, pp. 4–49.
30. A. Sleigh (Consultant Psychiatrist, Canadian Penitentiary Service) and J. F. D. Selkirk, "Special Narcotic Addiction Project," Addendum to "Special Narcotic Addiction Project No. II: A Pilot Project" (see note 24), n.d., p. 5.
31. B. K. Stevenson (Regional Representative, National Parole Service, Vancouver, British Columbia), Memorandum regarding "Special Narcotic Addiction Projects," August 17, 1967, pp. 1–4.
32. A discussion of the performance of SNAP III parolees during their first ten and one-half months on parole is presented in B. C. Murphy (Research Officer, Matsqui Institution), "An Analysis of the First 10½ Months Post Release Experience of Delinquent Addicts from Treatment Research Programme I (TRP I)," (Mimeographed), June 1968.
33. R. O. Bishop (Parole Service Officer, National Parole Service, Vancouver, British Columbia), "First Report on Problems of the Narcotic Addiction Project No. 3," (Mimeographed), p. 1.
34. *Ibid.*, pp. 2–5.
35. Stevenson, "Special Narcotic Addiction Projects," p. 1.
36. J. F. D. Selkirk, D. L. G. Dryden and R. O. Bishop, personal communication to the Commission, June 26, 1972.
37. D. L. G. Dryden, "Report of Special Narcotic Addiction Project (1970)," (Mimeographed), May 7, 1971, p. 6.
38. T. G. Street (Chairman, National Parole Board), personal communication to the Commission, March 14, 1973. See also note 36.
39. T. G. Street, personal communication to the Commission, August 29, 1972. See also note 36.
40. California, Youth and Adult Corrections Agency, *Special Intensive Parole Unit, Phase IV*, "Synopsis of Parole Outcome Study" (Sacramento, 1965);

see also, D. Lohman, A. Wahl and R. M. Carter, *The San Francisco Project: A study of Federal Probation and Parole*, School of Criminology, University of California, 1965 (Mimeographed) in Research Report No. 9 entitled "The Minimum Supervision Caseload: A Preliminary Evaluation" (September, 1966), p. 38. Both of these studies are cited in W. R. Outerbridge, "The Tyranny of Treatment.... ?", *The Canadian Journal of Corrections*, 10(2) (April 1968): 378–387.

41. This information was presented to the Commission on June 26, 1972.
42. A. Byman (National Parole Service, Assistant District Representative, Vancouver, British Columbia), personal communication to the Commission, August 1, 1972.
43. *Ibid.*
44. *Day parole* "is granted during a period of imprisonment for special rehabilitation purposes, e.g. to permit an inmate to continue in his regular employment, take an extended period of training in an outside setting, or as a gradual release just preceding discharge at expiry of sentence. Under day parole, the inmate returns to the institution at night." (Canada, Department of the Solicitor General, *National Parole Board: Statistics 1970* [Ottawa, n.d.], in "Glossary of Terminology Used in the Report".)
45. Byman, personal communication to the Commission, August 1, 1972.
46. Selkirk, Dryden and Bishop, personal communication to the Commission, June 26, 1972.
47. *Ibid.*
48. R. Gillies (District Representative, National Parole Service, Edmonton, Alberta), personal communication to the Commission, October 11, 1972.
49. D. Rempel (District Representative, National Parole Service, Winnipeg, Manitoba), personal communication to the Commission, October 12, 1972.
50. R. S. Beames (District Representative, National Parole Service, Toronto, Ontario), personal communication to the Commission, October 25, 1972.
51. *Ibid.*
52. L. Genest (District Representative, National Parole Service, Montreal, Quebec), personal communication to the Commission, October 19, 1972.
53. Canada, National Parole Board, *An Outline of Canada's Parole System for Judges, Magistrates and Police*, n.d., p. 7.
54. T. G. Street (Chairman, National Parole Board), personal communication to the Commission, August 29, 1972.
55. *Ibid.*
56. *Ibid.*

Appendix L

Civil Commitment in California

INTRODUCTION

The California Civil Commitment Program for Narcotic Addicts (usually referred to as the Civil Addict Program [CAP]) was instituted in 1961. It won political acceptance by being presented as a form of control that would be at least as effective as imprisonment in keeping the addict off the street and would at the same time offer some attempt at treatment.[1] The intent of the program is expressed as follows in the legislation:

> It is the intent of the legislature that persons addicted to narcotics, or who by reason of repeated use of narcotics are in imminent danger of becoming addicted, shall be treated for such condition and its underlying causes, and that such treatment shall be carried out for non-punitive purposes not only for the protection of the addict, or person in imminent danger of addiction, against himself, but also for the public. Persons committed to the program provided for in this chapter who are uncooperative with efforts to treat them or are otherwise unresponsive to treatment nevertheless should be kept in the program for purposes of control. It is the further intent of the Legislature that persons committed to this program who show signs of progress after an initial or subsequent periods of treatment and observation be given reasonable opportunities to demonstrate ability to abstain from the use of narcotics under close supervision in outpatient status outside of the rehabilitation center....[2]

JURISDICTION OVER PROGRAM

The California program is under the jurisdiction of the Department of Corrections. Commitment is made to the custody of the Director of Corrections. The California Rehabilitation Center (hereinafter referred to as "CRC"), which was established to carry out the program, is under the direct supervision of a superintendent, who is an employee of the Department of Corrections. CRC is referred to in the legislation as a "narcotic detention, treatment and rehabilitation facility", and its principal purpose is described as "the receiving, control, confinement, employment, education, treatment

and rehabilitation of persons under the custody of the Department of Corrections or any agency thereof who are or have been addicted to narcotics or who by reason of repeated use of narcotics are in imminent danger of becoming addicted."[3] The provisions of the Penal Code apply to CRC "as a prison under the jurisdiction of the Department of Corrections and to the persons confined therein insofar as such provisions may be applicable".[4] It is assumed that jurisdiction was entrusted to the Department of Corrections because of the importance attached to effective control. The program of CRC embodies a comprehensive and specialized attempt to achieve the objectives of control, treatment and rehabilitation, including supervision in the community.

Kinds of Commitment

The program provides for two kinds of commitment, voluntary and involuntary. There is voluntary and involuntary commitment outside the criminal law process, and involuntary commitment, within the criminal law process, of a person who has been convicted of a criminal offence. Despite the relationship of such commitment to the criminal law process, it is referred to as "civil commitment". This reflects the fact that it has been held to be unconstitutional, as cruel and unusual punishment, for a state to make addiction a criminal offence.[5] Despite penal characteristics, the California program has been held to be constitutional.[6] This conclusion followed almost inevitably from the opinion expressed by the Supreme Court in *Robinson v. California* that while it was unconstitutional to impose punishment for addiction it was constitutional to provide for the "compulsory treatment" of the addict.

Commitment exists under the California legislation for persons who are addicted to the use of narcotics (which for such purposes include the opiate narcotics and cocaine, but not cannabis) or who are, by reason of repeated use of narcotics, in imminent danger of becoming addicted.

Voluntary Commitment

A person who believes himself to be addicted to narcotics or in imminent danger of becoming addicted may report such belief to the district attorney who may, if there is probable cause, petition the superior court for the commitment of such person.[7]

Involuntary Commitment Outside the Criminal Law Process

Persons Who May Apply For Commitment. Anyone who believes that a person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use[8] may

report such belief under oath to the district attorney who may, when there is probable cause, petition the superior court for the commitment of such person.[9]

Any peace officer or health officer who has reason to believe that a person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use may take the person, for his best interest and protection, to the county hospital or other suitable medical institution designated by the board of supervisors of the county.

Upon written application of the peace officer or the health officer, the physician or superintendent in charge of the designated hospital or institution may admit the person believed to be addicted to the use of narcotics or in imminent danger of becoming addicted to their use. The application shall state the circumstances under which the person's condition was called to the officer's attention; the date, time and place of taking the person into custody; and the facts upon which the officer has reasonable cause to believe that the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use. The application shall be signed by the officer, and a copy of the application shall be presented to the person prior to his admittance to the hospital or institution.

Within 24 hours of admittance, a physician shall conduct an examination to determine whether the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use and may provide the person with medical aid as necessary to ease any symptoms of withdrawal from the use of narcotics.

If, after examination, the physician does not believe that the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use, he shall immediately report his belief to the physician or superintendent in charge of the hospital or institution, who shall discharge the person immediately.

If, after examination, the physician believes that further examination is necessary to determine whether the person is addicted to the use of narcotics or by reason of repeated use of narcotics is in imminent danger of addiction to their use, he shall prepare an affidavit which states that he has examined the person and has such belief. The physician or superintendent in charge of the hospital or institution thereupon shall have the power to detain the person for not more than an additional 48 hours for further examination.

If, after such further examination, the physician does not believe that the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use, he shall immediately report his belief to the physician or superintendent in charge of the hospital or institution, who shall discharge the person immediately.

If, after such examination, or further examination, the physician believes that the person is addicted to the use of narcotics or by reason of the repeated use of narcotics is in imminent danger of becoming addicted to their use, he shall prepare an affidavit which states that he has examined the person and has such belief, and which states the time and date of the examination and, if appropriate, the further examination. The physician or superintendent in charge of the hospital or institution thereupon shall report such belief to the district attorney, who may petition the superior court for a commitment of the person to the Director of Corrections for confinement in the narcotic detention and rehabilitation facility.

Unless the petition of the district attorney, accompanied by the affidavit of the examining physician, is filed in the superior court within 72 hours after admittance to the hospital or institution, excluding Saturdays, Sundays and judicial holidays, the physician or superintendent in charge shall discharge the person immediately.[10]

Examination and Hearing on Application for Commitment Outside the Criminal Law Process. Upon the filing for commitment the court shall order the person sought to be committed to be examined by two physicians. In the case of an application, pursuant to report by a physician or superintendent of a hospital or institution, the court need not order the person sought to be committed to be examined by any other physician or physicians.

The court may also order that the person be confined pending hearing in a county hospital or other suitable institution designated by the board of supervisors of the county if the petition is accompanied by the affidavit of a physician alleging that he has examined such person within 72 hours prior to the filing of the petition, including Saturdays, Sundays and judicial holidays, and has concluded that, unless confined, such person is likely to injure himself or others or become a menace to the public. In any case in which a person is so ordered to be confined, it shall be the duty of the person in charge of the institution to provide the person ordered confined with medical aid as necessary to ease any symptoms of withdrawal from the use of narcotics.

When the court orders that a person be examined it appoints two examining physicians. If the physicians report that the person is not addicted nor in imminent danger of becoming addicted the petition for commitment is dismissed. If the report is to the contrary, the person is brought before the court, which informs him of his right to counsel and to a defense, including the right to call witnesses and to cross-examine. If he is unable to pay for counsel the court appoints counsel and fixes the compensation to be paid by the county where the person cannot be represented by a public defender.[11]

At the hearing there is a right to have the examining physicians present and cross-examined.[12]

If the court determines after hearing that the person is addicted or in imminent danger of becoming addicted it must order the person committed to the custody of the Director of Corrections. Otherwise the petition is denied.[13]

The right to a hearing on this issue of addiction or imminent danger of becoming addicted may be waived.[14]

If the person committed or a friend of his is "dissatisfied with the order of commitment" he may obtain a trial by jury on the issue of addiction or imminent danger of becoming addicted. The order of commitment must not be read to the jury nor alluded to in the trial. The petition is dismissed unless a verdict of addiction or imminent danger of becoming addicted is found by at least three-fourths of the jury.[15]

Involuntary Commitment of Convicted Persons

Involuntary commitment within the criminal law process takes place following conviction in a municipal or justice court, or in a superior court, or following revocation of probation. Upon conviction of a defendant of any crime in a municipal or justice court, or following revocation of probation, previously granted, whether or not sentence has been imposed, if it appears to the judge that the defendant may be addicted or in imminent danger of becoming addicted, the judge must adjourn the proceedings or suspend the imposition or execution of sentence, certify the defendant to the superior court and order the district attorney to file a petition for a commitment of the defendant to the Director of Corrections for confinement in the narcotic detention, treatment and rehabilitation facility. Upon the filing of such petition there is a hearing in the superior court as in the case of commitment outside the criminal law process, with the same right to trial by jury if the person who is committed is dissatisfied with the order of commitment. The same procedures apply where the conviction has taken place in the superior court.

If the examining physicians or the court find that the person is not addicted nor in imminent danger of becoming addicted he is returned to the criminal court for such further proceedings on the criminal charges as are considered to be warranted.[16]

PERSONS WHO ARE NOT ELIGIBLE FOR COMMITMENT

The provisions for commitment following conviction do not apply to persons who have been convicted of murder, assault with intent to commit murder, attempt to commit murder, kidnapping, robbery, burglary in the first degree, mayhem, or certain other crimes of violence involving bodily harm or attempt to inflict bodily harm.[17]

In order to assist judges in determining the commitment eligibility of addicts, the California Department of Corrections regularly provides the court with a set of official eligibility guidelines.[18] Basically, persons whose

primary problem is opiate addiction, who are manageable within CRC's resources, who have only minimally trafficked in narcotics, who are over 18, and whose previous commitments have mainly been to county jail facilities, are "suitable" for the program. Persons who have a history of excessive criminality, arson or assaultive behaviour, who have been extensively involved in drug trafficking, who are extremely recalcitrant or therapeutically unresponsive, who suffer from certain medical or psychiatric disorders (e.g. sex deviance, chronic psychosis, senility), who have repeatedly absconded or experienced addiction relapse in the past, or who require extreme protective custody (e.g., homosexuals, persons having to serve a subsequent period of institutionalization), are considered unsuitable for commitment to CRC. In addition, judges are advised to give "careful consideration" to parolees and persons who have other confinements pending or outstanding deportation warrants before committing them to CRC.

The legislation provides that in unusual cases, where the interest of justice best be served, the judge may, with the concurrence of the district attorney and defendant, order commitment notwithstanding that the defendant falls within an ineligible category.[19]

CRC is not obliged to receive a person who has been committed. If the Director of Corrections concludes that the person, because of excessive criminality or for other relevant reason, is not a fit subject for confinement or treatment in such narcotic detention, treatment and rehabilitation facility, he shall return the person to the court in which the case originated for such further proceedings on the criminal charges as the court may deem warranted,[20] or in the case of commitment outside the criminal law process, he may order the person discharged.[21] According to one commentator there was initially some judicial resentment at committed addicts being refused by CRC, and there has since been a decrease in the rate of rejections.[22] Up to the end of 1969 only 584 persons were returned to the courts as "unfit" for treatment out of a total of 11,995 commitments, or approximately 4.9% of all commitments.[23]

Despite the restrictive eligibility criteria for civil commitment, CRC is apparently increasingly accepting violent and recidivist addicts.[24] To some degree, this must be seen as the result of increasing CRC vacancies, but it is probably also the consequence of many judges viewing the commitment "guidelines" as too exclusionary.

In the first year of the program only about 55% of the commitments were convicted felons, around 25% were convicted of misdemeanour offences, and approximately 20% were not criminally charged.[25] The averages for the period from 1962 through 1968 were: convicted felons—70%; convicted misdemeanants—17%; non-criminally charged—13%. By 1971, however, the figures were: convicted felons—91%; convicted misdemeanants—6%; non-criminally charged—3%. (The figures for the period 1962 to 1968 and the year 1971 apply to male admissions, but the proportionate distribution is substantially the same for females.) The latest information received

by the Commission is that 93% of the admissions of the Center are convicted felons and only 3% misdemeanants.[26] Voluntary commitments have never represented more than two to four per cent of all admissions in any year.[27]

Convicted felons, who would ordinarily be sentenced to lengthy prison terms, are increasingly becoming the mainstay of CRC commitments. The relatively inflexible nature of the commitment period favours felons because of the shorter "sentence", earlier "parole" opportunity and more liberal atmosphere provided by CRC than any of the medium or maximum security prisons. Convicted addict-felons civilly committed to CRC are likely to receive "parole" (outpatient status) within 7½ months while those sentenced to prison are not likely to receive parole for 42 months.[28]

This same relative inflexibility of the commitment period works to the disadvantage of persons convicted of a misdemeanour offence (particularly prostitution) for their maximum criminal sentence is only one year while they may spend up to seven (and in rare cases ten) years in the Civil Addict Program. It is in response to this gross inequity that the superior court judges are increasingly hesitant to send convicted misdemeanants to CRC. Recently, one of the more common sentencing alternatives for convicted misdemeanant addicts appears to be incarceration in a county jail (for not more than one year), with the sentence to be served, in whole or in part, as the probation officer directs. In many cases this means involvement in a community drug agency's programs during the day, with nights spent in jail.[29] Alternatively, a judge may order an addict to enroll in a community methadone program or allow him to serve his misdemeanour sentence in a state mental hospital.

Although there are no data to support this contention, it can probably be assumed that the recent introduction of methadone maintenance programs in California has not only provided committing judges with a preferable alternative to CRC for misdemeanour offenders, but it has also attracted a large percentage of that small group of addicts who would traditionally have been "voluntary" commitments to CRC.

Maximum Periods of Commitment

Involuntary commitment is for a maximum period of seven years, to which there may be an extension in exceptional cases of a maximum of three years. Voluntary commitment is for a maximum of two and a half years. This difference was meant to encourage voluntary commitments, but, as indicated above, only a very small proportion of admissions have resulted from voluntary commitment. An observer has described the manner in which addicts have been persuaded to seek "voluntary" commitment as follows:

> .... Frequently, following the examination, those people who have been ... called "addicts" or "imminently" in danger of becoming addicted, are given the opportunity to "volunteer" for commitment. They are told, with some reason, that if they do not volunteer for a two and a half year commitment, they will be involuntarily committed for seven.[30]

Appendix L

The Residential Program

Male inpatients live in residential units which house 60 persons each. The residential unit is the primary therapeutic unit with an eight-hours-a-day, five-days-a-week "counsellor" in each unit. Over 90% of the male inpatients are accommodated at the California Rehabilitation Center near Corona, which is a medium security institution. Most female inpatients were also housed at Corona until 1969, when the Corona women's section was closed down and the women were transferred to a wing of the Patton State Hospital in San Bernadino. The Patton State Hospital setting has been described by the Director of CRC as "a much more minimum security institution" than Corona. The escape rate at Patton is about four per cent annually while it is less than one per cent at Corona.

The California Rehabilitation Center at Corona has the security characteristics of a penal institution. It is surrounded by a barbed-wire fence, has armed guards, and maintains strict restrictions on visiting and communications between inmates and the outside community. Escape, or attempt to escape, from custody under the Civil Addict Program is a crime punishable by imprisonment for up to seven years.[31]

CRC's staff consists of administrative, correctional and rehabilitative personnel. Administrative personnel account for about 10% of the staff, the correctional personnel or guards, for about 70%, and the rehabilitative personnel, consisting of counsellors, psychiatrists, psychologists, and academic and vocational teachers, about 20%. There are approximately 3½ guards and one rehabilitation staff member for every 30 inpatients. As of September 1972 the women's facility had approximately a 2:1 inpatient to staff ratio (80 staff for 185 residents) while the men's facility's inpatient to staff ratio was slightly poorer than 3:1 (470 staff for about 1,600 residents).

The superintendent of CRC has said that the counsellors have "full college graduation, some experience in working with delinquents, or working in a correctional setting or in a social service agency". Most of the counselling staff have a Department of Corrections occupational background. Recently CRC has begun to hire ex-addicts for both counselling and non-counselling positions.

Upon arrival at CRC a new inpatient is assigned to a group of 60 (male facilities) or 45 (female facilities) residents with whom he or she may remain until transfer to outpatient status. Psychologists and counsellors initially administer a battery of psychometric tests and compile the new resident's social, criminal and narcotic-use history. "Work therapy", vocational and academic training, and recreational and religious facilities are available, as are marital and family counselling (excluding conjugal visits).

CRC's therapeutic program rests on the assumption that it is possible to change behaviour patterns by modifying certain personality factors. Drug dependent persons are conceived of as immature persons who must develop

a sense of personal and social responsibility that will enable them to live drug-free and crime-free lives.[32] The therapeutic goals, then, include not only continuing narcotics abstinence but also personality changes. As one observer has put it:

> It is hypothesized that drug use is merely a symptom of aberrant personality patterns and inadequate socialization and that it is useless to hope to change the symptoms without effecting changes in patterns of thinking and reacting.[33]

Until a few years ago the heart of the rehabilitation program, particularly at Corona, was daily group therapy, but there have been significant changes since 1969 in the direction of more individualized and heterogeneous programs. Each dormitory-unit may have a different treatment approach and differential interpretations of "group therapy". Some dormitories, for example, are purely vocationally or academically oriented. Some have intensive small-group programs, some are oriented towards behavioural modification, and some are deliberately modelled after therapeutic communities with extensive use of the large-group therapy format. Initial assignment to one or another of these dormitory-programs is completed within two weeks after CRC reception by a "service unit" at Corona and a "classification committee" (composed of staff and inpatients) at Patton State Hospital. Transfers from one dormitory to another can be made at any time, pending counsellors' approval.

Some observers have reported that new inpatients quickly learn to view the group therapy sessions (whether "small" or "large") as a game ("grouping") in which they strive to present themselves as reformed, responsible and mature persons since "it is largely their performance in the group which determines when they will be permitted to leave on parole."[34] Furthermore, the 60-man residential-therapy units apparently play the game together, covering for each other and teaching new inpatients various tricks and strategies.[35]

Release to Outpatient Status

Release to outpatient status and discharge from the program are supervised by the Narcotic Addict Evaluation Authority, which is composed of four members appointed by the Governor of California for a term of four years. The members are to be drawn as far as possible from persons having a "broad background in law, sociology, law enforcement, medicine, or education", and "a deep interest in the rehabilitation of narcotic addicts".[36]

When a person who has been committed has recovered from his addiction or imminent danger of addiction to such an extent that, in the opinion of the Director of Corrections, release in an outpatient status is warranted, the Director shall certify such fact to the Authority.[37] Cases in which there has not been a certification (or recommendation) by the Director for release to outpatient status are automatically brought once a year before the Authority

for consideration. The Authority makes the formal decision to release to outpatient status. The Director of Corrections is responsible for the supervision of persons in outpatient status.

Formerly there was a six months' mandatory period in inpatient status for all commitments. There is now no minimum inpatient period, and, technically speaking, committed persons can be automatically released to outpatient status. The proportion of committed persons in outpatient status has increased in recent years. The inpatient population of CRC grew steadily to a total of 2,586 at the end of 1968. Since that date, however, CRC's inpatient population has declined by about 36%. At the end of 1971 the California Civil Addict Program had approximately 8,400 persons committed to its custody. Of these, about 1,800 were inpatients, 5,351 were "active" outpatients, and the remainder were outpatients who had absconded.[38]

Inpatients are recommended for release to outpatient status when the staff feels they have made sufficient progress.[39] An important factor in the decision is the extent to which the community to which the addict is returning is able to provide him with a reasonable basis for leading a drug-free life through employment and satisfactory relationships.[40]

Prior to the removal of the mandatory minimum six-month period in residence, the median inpatient period was about one year (range: 10 to 15 months for males and 10 to 12 months for females). In recent years, however, there has been increasing pressure to reduce the period of residence, and in 1971, the median time in residence for users dropped to seven months for males and eight months for females. Non-criminally charged residents have essentially the same median period in residence as those who have been criminally convicted, and there is no significant difference in median period of residence between those convicted of felonies and those convicted of misdemeanours.

CRC was engaged in an experimental "direct community release program" from July 1st, 1971 until June 30th, 1972, when federal funding was curtailed. Eligible commitments were sent directly to Parkway Center (a Los Angeles-based halfway house of CRC), where, after two to six weeks of relative residential freedom, they were released to outpatient status. This project was designed to handle about ten commitments a week, but because the Narcotic Addiction Evaluation Authority was not too favourably disposed towards it, the direct release program was receiving only one or two commitments per week. The relative success of this program is presently being evaluated.[41]

In addition, since November 1970, CRC has had an experimental "early release program" whereby the new commitments identified as the ten per cent "most likely to succeed" are released to outpatient status after "an average of about 53 days" on inpatient stay.[42] An earlier experiment with the effects of early release indicated that after one year only 16% of the experimental group was still in good outpatient standing as compared to

32% of the control group who had been released in the usual manner.[43] This experiment, however, did not choose the ten per cent most likely to succeed as in the early release program. It is felt that the results would have been better had it done so.[44] With respect to the rehabilitative effect of the marked reduction in the initial inpatient stay, from a mean of 12 months in 1968 to a mean of about 8½ months in 1971, Ronald W. Wood, the Superintendent of California Rehabilitation Center, said:

> I think we do just as well in a shorter period of time as we were doing in the longer period of time. I don't think there is any relationship between time as such and whether the individual is really going to be able to make it on the outside.[45]

Supervision in outpatient status is similar to parole. Outpatients enter approximately a 30-man caseload supervised by especially trained agents who work solely with releases from the Center. As described by Wood,

> ... the outpatient program offers close but supportive supervision, small caseloads, antinarcotic testing, weekly group therapy, limited outpatient psychiatric care, job placement assistance, and halfway houses.[46]

Formerly, four routine and one "surprise" nalline tests were administered monthly for at least the first six months in outpatient status in order to detect a return to the use of narcotics,[47] but nalline testing was curtailed for budgetary reasons when CRC began to allow outpatient use of methadone.[48] Regular urinalysis was abandoned for budgetary reasons in late 1965 or early 1966. Urinalysis for opiates, barbiturates, amphetamines and, if relevant, methadone, is conducted on a "surprise" basis for all outpatients. This surprise testing, however, is routinely patterned and most persons on outpatient status are aware of the testing pattern and can, if not readdicted, schedule their drug use accordingly. Furthermore, urinalysis (although felt to be much more reliable than nalline) is still inaccurate (both "false positives" and "false negatives") about 20% of the time. In the summer of 1971, a validity check of CRC's contracted laboratory services revealed a urinalysis inaccuracy rate of 50%. The present 20% inaccuracy rate is a relatively recent development and is apparently considered acceptable.[49] Superintendent Wood has stated, however, that CRC's present urinalysis program is 95% accurate, although he admitted that quality control problems had obliged CRC to change urinalysis laboratories about four times in the last ten years.[50]

CRC has two halfway house facilities in Los Angeles, one for men and one for women. They serve as temporary residences for outpatients desiring release to Los Angeles who do not have any personal resources in that city. There are also several other halfway houses in the state which are used by CRC. In the opinion of observers, however, the halfway houses have not proved any more successful than direct release.[51] The Center does not operate any sheltered workshops.

Methadone Maintenance

An important change in the policy with respect to outpatient status has been the decision to permit outpatients to enter an approved methadone maintenance program.[52] When methadone maintenance was first introduced in California, an outpatient at CRC had to obtain his parole agent's permission before he could enter such a program. At present, however, an outpatient may, in many cases, enter a private methadone program of his own selection and then inform his parole agent. At the end of 1971, 11% of all "active" outpatients were in such programs. By May 1972, 17% were on methadone and 20% were on private methadone program waiting lists.[53] It is expected that 50% of all outpatients of CRC will be voluntarily participating in methadone maintenance programs by the end of 1973.[54]

In addition to these "private" programs, the California Department of Corrections has, since June of 1971, sponsored its own experimental methadone program for 200 addicts, 100 of whom are outpatients of CRC; the other 100 are parolled felon-addicts.[55]

Suspension of Outpatient Status and Discharge from the Civil Addict Program

As indicated above, the maximum commitment period, including inpatient and outpatient programs, is two and one half years for voluntary commitment and seven years for involuntary commitment, unless there is an extension of three years, in which case the total maximum period for involuntary commitment is ten years.

An outpatient can, however, be completely discharged from the program after a minimum of two years free from narcotics or three on methadone maintenance while abstaining from other narcotics, if he has otherwise complied with the conditions of his outpatient status, and if the Narcotic Addict Evaluation Authority concurs.[56]

A single member of the Narcotic Addict Evaluation Authority may suspend the release to outpatient status and cause an individual to be returned to CRC if he believes that a violation of the conditions of outpatient status has occurred.[57] When a person is returned to inpatient status, it is necessary to obtain the approval of the Narcotic Addict Evaluation Authority before the individual can once again be released as an outpatient.

The grounds for return to inpatient status include illicit drug use, criminal arrest, poor "adjustment" (for example, failure to attend group counselling, alcohol abuse, associating with known addicts or delinquents, failure to maintain regular or acceptable employment, changing jobs or residences without permission), and absconding.[58]

Restrictions on outpatient status have been held to be "slightly more encompassing than parole restrictions on non-addict felons and are usually administered more strictly".[59] While the ultimate authority for the decision as to suspension of outpatient status rests with the Narcotic Addict Evalu-

ation Authority, the crucial recommendation is made by the supervising agent. It appears that supervising agents are flexible and are becoming increasingly tolerant.[60] Upon detection of narcotics use the parole agent may, for example, allow the outpatient to "clean himself up" and return for another test a week later, or he may temporarily suspend his outpatient status, reinstating such status upon evidence of non-use.

One recent innovation in the Civil Addict Program is "limited placement". Although not described in the law, limited placement allows a readdicted outpatient to return voluntarily to inpatient status for a maximum period of 60 days. This permits the individual to withdraw from heroin in the institution while assuring him of a rapid release from confinement. Once returned to outpatient status, the individual begins anew the drug-free period entitling him to early discharge.

Outpatients who are apprehended for committing a felony are often returned to CRC without being prosecuted.[61] In such cases district attorneys are apparently prepared to forego prosecution if the outpatient is returned to CRC.

Less than 20 per cent of the outpatients in the program have remained on outpatient status for three consecutive years and thereby managed to obtain an early discharge from the program. Most are returned to CRC at least once for further inpatient treatment. While an outpatient may have his outpatient status revoked for violating any one of several parole conditions, the most common reason for such suspensions is illicit drug use. Fifty per cent of the first 1,209 outpatients released by the Center to outpatient status between June 1962 and June 1964 were detected using opiates and six per cent marijuana or "dangerous drugs" during their first year on outpatient status.[62] There were similar rates of drug use detection for first year releases from 1966 through 1968 with a dramatic decline in detected drug use beginning in 1969.[63]

For most persons who are committed under the Civil Addict Program of California, the Program operates as a "revolving door" in which they continuously shuttle between inpatient and outpatient status until they are mandatorily discharged. By the end of 1968, for example, only 7½% of those male commitments first released to outpatient status in 1962 had been returned to their committing court for recommended pre-expiration date discharges from the Program. For 1963 first releases to outpatient status the discharge figure was about 14% by the end of 1968, and for 1964 first releases to outpatient status about 15% by the end of 1968.[64]

One observer has described the process as follows:

> . . . the typical addict committed to this program will spend three and a half or four years locked up, perhaps a year 'on the lam' and only two or two and a half years of the seven, free in the community.[65]

Very few committed persons are able to complete the continuous drug-free period required for early discharge before being returned to in-

patient status. For example, only 35% of the first 1,209 persons placed on outpatient status between June 1962 and June 1964 remained in "good standing" (that is, active outpatient status) after one year. Afer three years (the minimum continuous drug-free period in outpatient status required at that time for early discharge from the Program) only 16% were still in "good standing".[66] The following summation has been made of results between 1962 and 1968: only about 30% of those released to outpatient status remained in such status after one year; 25% were in "good standing" after two years; and only 17% were discharged as "successes" after three consecutive years in outpatient status.[67]

Outpatients who have been returned to the California Rehabilitation Center and released again after a second period of institutionalization have tended to fare even more poorly than those on first release to outpatient status: 26% in "good standing" one year after second release to outpatient status, as opposed to 35% in "good standing" one year after first release.[68]

It has been further observed:

> ...that a large proportion of those who 'succeed' are not typical of the majority of the addict population. They are individuals who may have had little or no contact with opiates or were primarily users of opiate-containing syrups or tablets.[69]

Some of the "successes", as well, are atypical by virtue of their psychotic or mentally defective states.[70]

There has, however, been a distinct improvement in the success rate in the last few years. This is attributed, in some measure, to more lenient enforcement of the conditions of outpatient status. The improved results have been described by certain observers as follows:

> ...with the institution of more lenient conditions for those remaining on outpatient status in 1970, the current percentages of one-year successes on first release are 45% for men and 50% for women.[71]

Out of about 8,400 persons in the Program as of December 31, 1971 (inpatient and outpatient), 1,995 were returned to the institution in 1971 for violation of their conditions of release. In the same year 644 successfullly completed the Program and were recommended for discharge. This was nearly double the number who successfully completed the Program in 1970.[72]

The policy of increased leniency towards violations of the conditions of outpatient status has been described by the Center as follows:

> The policy of the Board [the Narcotic Addict Evaluation Authority] has been to give these addicts breaks; that is, reinstatements or limited placements (short-term returns to the institution) when they are able to work with their parole agent and not get involved in criminality. When they do get involved in criminality, they are, as a rule, returned to the institution for longer periods of treatment. At the present time the average length of stay in the institution is eight months for new commitments and about three months for those returned as a result of violating the conditions of their release.[73]

From September 15, 1961 through December 31, 1971 there were total commitments of 16,713: men—14,590; women—2,123. As of December 31, 1971 a total of 1,685 men and women had been recommended for discharge from their civil commitment after having completed two or three consecutive drug-free years in the community.[74]

The procedure upon discharge is as follows. Convicted persons are returned to their committing court, where they are discharged from the Program and returned to their original convicting court (municipal, justice or superior), which may resume the criminal proceedings or dismiss them. If the defendant is sentenced, any time served in the Civil Addict Program is credited to the length of sentence imposed. Non-criminally charged persons are simply discharged from the Program by the Narcotic Addict Evaluation Authority.[75]

If a person is retained in the Program for the maximum period of seven years in the case of involuntary commitment, he is then returned to his committing court. Unless the Director of Corrections recommends an extension of the commitment period (for a maximum of three additional years) and the committing court concurs, non-criminally charged persons are discharged from the Program and convicted persons are discharged and returned to their original convicting court for further proceedings, if any.[76]

Persons who are detained for an additional three years must be released from the Civil Addict Program on or before expiration of ten years from the date of the original commitment.[77]

Where convicted persons are recommended for discharge before the maximum period of commitment and returned to their convicting court, the usual procedure, at least in northern California, in the case of conviction for a misdemeanor, is immediate release, and in the case of conviction for a felony, a nominal sentence of a few days to be served in the county jail.[78]

Evaluation

In the *Treatment Report* we made some reference to critical evaluation of the California Civil Addict Program.[79] John C. Kramer, who was Chief of Research of the Program for three years, was severely critical of it when he wrote in 1970. His general conclusion was that the Program was essentially one of imprisonment under the guise of treatment, and that it did not appear to be more successful in rehabilitation than the regular prison programs for addicts in California.[80]

While there has been no systematic research comparing the success of those on outpatient status with paroled felon-addicts, an officer of the Department of Corrections has expressed the opinion that the latter probably do better "because, if they are returned to prison, they will probably end up doing eighteen months in prison versus two or three months at CRC".[81] He observed, however, that comparison is difficult between the Civil Addict Program and the "felon program" because in the latter there is no regular reporting of drug use.

The Civil Addict Program must be evaluated with respect to its goal of treatment and its goal of control. With respect to treatment with a goal of abstinence there is no clear evidence that it is more successful than regular imprisonment and parole. In fact, however, there has been no controlled comparison of the two approaches. Nor do there appear to have been any follow-up studies of CRC commitments after discharge from the Program. Success is measured essentially in terms of good standing in outpatient status and the number of addicts who obtain early release through non-detection of illicit narcotics use for two, or in the case of methadone maintenance, three years. It is noteworthy, however, that while over 90% of the persons in the Civil Addict Program are committed after being convicted of a felony, only about three per cent are returned from outpatient status for a new felony conviction.[82] This statistic must be read, however, in the light of the fact, noted above, that a high proportion of outpatients who commit felonies are returned to inpatient status without prosecution.

The chief claim of the California Program is that regardless of its relative success as a treatment measure it is effective as a measure of control. This was the function which was stressed when the Program was adopted, and it has been repeatedly emphasized in the literature concerning the Program. Its chief claim to support has always been that it keeps a significant number of addicts off the streets and out of drug-related crime. The Program has also emphasized the economies effected by the increasing shift of emphasis to outpatient status. These claims are reflected in the following statements from literature published by the Program:

> The Narcotic Addict Outpatient Program staff have been able to control thousands of hard core addicts with the least expense to the public....
>
> The cost of maintaining a person on outpatient status is about $850.00 per capita while the cost of maintaining a person in the institution is about $3,900 per capita. Thus the Taxpayers have been saved considerable expense by decreasing the population in the institution and controlling these hard core narcotic addicts in the community.[83]

The case for control was stated by Roland W. Wood, Superintendent of the California Rehabilitation Center, in 1967:

> Upon commitment to the Civil Addict Program at the California Rehabilitation Center persons who are uncooperative with efforts to treat them or are otherwise unresponsive to treatment nevertheless may be retained in the program for purposes of control. After a careful evaluation of experience in several jurisdictions (as well as our own), a long period of legal control was necessarily provided for therapeutic reasons. Without a legally enforceable commitment, a very large percentage of addicts will not undertake treatment. Given the opportunity, an extremely high percentage of addicts will leave treatment before medically indicated. Also, without a legally enforceable commitment, there is no effective way to insure post-institutional treatment. The lack of such treatment has been widely blamed for the high rate of failure in other efforts to control and treat addiction.[84]

Observers concede that the Program appears to have been fairly effective in its control objective—although it has an absconding rate of about 20%[85]—and this is attributed in some measure to the fact that the Program comes under the jurisdiction of the Department of Corrections. Wood has explained the reasons for assigning the Program to Corrections rather than a public health jurisdiction:

> The decision was deliberately made, by the California Legislature, for specific and sound reasons, to place responsibility for the state-level program of handling narcotic addicts in California, with the Department of Corrections. Narcotic addicts are typically delinquently-oriented and most of them have long histories of anti-social action. In most cases, addiction is not the only problem, since most addicts are also thieves, burglars, robbers, forgers, and sellers of narcotics. Some addicts may be hostile, rebellious, and assaultive as well. In fact, some addicts employ every possible means of escape and may go to great lengths to obtain narcotics during confinement. The narcotics addict also poses a management problem which is familiar to people involved in correctional work, but in some aspects clashes with commonly-held mental health concepts. Another feature of the Department of Corrections' program which was instrumental in influencing this decision to place responsibility with the Department of Corrections, was the existence of a highly-developed professional aftercare service with experience in the post-institutional care of narcotic addicts under parole supervision.[86]

The California Program has shown a definite trend away from institutionalization and towards supervision in the community. It is estimated that at the end of 1971 about 25% of all commitments were in residence and 75% were in the outpatient program.[87]

It is estimated that about 23% of the addict population of California is in the Civil Commitment Program.[88]

One reason for the failure of civil commitment programs in the United States to attract a higher proportion of the addict population has been the reluctance of judges to order commitment in cases where the total period in custody may be considerably longer than any prison term which could reasonably be imposed for the crime under consideration.[89] It has been suggested that with greater emphasis on early release into the community and with increasing use of methadone maintenance to make such release more feasible, this judicial reluctance could conceivably diminish.

NOTES

1. J. C. Kramer, "The State Versus the Addict: Uncivil Commitment," *Boston University Law Review*, 50(1) (1970): 1.
2. California *Narcotic Rehabilitation Act* (*NRA*), Welfare and Institutions Code, Division 3, Chapter 1, Article 1, section 3000.
3. *NRA*, section 3001.
4. *NRA*, section 3305.
5. *Robinson v. California*, 370 U.S. 660 (1962).
6. *In re De La O*, 59 Cal. 2nd 128, 28 Cal. Reptr. 489, 378 2d 793, cert. denied, 374 U.S. 856 (1963).
7. *NRA*, section 3100.
8. In *People v. Victor*, 62 Cal. 2d 280, 393 P. 2d 391, 42 Cal. Reptr. 199(1965), the California Supreme Court held that to be in "imminent danger of becoming addicted" within the meaning of the statute a person must not only have made "repeated use of narcotics" or be "accustomed or habituated" to their use, but such use or habituation must have reached the point that he is in imminent danger "of becoming emotionally or physically dependent on their use."
9. *NRA*, section 3100.
10. *NRA*, section 3100.6.
11. *NRA*, section 3103.5.
12. *NRA*, section 3106.
13. *NRA*, section 3106.5.
14. *NRA*, section 3107.
15. *NRA*, section 3108.
16. *NRA*, sections 3050 and 3051.
17. *NRA*, section 3052.
18. California, Department of Corrections, *Civil Addict Program: Guidelines and Criteria for Those Eligible*, mimeographed (June 1, 1972).
19. *NRA*, section 3050.
20. *NRA*, section 3053.
21. *NRA*, section 3109.
22. H. A. Katz, "California Rehabilitation Center: A Critical Look," *The International Journal of the Addictions*, 6(3) (1971): 546.
23. Ibid.
24. S. Gardiner (Superior Court Judge, San Raphael, California), personal communication to the Commission, July 14, 1972.
25. California, Department of Corrections, *Summary Statistics, Civil Commitment Program for Narcotic Addicts: 1968.* (Sacramento, California: California Office of State Printing, as of December 31, 1968).

26. R. W. Wood (Superintendent, California Rehabilitation Center, Corona, California), personal communication to the Commission, September 5, 1972.
27. W. H. McGlothlin (Psychologist, U.C.L.A., Los Angeles, California), personal communication to the Commission, July 7, 1972.
28. Wood, personal communication, September 5, 1972.
29. Gardiner, personal communication, July 14, 1972.
30. Kramer, "The State Versus the Addict," p. 16.
31. *NRA*, section 3002.
32. McGlothlin, personal communication, July 7, 1972.
33. J. C. Kramer, R. A. Bass and J. E. Berecochea, "Civil Commitment for Addicts: The California Program," *American Journal of Psychiatry*, 125(6) (December 1968): 129.
34. Kramer, "The State Versus the Addict," p. 13.
35. V. Chiapolli (Detoxification Program Director, Marin Open House, San Raphael, California), personal communication to the Commission, July 11, 1972.
36. *NRA*, section 3150.
37. *NRA*, section 3151.
38. California, Department of Corrections, *Statistical Review* (as of December 31, 1971), mimeographed. *See also* McGlothlin, personal communication, July 7, 1972.
39. R. W. Wood, "Major Federal and State Narcotics Programs and Legislation," *Crime and Delinquency*, 16 (1970): 50.
40. T. Duster, *The Legislation of Morality: Law, Drugs and Moral Judgment* (New York: Free Press, 1970), p. 151.
41. B. Wilson, Jr. (Parole and Community Services Division, California Civil Addict Program), personal communication to the Commission, September 4, 1972.
42. Wood, personal communication, September 5, 1972.
43. J. C. Kramer and G. E. Sing, "Short Stay-Arbitrary Release vs. Longer Stay-Routine Release in a Civil Addict Program," *The International Journal of the Addictions*, 4(2) (June 1969): 196-197.
44. Wilson, personal communication, September 4, 1972.
45. Wood, personal communication, September 5, 1972.
46. Wood, "Major Narcotics Programs and Legislation," pp. 21-22.
47. R. W. Wood, "The Civil Narcotics Program: A Five Year Progress Report," mimeographed (Corona, California: California Rehabilitation Center, March 8, 1967), p. 14.
48. Wood, personal communication, September 5, 1972.
49. Wilson, personal communication, September 4, 1972.
50. Wood, personal communication, September 5, 1972.
51. J. E. Berecochea and G. E. Sing, Jr., "The Effectiveness of a Halfway House for Civilly Committed Narcotic Addicts," *The International Journal of the Addictions*, 7(1) (1972): 131. *See also* McGlothlin, personal communication, July 7, 1972.

52. *NRA*, section 3154.

53. McGlothlin, personal communication, July 7, 1972.

54. Ibid.

55. Wilson, personal communication, September 4, 1972.

56. *NRA*, section 3200.

57. *NRA*, section 3151.

58. Kramer et al., "Civil Commitment for Addicts," p. 130.

59. Ibid., p. 129.

60. McGlothlin, personal communication, July 7, 1972.

61. Katz, "A Critical Look," p. 548.

62. Kramer et al., "Civil Commitment for Addicts," p. 133.

63. G. E. Sing, "A One Year Followup of All Residents Released from the California Rehabilitation Center to Outpatient Status in 1970," mimeographed (Corona, California: Civil Addict Program Research Unit, October 1971), p. 10.

64. California, Department of Corrections, *Summary Statistics: 1968*, as of December 31, 1968.

65. Kramer, "The State Versus the Addict," p. 12.

66. Kramer et al., "Civil Commitment for Addicts," p. 132.

67. W. H. McGlothlin, U. C. Tabbush, C. D. Chambers and K. Jamison, "Alternative Approaches to Opiate Addiction Control: Costs, Benefits and Potential," paper prepared for the U.S. Department of Justice, Bureau of Narcotics and Dangerous Drugs, February 1972, mimeographed, p. 45.

68. Kramer et al., "Civil Commitment for Addicts," pp. 131-132. *See also* J. C. Kramer and R. A. Bass, "Institutionalization Patterns among Civilly Committed Addicts," *Journal of the American Medical Association*, 208(12) (June 23, 1969): 2301.

69. Kramer, "The State Versus the Addict," p. 12.

70. Kramer and Bass, "Institutionalization Patterns," p. 2298.

71. McGlothlin et al., "Alternative Approaches to Control," p. 46, citing G. E. Sing, "January-June 1970 Releases: A One Year Followup, Civil Narcotic Addicts Released to Outpatient Status," California Rehabilitation Center, Corona, California, November 1971.

72. California, Department of Corrections, *Highlights of the Civil Addict Program*, mimeographed (one page), CRC internal Research Note, March 22, 1972.

73. Ibid. See also the following statement by G. E. Sing in a CRC internal Research Note of April 1972: "... increases in the percentage of outpatients in active status one year following release... appears to reflect further changes in both the policies of the Narcotic Addict Outpatient Program and of the Narcotic Addict Evaluation Authority. The new policies involve increased efforts to maintain and program Civil narcotic addicts in the community," (One Year Follow-up of All Residents Released from the California Rehabilitation Center to Outpatient Status in 1970," p. 1).

74 California, Department of Corrections, *Statistical Review*, as of December 31, 1971.

75. *NRA*, section 3200.

76. *NRA*, section 3201.
77. Ibid.
78. Gardiner, personal communication, July 14, 1972.
79. Canada, Commission of Inquiry Into the Non-Medical Use of Drugs, *Treatment: A Report of the Commission of Inquiry Into the Non-Medical Use of Drugs* (Ottawa: Information Canada, 1972), p. 16.
80. Kramer, "The State Versus the Addict," p. 17.
81. Wilson, personal communication, September 4, 1972.
82. California, Department of Corrections, *Highlights.*
83. Ibid.
84. Wood, "A Five Year Progress Report," p. 2.
85. McGlothlin et al., "Alternative Approaches to Control," p. 47.
86. Wood, "A Five Year Progress Report," p. 4.
87. McGlothlin et al., "Alternative Approaches to Control," p. 46.
88. McGlothlin et al., "Alternative Approaches to Control," p. 46.
89. Ibid.

Appendix M

Innovative Services

INTRODUCTION: THREE YEARS OF EVOLUTION

In 1970, in its *Interim Report,* the Commission used the term "innovative services" to designate social and medical agencies (for example, clinics, drop-in centres, communes and therapeutic communities) which had appeared primarily in response to drug-related problems, and which tended to reflect the aspirations and values of young people involved, not only in drug use, but also in various forms of social protest. The appearance of these services was often a result of the inability or unwillingness of established agencies to provide medical, psychological, and other kinds of assistance to drug users, and the desire of young people to be treated without being judged and without fear of being reported to their parents, the police or other authorities.

Innovative services in 1970 provided an outlet for the expression of non-traditional values and, for many of those embracing new life styles, they were becoming both a focal point and a means of projecting their values. Some of these services not only dealt with acute drug-related crises but also began drug education programs. The orientation of these programs tended to differ radically from those sponsored by the police, the schools and other established institutions.

Since the publication of the *Interim Report,* the Commission has endeavoured to follow the development of the innovative services. This was accomplished through the distribution of questionnaires, field trips (in more than a dozen Canadian cities) and personal contact with the staff members of these agencies.

In the last three years, the innovative services have undergone a number of changes in structure, orientation, quality, number and type. Some of these changes are clearly visible, others less so, and still others are quite intangible.

Changes Relating to Government Policy

The most visible changes in the innovative services have occurred as a result of the response of various government departments on both the

provincial and federal levels. Policies have been developed and structures have been established to coordinate, subsidize and evaluate innovative services, to prepare directories of such services and to encourage research into the non-medical use of drugs.

Since the publication of the Commission's *Interim Report,* the Federal Government has provided support for innovative services in a number of ways. On January 27, 1971, the Minister of National Health and Welfare stated that his Department would support a greater number of innovative services designed to meet drug-related social problems, that grants would be made for experimental programs undertaken by new or existing organizations, and that other forms of help or short-term financial assistance would be available to the originators of these services.[1] The Commission had recommended in its *Interim Report* that innovative services receive "the wholehearted moral support and official recognition of the Federal Government". The Commission had also suggested financial support for these services, although without specifying the terms. In addition, the Commission stressed that it was essential for the provinces and municipalities to take an active interest in these services.

Federal Government grants have in fact been steadily increasing since 1970. The sum of $400,000 was allocated in that year to demonstration projects and experimental programs by the Department of National Health and Welfare. In 1972–73, the budget of the Non-Medical Use of Drugs Directorate (NMUD) was an estimated $8,368,000, a major proportion of which ($3,750,000) was slated to go directly to the financing of innovative services. (See Table 1 on page 187.) A portion of the money allotted to drug-related research and educational programs was also available to innovative services, depending on the extent of their involvement in research and education.

Late in 1971, NMUD published a list (necessarily and admittedly incomplete) of some nine hundred agencies and services dealing with drug-related problems.[2] Many of the services listed were youth-oriented "street agencies". NMUD provides year-round financing for some 75 of these groups and services in addition to supporting approximately 150 others through grants for summer staffing. Other projects receive financial assistance through the Local Initiatives Program, and a few through Opportunities for Youth.

NMUD interprets its mandate fairly broadly and does not feel bound to assist only those services directly and exclusively concerned with drug users. Some experimental programs that receive grants from this and other federal agencies may be only peripherally or historically related to drug problems as such. Some of the assisted services have an openly preventive orientation, providing health and nutritional counselling as well as education in the health field in general. On the other hand, a number of services which had previously focussed specifically on drug-related issues have evolved into agencies of much wider scope with a very broad range of

activities. Among the latter are the "street clinics" that have moved into the controversial fields of community health and medical treatment especially related to the problems of adolescents.

Evolutionary Changes

The purpose of most of the earliest innovative services was simple and clear-cut: to fill the void caused by the lack of adequate medical facilities for drug users suffering acute health problems. The established agencies were inexperienced in handling these special problems, and many young people, especially those whose values and life style departed radically from conventional standards, were reluctant to appeal to them for help. At that time, the very appearance and existence of innovative services was symptomatic of an already serious conflict between certain categories of young people and the adults and institutions responsible for their health and education.

Since 1970, there has been a significant change in attitudes among some staff members of health and educational institutions. Many of them have criticized the relative incompetence of the established health services in their handling of non-medical drug use problems, and urged the addition of young people who are fully conversant with the drug scene to established agency staffs (for example, certain hospital outpatient clinics). Such measures are meant to 'bridge the generation gap' by facilitating the experiences of young people in these institutions, as well as sensitizing the adult personnel to their special needs and problems.

Young people too have acquired a new outlook on the non-medical drug use phenomenon. The issue no longer generates the same intense feelings that it did in 1968 and 1969. While excessive or chronic use of drugs may still be symptomatic of social and psychological alienation, it seems that most young people who use drugs occasionally and in moderation do not do so to express rejection of adult society or the bureaucratic "system". Groups of individuals who have broken away from traditional life styles are increasingly expressing their dissidence in a clear and constructive manner, through provision of and participation in services.

These services cover a broad range of activities. At one end of the scale are crisis centres and street clinics that are directly in touch with drug users and their problems and provide free medical assistance without conditions; at the other end are drop-in and community centres, communes and other collectives, some using semi-therapeutic methods of treatment, some forming therapeutic communities, and others simply offering alternate life styles. Some came into being for the purpose of dealing with drug-related problems but have evolved into places of refuge where young people can find an atmosphere and life style not to be found elsewhere; others have retained their function of providing medical services for drug users and for a variety

of other medical problems such as venereal disease. Still others, however, were created with the intention of offering and encouraging alternate life styles rather than as specific response to the non-medical drug use phenomenon *per se.*

SOME TYPES OF INNOVATIVE SERVICES

Crisis Centres

Although most of these services were originally created to deal with drug-related emergencies, their functions have continued to diversify. Over the past two years, there has been a continuous growth of "community switchboards" and "hot lines", which are available on a 24-hour per day basis. Today their clientele are often people of all ages who are seeking information and help for a wide variety of critical problems, ranging from social welfare to housing. Similarly, youth clinics are increasingly oriented to referral and counselling rather than treatment of acute drug crises.

The change in social attitudes that we have observed in established agencies has had a certain effect on the function of both crisis centres and youth clinics. Once hospitals and conventional medical clinics had begun to show a more tolerant attitude toward drug use, venereal disease and other adolescent problems, the referral services and crisis lines began to refer cases to them. This meant that crisis centre staffs were relieved of many serious and acute medical problems.

It should also be observed that recently there has been a marked decrease in psychedelic drug emergencies brought to the attention of crisis centre workers. The decrease does not necessarily mean that fewer people are using psychedelic drugs. It seems rather that young users have become more familiar with drug effects than they were three years ago, and are less likely to experience crises which cannot be handled by their friends. In addition, while there are considerably fewer calls related to drug use in general, the calls received now more often involve prescription drugs and multiple drug use, including interactions between alcohol and other drugs.

Hospital Youth Workers

In its *Interim Report,* the Commission recommended that representatives of the medical profession (including psychiatrists, psychologists and other counselling professions) establish a system of communication and cooperation with the innovative services.

In February 1971, the Canadian Hospital Association passed a number of resolutions to this effect at a conference held in Montreal under the auspices of the Department of National Health and Welfare. This conference was attended by many innovative service representatives. The two most

explicit of these recommendations were one suggesting an exchange of personnel between hospitals and detached free clinics on a rotation basis and another proposing the addition of street workers to hospital treatment teams.[3]

The Toronto General Hospital seems to have developed the most comprehensive operational model for the inclusion of young people in its services.[4] Young people who are thoroughly familiar with the non-medical drug use scene have been working there since March 1971. These young adjuncts to the normal hospital staff are generally members of the youth culture and understand its customs and mannerisms. They work side by side with professionals in the hospital's emergency department, where they are available 18 hours a day. They make the initial contact with young people brought to the hospital, try to establish a positive rapport between them and the medical personnel, and stay with the young patients throughout all the phases of their hospital treatment. These youth culture representatives are also directly involved in the work of the hospital's social service department. When a young patient is about to be discharged, a youth worker will try to find him food, clothing and shelter if necessary. The youth workers also keep the hospital personnel informed of community services available to meet the unique needs of transients and other young people.

These hospital youth workers, then, serve as interpreters for young patients who have special needs and may feel alienated in the hospital setting. In addition, youth representatives may conduct lectures and seminars, providing in-service training for doctors, nurses and other medical personnel who wish to acquire a better understanding of young people.

Street Clinics[5]

Since 1968–69, some crisis centres have evolved into multi-purpose clinics staffed night and day by young non-professionals, with the help of nurses and doctors. Many of these donate their time and services on a volunteer basis. Over the last two years, other "free clinics" have also been set up, some with financial support from the provinces in the form of health service demonstration grants, and some with help from Federal Government employment programs. A background paper for a brief presented to the Commission (prepared by the Council on Community Health Care, a subcommittee of the Canadian Medical Association) observes that street clinics in large cities are now seeing fewer young people with drug problems *per se* and more who are suffering from other medical problems.[6]

Street clinics and free clinics have left behind the purely emergency orientation of their early days, and now also engage in preventive health counselling, particularly in nutrition and hygiene, including dental hygiene. In addition, they try to disseminate reliable information on public health matters. Often they are the first direct contact points in the detection and treatment of venereal and other infectious diseases. They also give first aid. Most have developed educational and "outreach" programs to serve their

communities, dispensing birth control information, assisting school authorities with drug education, and holding well-baby and early childhood clinics.

Street clinics and free clinics are playing an increasing role in practical training for medical personnel.[7] In a number of instances, they have been responsible for changing the attitudes of certain Canadian health service professionals. They have often shown the way to a less moralistic approach toward young people, their use of drugs, their life styles and their sexual behaviour.

Some observers have predicted that in the future medicine will become more oriented to the style of "participatory medicine", involving free and easily accessible medical care dispensed by community-oriented health agencies. Thus, these street clinics, originally developed for dealing with problems related to the non-medical use of drugs, may be pointing the way for the development of health care in the future.

Street Community Centres

With the traditional medical agencies becoming increasingly responsive to the needs of young people with drug-related problems, and with street clinics and free clinics handling other aspects of health care for young people, many innovative services have moved away from the health orientation which was their original *raison d'être* and have taken up much broader activities. A number have turned to the creation of "alternatives" for the young and less young who feel alienated from the society they live in. Often the basic difference between these alternatives and established social institutions is not so much one of program content as of the degree of client participation in the organization and administration of these facilities. Some of these broader-based innovative services were begun in order to offer alternatives to chronic drug use. Others were created to provide alternatives to established institutions, conventional schools, for example, which have lost relevance in the eyes of some young people. Thus "free schools", arts and crafts workshops, ecology activist organizations, food cooperatives and so forth have appeared in great variety.

Street community centres may serve as meeting places for theatre workshops or housing cooperative organizations, for yoga classes or music practice; they may provide space for "free stores" where clothing and other objects are exchanged, for political meetings, and many other activities. Some have developed "free universities" or are associated with "free school" experiments addressed to young people unsuited to or unwilling to participate in conventional school life. Today, very few deal in any concrete way with drug-related problems or drug crises.

These street community centres differ from therapeutic life style projects (described in the next section) in that they do not have the degree of formal organization necessitated by the latter's treatment focus.

Therapeutic Communes[8]

In its *Treatment Report,* the Commission described a number of services which it called "therapeutic communities"; these differ somewhat from the services to be discussed in this section. Therapeutic communes are generally youth-managed projects with treatment methods and philosophies similar to those of therapeutic communities like X-Kalay and Day Top, but with less intensive and rigorous application. The founders of these therapeutic communes do not put much store in "treatment" in the conventional sense, and do not make extensive use of high-powered encounter and confrontation group methods. Some consider the classic therapeutic community tactics to be somewhat manipulative and authoritarian. Therapeutic commune staffs will concede that this mode of treatment may be helpful to some, but insist that such intensive treatment is not needed by all drug users, even chronic users.

Therapeutic communes are for the most part residential, though some function primarily as "outreach workshops" that provide activities and group therapy sessions without live-in facilities. Many function as halfway houses to which the courts and social agencies may refer young delinquents with drug histories; they also provide a re-entry portal for young people who have undergone, willingly or unwillingly, more intensive treatment modalities. The personnel of these communal services are largely young non-professionals, some former drug users themselves.

A service of this type provides a communal living experience and a supportive peer group, an alternative milieu to the drug-oriented one in which the chronic drug user has been involved. The avowed intention is to break the cycle of dependency and compulsion, and to remove the drug user from the circle of friends who may encourage relapse.

These services use some of the techniques of group therapy current in a number of therapeutic communities, but they do so in a rather loose and paraprofessional way. They also utilize the assistance of professionals, especially psychiatrists. Their success depends to a great extent on the quality of client relations (with a supportive peer group composed very largely of young people) and their ability to follow up former residents.

The length of residence, where residence is involved, varies from one group to another, and even within a group. Oolagen House, for example, gives residence contracts for 2 to 12 months, but will occasionally allow a person to stay longer.

There are now a number of "rural communes",[9] life style projects intended for chronic speed and multiple drug users who need (or are thought to need) to be removed from surroundings where drugs are easily available. The rural commune provides a setting for abstinence, rest, and personal re-assessment. However, it seems that these services are now attracting young people with serious emotional and family problems quite apart from,

though often including, excessive drug use. Although professional social workers and psychiatrists are involved with some of them, these communal projects rely mostly on healthy surroundings, group living, cooperative work, a period of freedom from the pressures of city living and an alternative to the life style of obtaining and using drugs.

The criticism often levelled at rural foster homes for city children applies to rural communes too, inasmuch as they count heavily on the intrinsic therapeutic value of life on the farm. However, the mere fact of getting away from the city and living in the country is no cure in itself, although it may be of value to some. Few rural communes are in fact self-sufficient, as their philosophy would have them; most depend on city-based projects for funds. Moreover, it would be quite unrealistic to try to convert speed freaks into permanent farmers. The rural communes recognize this, or most do, and have associated with halfway houses or urban residences where the cure begun in the country can be completed, and re-entry into the urban environment facilitated.

Therapeutic communes, both urban and rural, seem to follow an educational model rather than a medical or moral one. Their basic assumption seems to be that with the acquisition of certain survival skills, the experience of group living with its day-to-day give and take, and with increasing group awareness, the obsessive need to use drugs will tend to disappear. In these groups, the drug need is regarded as a symptom of personal maladjustment, stemming from feelings of social alienation. It is believed that with the activity of communal living and the necessities of feeding, clothing and housing the group, the need for drugs ceases to be the predominant preoccupation. Urban and rural therapeutic communes in general, rather than being anti-drug as such, try to instil in their members a desire to be freed of the drug obsession, which they consider to be a hindrance to the achievement of satisfaction in life.

In this the communes do not differ significantly from the therapeutic communities, whose basic principle is group responsibility. In this system, rewards are in the form of self-fulfilling contribution to the life of the group as a whole, and the contribution of each participant will increase along with his capacity to assume responsibility within the group.

PROBLEMS FACED BY INNOVATIVE SERVICES

Inherent Limitations

While the Commission has explicitly demonstrated its support for the innovative services, and has recommended that they receive assistance from the various governments, we must point out the limitations of this form of social service and suggest that here, as with established agencies, there is room for constructive criticism.

The first caveat arises from the fact that these agencies, like any other, can fall into rigid routines and lose contact with those they intend to serve because of their preoccupation with their own vested interests. While it is true that most innovative services have remained flexible and have kept their personal character, and while generally speaking their contribution has been extremely important, there are certainly some, in no greater or lesser proportion than among other social institutions, which have in fact fallen prey to rigidity or corruption, thus destroying their communication with those they had originally set out to serve. No less than for other, more traditional service groups, it is imperative that the innovative services constantly re-examine the relevance of the services they offer and the effectiveness of their adaptation to the needs of their clientele.

They must also resist the tendency to consider that they and they alone are capable of meeting the needs of young people. They have no monopoly in this field, and one of their most important roles is, and will certainly continue to be, the interpretation of the needs of a segment of the Canadian population to the more traditional institutions. Ideally, the reverse would be desirable as well.

All experts are agreed upon the fact (which is no novelty to most of the competent young people now in charge of the innovative services) that our drug problems are bred by a combination of widely varying factors, many of which originate in the nature of our social institutions and the structure of Canadian society. This generative relationship has been perceived by the innovative services; they consider most of the problems coming to their attention, whether involving drug use or not, to be normal problems experienced by the great majority of young people struggling to establish and maintain an identity in the face of the constant social and psychological stresses characteristic of our urban environment. When young people discuss the causes of their alienation with innovative service personnel, they themselves identify such things as high unemployment (especially among young people), dissatisfaction with schools, communication breakdowns in families, and radical shifts in values and attitudes. This indicates that the innovative services are part of a much larger scene, and must take into account the entire complex of interrelated social forces. Street clinics, therapeutic communes and other non-conventional services cannot alone counterbalance the enormous, ever-present forces that create stress and alienation. In exercising their awareness of the factors underlying drug use, innovative staffs and their clientele must realize that they occupy a very small place in the total social mosaic, and that their efforts alone are not enough to offset the sources of maladjustment and alienation. They must also recognize that they can contribute to, as well as ameliorate, the alienation of their clients.

There are signs, however, that this realization is in fact coming to pass. While the innovative services express a lack of faith in certain treatment modalities (the methods of classic therapeutic communities, for example), we have observed that some of them, and indeed an increasing num-

ber, do turn for help to established medical services. It is not out of the ordinary for innovative services to send their clients to psychiatrists or to social service and mental health clinics. They appear to be recognizing the necessity of an interrelationship with the established services, and to be more conscious of the importance of follow-up for their clients. In short, the innovative services seem to be recognizing increasingly that their role is to meet particular needs, but that they are not alone in the community and that their clients live in a social context whose facilities they are entitled to use.

Innovative Services as Social Critics

Innovative services are not always regarded kindly by the health and welfare professionals with whom they should be working, because they have assumed the role of social critics with regard to established services. They have often protested, sometimes with good reason, that the professionals concern themselves only with individual functioning and look no further than at the immediate causes of personal maladjustment. The radicals among the innovators have accused the professionals of being social manipulators who force adaptation to the social system, rather than being agents of creativity, change, self-determination and personal fulfillment. These criticisms have frequently been lacking in tact, and established services, particularly child welfare agencies, have sometimes responded with considerable animosity. Thus, the established agencies have themselves had occasion to feel alienated in their search for innovative means of dealing with youth problems.

It must be admitted, however, that many of the innovative services would not have come into being had welfare agencies and social service bureaux not become ossified and unable to respond satisfactorily to the needs of contemporary Canadian youth. The established agencies' failure to adapt and the negative image entertained by young people with respect to such institutions are certainly factors behind such criticisms. However, there have been instances, or there were two or three years ago, where innovative services have not only been harshly critical but have flatly refused to cooperate with the established agencies. In such cases, the innovative services have carried on in isolation, to the detriment of their clientele. Significantly enough, subgroups within certain innovative services have been seen to break away and set up community services working in genuine interrelationship with established services.

Non-Medical Drug Use in Innovative Services

Many centres for young people with alienation or drug use problems have strict rules regarding the use of drugs on the premises. For many, the rule is total abstinence, and the use and distribution of any psychotropic

substance is forbidden, although in some cases little effort is made to enforce these regulations. Such rules are of course no absolute assurance that an innovative service will never contribute to the distribution or use of drugs. Other innovative services are much more lenient in this respect, have no rules against use or trafficking and do not refuse their services to clients on those grounds.

The Canadian people and their governing bodies must decide whether financial and moral support should be given to services which may, directly or indirectly, in some cases and for a certain proportion of their clientele, encourage the illegal use of psychotropic drugs. However, two facts in particular should be considered: first, that centres maintained by these services are not the only places where young people gather and where drug transactions and use could take place; second, that in many cases the innovative services have indeed tried to evolve a philosophy that at least does not encourage drug use, and many of them frankly discourage it. Rather than attacking the drug problem directly by imposing total abstinence, most services have tended to treat drug use as a symptomatic and relatively unimportant activity, one which is unfulfilling both socially and personally, and for which they try to provide alternatives by emphasizing other activities of a creative and group nature.

Another facet of the question of drugs and their use in the innovative services is the presence of young ex-users on staff. In Canada and the United States, many of the classic therapeutic communities are staffed with and run by former heroin users. However, the innovative services sometimes employ people who are current users of illict drugs (cannabis, for example) as well as those who have been seriously involved in chronic drug use in the past. In the innovative service context, experience with drug use is considered to be a useful asset, increasing the staff member's understanding of his clients' problems and facilitating recognition of the various types and phases of intoxication. However, there appears to be a tendency on the part of innovative services to evaluate a potential staff member's competence on the basis of his ability to handle specific responsibilities rather than on his drug history.

Canadians would probably find it reassuring to see a former heroin addict hired for the staff of an innovative service, feeling that he would be likely to promote abstinence in the clientele. If a staff member is a current user, however, a great many parents, teachers and others interested in the service would justifiably have reservations, fearing that he might condone or even encourage the use of drugs by young people. While innovative services are not expected to be monasteries or places of penitence, backers and staff members should see that norms compatible with the stated and implicit goals of the service and compatible with existing laws are laid forth and respected. There are cases where this means complete abstinence for both staff and clientele.

Drug Information Role for Innovative Services

There is no doubt that the innovative services have played a useful role in the dissemination of information about drugs. This was particularly true in the period when there were few other sources, since many doctors, educators and others from whom such information is usually sought knew little about psychotropic drugs, the youth culture, or the underlying factors of drug use. Today, however, there are many doctors, psychiatrists, nurses, educators and parents who are reliably knowledgeable about these things, and who have a sympathetic understanding of the special problems of young people. They can now also be counted on for information concerning drugs and the youth culture.

The Commission is of the opinion that, while the innovative services should continue to play an informational and educational role regarding psychotropic drugs, it should not be their exclusive responsibility, as some of them seem to think it should, and they should cooperate with others who have special expertise and insight. The community is perfectly within its rights in requiring that innovative services, like other agencies which dispense such information, must be accurate and that their knowledge of drugs, drug effects and the factors underlying their use be as complete as possible.

Some Legal Questions of Concern to Innovative Services

Can the innovative services give shelter to juveniles without parental permission? Can they encourage juveniles with health problems to submit to medical treatment without formal authorization from their parents or guardians?

The *Criminal Code* provides severe penalties for those who seek to deprive parents or guardians of the possession of an unmarried girl under the age of 16 or a child of either sex under the age of 14.[10] There would not appear to be any liability under these provisions for members of an innovative service who are merely providing shelter or other services to a runaway without any attempt to interfere with the right of parents or guardians to the possession of the minor. Under these provisions there is no duty to report the whereabouts of a runaway child, but a refusal to comply with a parent's request for information might give rise to a question concerning intent.

Under the federal *Juvenile Delinquents Act*[11] it is an offence to induce or attempt to induce a juvenile to leave a house of detention, industrial school, foster home or other establishment in which he has been placed under the terms of the Act. When a juvenile has escaped from one of these establishments, it is illegal to offer him shelter without notifying the juvenile court or the police. Innovative service staff must therefore notify the appropriate authorities when they have on the premises a juvenile known to have escaped from a place of detention, and if they fail to do so they could be

found guilty of an offence. Under some provincial statutes, too, it is an offence to induce a juvenile to leave a place of detention, and knowingly to give him shelter when he has run away from such custody.

Although there is a dearth of Canadian judicial authority[12] on the point, it is generally assumed that parental consent is required for the medical treatment of a minor in other than emergency situations. This assumption is reflected in provincial child welfare and protection legislation which provides for judicial intervention in cases in which parents refuse to consent to necessary medical treatment for their children.

Such procedures are not always easy to apply in practice. Furthermore, obtaining parental consent, whether of necessity or as a precaution, can pose real problems because young people often do not want their parents to know of their difficulties.

Clarification of this situation in provincial legislation would be highly desirable. *The Public Health Protection Act*[13] in the Province of Quebec now allows for the treatment of minors of 14 or over without parental consent; parents must be notified, however, if the minor is sheltered for more than 12 hours or the case is one of extended treatment. An effort at overhaul and updating of legal guidelines is badly needed throughout the rest of Canada too, for certain long-standing assumptions concerning parental control and consent may now be thoroughly outdated and inadequate in view of the physical mobility of today's adolescents.

Staff Burn-Out

The innovative services have been plagued by the problem of staff "burn-out", the loss of staff due to physical and nervous exhaustion. In some services this has been alleviated of late, but in others it continues. It results in a high rate of staff turnover and impedes effectiveness to some extent because of a loss of continuity in traditions, rules and standards evolved through experience. It is apparent that there is still room for more careful staff selection, as well as some system of training, however informal, to make staff members more resilient to the abrasive conditions they encounter. Burn-out is certainly also partly attributable to the unrealistic goals that services sometimes set for themselves, particularly when the staff is untrained and inexperienced. The psychological characteristics of people attracted to innovative service work may also contribute to the problem. Generally the young adults who undertake this work are particularly effective because they have a great degree of empathy for the young people they are called on to serve, and yet are personally and socially mature enough to help others come to grips with their problems. The ideal staff candidate must therefore be able not only to resolve the alienation-bred conflicts he shares with other young people, but also arrive at a compromise between youthful aspirations and certain social exigencies.

Traditional health and welfare agencies and social work schools have recently begun to be much more open to establishing contacts and closer liaison with the innovative services, exchanging services with them and requesting them to assist in the training of their own professionals.[14] This development may be one solution to the problem of staff burn-out in the innovative services. This rapprochement moreover, is seen by innovative staff as recognition of their own value and usefulness, and an indication of growing interest in what they are doing. It also gives them the opportunity to turn for guidance to people involved in more systematic approaches to understanding human behaviour.

A second solution for burn-out would undoubtedly be hiring more and more competent personnel. The unorthodox structure and operation of services, the direct and continuous contact with young people, and the stresses of day-and-night service on a limited staff would seem to make burn-out inevitable in some cases. NMUD demonstration grants have recently made it possible for some innovative services to hire more staff and introduce shift work to reduce the strain.

Generally speaking, staff burn-out and high turnover are less serious now than two years ago. This is undoubtedly due in part to greater experience in managing the unorthodox innovative service methods, but also to the fact that, with more adequate financing, many services have staffs that are numerically more adequate for the job to be done.

Organizational Structure

It is typical of the innovative services that day-to-day decisions affecting conditions for the clientele are made by the staff at informal meetings. Most of the services, however, also have boards of directors or advisory boards which, in principle, make the larger organizational decisions. The short history of innovative services is fraught with conflicts arising from differences between board members or advisors on the one hand and staff members in direct contact with day-to-day realities on the other. Many young staff members have no doubt been 'turned off' by the necessity of complying with directives or of taking counsel from advisors who seem, and often are in fact, far removed from the realities of the service. It is clear that over the last two or three years a considerable number of young people involved in the organization and operations of the services have acquired a positive sense of social responsibility and also by now a good deal of experience in the management of social services. However, it is not easy to persuade innovative staff members that conflicts between the generations will hardly diminish if they themselves cannot be articulate in explaining the needs of young people to adults who are sufficiently interested in them to serve voluntarily on innovative service boards.

If innovative services are to avoid the problems of impersonality inherent in "top-down" planning and policy-making without consultation, their

size and scope must be kept within reasonable proportions. There is no doubt that unwieldy size breeds formality and impersonality, and necessitates a complex bureaucratic structure.

Detection and Control of Youthful Heroin Use

Judging from reports received by the Commission from its observers in the various provinces over the past year, there has been a marked increase in heroin use among young people. Intervention during the 'honeymoon' (or 'chipping') period of experimentation is of course crucial in heading off dependence. Most well established treatment programs have no direct means of contacting youthful heroin users who are not yet dependent on the drug but are in danger of becoming so. Nor do they have any indirect means of reaching them. The innovative services, particularly the youth-run services with outreach programs, could play an important role with youthful heroin users of this kind. The staffs of these services, by developing a good rapport with these young people and maintaining continuous friendly contact, may be able to prevent them from assuming a daily consumption pattern, even if they cannot persuade them to give up the drug entirely. If they are alert and keep close watch over young people who have either tried heroin or are exposed to its use, they could prevent the latter from using and encourage abstinence (or detoxification, if necessary) among novice users.

FUNDING: POLICY AND PROGRAMS

As mentioned earlier, federal funding has been available to the innovative services from three sources. Most important are grants for experimental and demonstration projects from the Non-Medical Drug Use Directorate, but there are also sums of money provided through the Local Initiatives and Opportunities for Youth programs to cover staff salaries for services which are generally of an innovative nature. The application of funds from these sources tends to overlap to some extent. We note five special problems related to the funding of innovative services.

Provincial and Municipal Support

In granting funds through NMUD for the launching of experimental or demonstration projects, the Federal Government's intention has been to give these projects an opportunity to prove their usefulness. It is hoped, once their usefulness to their communities has been demonstrated, that their support would be taken over by the provincial and local governments whose jurisdictions benefit by these programs and the efforts of their staffs.

Some projects do not succeed in demonstrating sufficient usefulness within the time allotted (three years maximum). This is either because pro-

vincial and municipal criteria for the fixing of priorities differ greatly from those of the innovative service founders, or because the usefulness of a service is simply not apparent. Some services, moreover, have failed to look to the future; they have realized too late that after a year or two their role might well be taken over by the more traditional services (hospital outpatient clinics, community centres or local health centres) and have not made efforts to establish an interpretative and coordinating relationship with those services.

If the innovative services have difficulty in finding other sources of support when their federal grants terminate, the Federal Government is at least partially at fault. There has been no joint planning or anticipatory agreement with the provinces and municipalities, and no effective dialogue on health and welfare which might lead the provinces to realize the importance of gradually taking over the support of services which have proven their usefulness. This being so, it is understandable that provincial health and welfare departments may be disinclined to take over sponsorship of services that they did not bring into being and which may not fit into their system of priorities.

A number of arrangements could be worked out to ease the transition from federal to other funding. While we recognize that the Federal Government has put a time limit on its support in order to avoid making direct operating grants to services properly falling within the jurisdictions of provincial and municipal health and welfare departments, nonetheless it could have conceived other ways of withdrawing the financial support of these services. Instead of simply cutting off its support after two or three years, NMUD might have devised a predetermined tapering off, contributing, say, 75% of operating costs for the second year, 60% for the third, 30% for the fourth. Such a solution would give the services time to find alternate funding from the provinces, municipalities or private sources. It might encourage them, too, to sell their usefulness and effectiveness to a number of potential backers, including some in their own local communities.

Grants for Staffing

As we have observed, both the Opportunities for Youth summer programs and the Local Initiatives programs have provided funding for many projects, particularly for staff salaries. In the interests of establishing a fully consistent body of policy regarding non-medical drug use and its prevention, it appears to the Commission that all federal grants to innovative services might best be handled, directly or indirectly, through NMUD. Despite its own early organizational difficulties, the Directorate is now in a position to operate its programs effectively and to keep pace with the evolution of the social movement that has sprung from drug abuse problems and the solutions that young people and the society as a whole have tried to bring to those problems.

Without discarding the possibility of coordination between NMUD demonstration projects and Local Initiatives and Opportunities for Youth projects, the Commission feels that NMUD and the Department of National Health and Welfare are in the best position to develop the kind of broad-based planning that will foster a degree of social cohesion.

The "Innovative" Label

NMUD has attempted to give its grants to projects considered "innovative" or original. The Commission does not intend to be negative about the practicality of this criterion, but nevertheless wishes to point out that innovation is a very relative concept. What is innovative for a town 200 miles north of Ottawa is probably not so for Toronto, Montreal or Vancouver. Some projects have in fact made a step in the right direction and have filled a need in communities where services are few or lacking in variety, and yet have failed or found it difficult to prove sufficient innovativeness to obtain grants. No doubt there has been reason to question the originality of certain small-town projects which are no more than copies of well established services in large cities. However, it seems reasonable for the Directorate's regional and local representatives to rate such a project in relation to whether or not the community needs its service, since it may indeed be new and original in that particular context.

Program Design in Relation to Drug Use Problems

Of late, NMUD has been less insistent that innovative services be designed specifically to deal with drug-related problems. To qualify for grants, experimental and demonstration projects no longer need to show that their purpose is first and above all to serve a clientele already suffering health problems arising directly from drug abuse.

The Commission believes that this change of emphasis was appropriate. Indeed, as we have already observed, innovative service staffs are becoming increasingly aware that if their projects are to be effective they must take into account much broader-based factors than the drug phenomenon *per se*. In other words, they must look to the social causes of youthful alienation and discontent and endeavour to offer meaningful and creative activities and alternatives to young people who are unable to find them in conventional institutions. The services have been shifting their focus from drug treatment to prevention (as the Commission recommended in both its *Interim Report* and its *Treatment Report*) and have been engaging in broader community-based activities.

At the present time it is not always easy to determine whether certain services are sufficiently oriented to drug problems to be properly within NMUD's mandate. Furthermore, many services which once provided emer-

gency drug-crisis intervention have moved away from their original purpose. Nevertheless, we believe that federal sources should continue to assist those services which, through social and community development activities and a variety of other preventive measures, are in a position to play a useful role in heading off situations which may lead to problem drug use.

NMUD Policy and Administration

In the preceding paragraphs we have made reference a number of times to NMUD policy and structure. At this point we have a number of comments to make in this regard. Since its inception, the Directorate has changed directors a number of times and, no doubt being aware of the rapid development and shifts in emphasis of the innovative services, does not appear to have been able to formulate any well defined body of policy. However, it has made a number of moves that call for comment.

The first is certainly the establishment of regional offices. The appointment of regional representatives is an excellent step in the development of the Directorate's administrative structure. These representatives are in close touch with the needs of communities in their areas and are in a position to bring about a considerable degree of understanding and empathy in transmitting both local needs to the federal authorities and federal norms and directives to the local services.

However, there are hazards inherent in these regional structures. Some of the provincial offices are already very bureaucratic and, perhaps because of the large number of services they must know, assist, coordinate and sometimes manage or regroup, their contact with the 'grass roots' may be poor or even non-existent. There have been cases of erroneous information received from regional offices by observers, researchers and others concerned with the innovative services, leading to miscalculations and considerable loss of time.

Some of the regional representatives were at one time initiators of innovative services. Such choice is logical and in many cases has been highly successful, for such people often have remarkably charismatic personalities in addition to an understanding of the problems and priorities of young people. Although sometimes lacking experience, many former innovative service managers have in fact developed considerable talents as coordinators and organizers. It cannot be assumed, however, that all young people are capable of making the transition from the youth culture to effective representation of NMUD.

There are certain problems inherent in the Directorate's methods of evaluating innovative services. NMUD should realize that evaluators sent from Ottawa can hardly be expected to make a profound analysis of a service's operation, philosophy and usefulness in a total context on the basis of a whirlwind one-day visit. The local representative's judgment, on the

other hand, may be biased, either because of too close a proximity to a service or concern that service managers may go to the regional director protesting reductions in their grants or the imminent demise of their services. It must further be recognized that wise and impartial evaluation of services is often difficult for federal or regional representatives whose personal values and priorities may differ from those of the innovators.

In order to overcome these difficulties, the Directorate should require that project plans include at least an outline of evaluative research and a statement of the criteria through which, in the judgment of the project initiators themselves, the proposed service will be able to function adequately and achieve its goals. This requirement would stimulate the initiators to consider the various operational methods of evaluating their service; it would also help them to identify the signs of their success or failure. Effective evaluation of a project and the size of the grant assigned to it should be based at least partially on self-evaluation and self-imposed criteria.

EVALUATION: THE IMPORTANCE OF CLIENT PARTICIPATION

There are a number of different criteria which may provide a basis of classification of innovative services, allowing comparison between services as well as a method of evaluation of the effectiveness of their responses to the social factors underlying the non-medical use of drugs. Innovative services could be compared on the basis of their sources and modes of financing. At one extreme would be those that have never needed government funding, and at the other those that would not have come into being and would not survive without it. A second basis of classification might be the clientele. Does a service address young people only, or a mixture of age groups? People with drug problems, or people simply looking for a life style other than any offered by conventional society?

A third basis of classification might be the kind of team assembled to operate the service. Is the staff composed exclusively of professionals, or of non-professionals? Are its directors young people, adults, or a mixture of the two? Were present staff members previously clients? On the other hand, services could be classified with reference to their procedures and orientation. Is a service built around traditional medical and paramedical forms of treatment, or the methods of social psychology (sensitivity and encounter groups, etc.)? Is it mainly educational? Does it primarily offer an alternative life style?

All these dimensions might provide points of departure for defining the differences between the innovative services. However, we are convinced that the continuum providing the most important and most fundamental distinction lies in the degree of meaningful and competent participation by the 'grass-roots' elements, that is to say, by those individuals with the specific needs the service is designed to meet. At one end of the spectrum are services

in which there is total absence of such participation, and at the other, those where there is full participation in all aspects of the service, from conception and establishment to continuing day-to-day operation. The first might be qualified as exogenous or "injected from the top down", the second as endogenous or "emerging".

In our opinion, the innovative services most likely to provide a counterbalance to the phenomena of alienation, personal disaffection and isolation are those closest to the endogenous or "emerging" type, that is to say, those that grow from within as an outcome of a common awareness of problems shared with others. Although it is evident that client participation may not always be appropriate in some areas of decision-making and under certain specific circumstances, the Commission believes that it is an important aspect of innovative services and that evaluation of services should take account of their origin, structure and internal creative strength, their contact with those they serve, the participation they allow their clients in decisions affecting them, and the inclusion of clients in their managing bodies, including boards of directors.

An innovative service may both originate and evolve either from the top down or from the bottom up. Some services begun by people attempting to come to grips with their own problems have gradually been taken over by staffs who have never had and likely never will have the problems the service is intended to deal with. It is evident, too, that certain services are at present assuming an increasingly medical orientation, in Quebec particularly, hoping to attract provincial grants for community clinics. In order to qualify for these grants, drop-in and community centres that have been dealing primarily with psycho-social problems are adding medical services; some, having abandoned them, are returning to them. This is a shift in emphasis that calls for careful scrutiny to determine whether it is prompted by the injection of grants or whether it really reflects the needs of the population.

Among the factors involved in evaluating the innovative services, the Commission considers that the following five criteria deserve particular attention:

1. Was the innovative service founded to compensate for real deficiencies in conventional medical and social services? Where this is so, and where the conventional services have not corrected those deficiencies, financial support of the innovative service is entirely justified.
2. Is the innovative service structured so as to remain fully in touch with the real needs of its clientele? Has it avoided becoming unnecessarily routinized in its operations? Does it invite useful and appropriate client participation in decision-making?
3. Has the innovative service established a system of self-evaluation? Has it shown itself capable of critical self-examination in the pursuit of its goals, both latent and explicit?

4. Does the innovative service make efforts to redefine its role as hospitals and social services become better equipped to take over functions that are properly theirs?
5. Does the innovative service act as a stimulant to the conventional services, and can the public rely on it to interpret the needs of a dissident or deviant clientele? Does it cooperate with the other services in the community?

CONCLUSIONS AND RECOMMENDATIONS

In recent years the innovative services have been receiving a considerable amount of financial and moral support, certainly from the Federal Government, and in many cases from provincial and municipal governments. This support has enabled them to diversify and move into new areas of activity. It is highly probable that the innovative services will be increasingly concerned with social rather than medical activities, offering alternatives to conventional life styles through drop-in and community centres, communes and the like. The Commission, in view of its analysis of the factors underlying the non-medical use of drugs, strongly urges innovative service staffs and funding sources alike to pursue the move in this direction.

1. **Notwithstanding its observations regarding the limitations of innovative services, and the fact that certain of their present functions may be taken over by traditional services (those functions which should normally fall, for example, to hospital emergency services or local health centres), the Commission recommends that the Federal Government continue to afford direct and specific financial and moral support to the innovative services. However, the Federal Government should take concrete steps to obtain provincial participation in this support, either through cost-sharing arrangements or some other mechanism.**
2. **It is essential for the three levels of government and the various federal, provincial and municipal agencies concerned with the innovative services to cooperate fully in circulating all pertinent information, without which rational funding policies are very difficult to formulate and apply.**
3. **Where federal programs[15] overlap in the area we have described as that of the innovative services, there should be more effective circulation of useful information and coordination of activities.** It may in fact be preferable for NMUD to take charge of coordination in planning and funding where the innovative services are concerned, and to be responsible for keeping evaluation records up to date.
4. **The Commission recommends that the Federal Government, in conjunction with the provinces and local community representatives, take**

steps to decentralize the mechanisms of funding and evaluation of the innovative services, and that the regional structures be given real powers of decision.

5. It is imperative that government agencies involved in innovative service funding develop better criteria for evaluation, and that they do so in consultation with the innovative service staffs. As we have already suggested, project plans submitted for approval should necessarily include an outline of the innovators' own standards of evaluation so that the criteria established may relate accurately to the service's own predetermined goals. Moreover, it should be possible to construct relatively simple evaluation techniques and guidelines that would not intrude on the operation of the services or undermine their originality. Wherever feasible, the innovative service staff and clientele should be involved in the evaluation process.

6. Demonstration projects sponsored by the Federal Government or the provincial governments should be able to provide for capital expenditures in their budgets as well as operating expenses. At present only the latter are allowed.

7. Under present regulations, demonstration projects are subject to annual review and cannot in any event receive federal grants for more than three years. The Commission recommends that these projects receive annual grants on a predetermined decreasing scale, the decrease to begin the second year of operation provided that other sources of support become available by that time. Such measures would only be feasible if the Federal Government were to work out some form of cost-sharing arrangement and mutually acceptable scale of priorities with authorized provincial government representatives.

8. Government bodies engaged in funding "free clinics" should be sensitive to the fact that these experimental services, which often are and should be critical of conventional medical institutions, have a special need to remain relatively independent in the conduct of their operations.

9. Hospitals should seriously consider implementing projects of the type we have described involving the incorporation of youth workers in hospital teams, in order to maximize their ability to adequately serve the whole population.

10. As the drug crisis intervention and drug information roles of innovative services are absorbed by larger institutions, the youth-operated services should increase their efforts to develop other forms of community, recreational, vocational, social and self-help programs.

11. Community colleges and schools of social work should continue and expand upon the practice of using innovative services for in-service training, where this is consistent with their projects' goals and needs. Services performed at crisis centres, street clinics and therapeutic com-

munes and communities should be, where appropriate, accreditable at institutions that grant degrees and diplomas in these aspects of social work.

12. **In evaluating the innovative services, the Federal Government, its regional representatives, provincial government representatives and local bodies should give particular attention to the quality of client participation in the operation of the services.** The innovative services can and should play a role in mitigating the feelings of alienation, socio-political disaffection and powerlessness that have contributed to the non-medical use of drugs. This role they can only perform by remaining faithful to the principles and goals that brought them into being. **The five evaluative critera outlined above should be regarded as among the most important factors to consider in the evaluation of the services.** Originality and realism of inspiration; the quality of client participation in decision-making and freedom from routinization; a capacity for self-evaluation; adaptability to the real needs of clients; a capacity for working with the community's other services: these, in our opinion, are among the most vital indicators of their worth. At the same time the personnel engaged in these services must face squarely and accept their own limitations and not strive to function beyond their capacities. They have chosen to intervene actively and purposively in the lives of others. They must show a willingness to acquire the full expertise necessary to perform their task with responsibility and competence. Care must also be taken to ensure that these services do not become centres of alienation feeding on, and at the same time reinforcing, the alienation of their clients.

Appendix M

NOTES

1. Canada, House of Commons Debates, January 27, 1971, 115(63): 2801.
2. Canada, Department of National Health and Welfare. *Agency Catalogue* No. 1, 1972. A second edition of this catalogue is expected in the late summer of 1973.
3. Canadian Hospital Association. Resolutions tabled at the Canadian Hospital Association Conference, Montreal, February, 1971.
4. Youth worker projects have also been established at the Jewish General Hospital and the Lakeshore General Hospital in Montreal. In addition, an independent clinic, Youth Clinical Services, is associated with the York-Finch Hospital, Toronto.
5. Some examples: Montreal Youth Clinic, People's Free Clinic of Cote St. Luc (Montreal), Toronto Free Clinic, Scarboro Medifree, Rochdale Klinic (Toronto), Ottawa Street Clinic, Clinic Collective (London), Medifree Project (Kitchener), Klinic (Winnipeg), Vancouver Free Clinic.
6. Canadian Medical Association, Council on Community Health Care. Report to C.M.A. Board of Directors. Ottawa, March 14, 1971.
7. For example, Montreal Youth Clinic is an official extension of Meque Teaching Hospital.
8. Some examples: Dirnan (Halifax), Head and Hands (Montreal), Oolagen House (Toronto), Kiazam (Winnipeg).
9. Some examples of rural communes organized for therapeutic purposes: "New Options" near Halifax, Nova Scotia; "Aware House" near St. John, New Brunswick; "Crossroads" near Windsor, Ontario; "Get Your Act Together Enterprises", a Local Initiatives Project near Ottawa; "La Terre" at Wotton, Quebec.
10. *Criminal Code*, Sections 249 and 250.
11. R.S.C. 1970, c. J-3, s. 34.
12. In *Johnston v. The Wellesley Hospital and Willliams* [1971] 2. O.R. 104, [1971] 17 D.L.R. 3d 139, it was held that a twenty year old youth could give a valid consent to a course of medical treatment. The inference from the approach in this decision would appear to be that it is a question of fact in each case whether there has been a valid consent by the minor. This approach has been referred to as that of the "mature minor." For recent discussions of consent to the medical treatment of minors see Eekelaar, J. M., "What are Parental Rights," (1973) 89 L.Q.R. 210 at 224ff, and Waddington, W., "Minors and Health Care: The Age of Consent," (1973) 11 O.H.L.J. 115.
13. 1972 Stat. Que., c. 42, s. 36.
14. Many "paramedical" staff members of innovative services want eventually to enter medicine in paraprofessional or professional roles. The director of the Ottawa Street Clinic has suggested a "medical indenturing" system whereby clinic personnel could attend medical school part time, while being credited for clinic work.
15. Particularly Opportunities for Youth and Local Initiatives.

Appendix N

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Suprenant, J. R. G.
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Appendix P

Organizations and Individuals Who Presented Submissions to the Commission

ORGANIZATIONS

Abbotsford Ministerial Association, Abbotsford, British Columbia.

Activator Society of British Columbia, Vancouver, British Columbia.

Addiction Research Foundation, Toronto, Ontario.

Alberta Association of Students, Edmonton, Alberta.

Alberta Department of Education, Edmonton, Alberta.

Alberta Pharmaceutical Association, Edmonton, Alberta.

Alcohol and Drug Concerns Inc., Toronto, Ontario.

Alcohol-Drug Education Council, Vancouver, British Columbia.

Alcohol Education and Community Services Division, Department of Health and Welfare, Saint John, New Brunswick.

Alcohol Education Service, Winnipeg, Manitoba.

Alcoholics Anonymous, Temporary Central Office, Vancouver, British Columbia.

Alcoholism and Drug Addiction Foundation of Newfoundland, St. John's, Newfoundland.

Alcoholism Foundation of British Columbia, Vancouver, British Columbia.

Alcoholism Foundation of Manitoba, Winnipeg, Manitoba.

Alcoholism Foundation of Prince Edward Island, Charlottetown, Prince Edward Island.

Alcoholism Rehabilitation Centre, Saskatoon, Saskatchewan.

Alma Mater Society, University of British Columbia, Vancouver, British Columbia.

Association des parents catholiques du Québec, Racine, Quebec.

Association of Canadian Distillers, Montreal, Quebec.

Beta Hi-Y, c/o Y.M.C.A., Halifax, Nova Scotia.

Bible Holiness Mission, Vancouver, British Columbia.

B'Nai B'Rith Women, District 221, Montreal, Quebec.

Board of School Commissioners' Special Services Department, Halifax, Nova Scotia.

Boy Scouts of Canada, Kingston Branch, Kingston, Ontario.

British Columbia Parent-Teacher Federation, Vancouver, British Columbia.

British Columbia Pharmaceutical Association, Vancouver, British Columbia.

British Columbia Special Counsellors' Association, Vancouver, British Columbia.

British Columbia Voice of Women, Nanaimo, British Columbia.

Calgary Public School Board, Calgary, Alberta.

Canadian Association of Social Workers, Ottawa, Ontario.

Canadian Bar Association, Young Lawyers' Conference, Toronto, Ontario.

Canadian Barristers' Association, Alberta Division, Junior Bar Section, Calgary, Alberta.

Canadian Civil Liberties Association, New Brunswick Chapter, Fredericton, New Brunswick.

Canadian Council of Young Drivers, Toronto, Ontario.

Canadian Criminology and Corrections' Associations, Ottawa, Ontario.

Canadian Federation on Alcohol Problems, Toronto, Ontario.

Canadian Home & School & Parent-Teacher Federation, Drug Education Committee, Toronto, Ontario.

Canadian Labour Congress, Ottawa, Ontario.

Canadian League of Rights, British Columbia Branch, Vancouver, British Columbia.

Canadian Medical Association, Ottawa, Ontario.

Canadian Mental Health Association, Ottawa, Ontario.

Canadian Mental Health Association, British Columbia Division, Vancouver, British Columbia.

Canadian Peace Research Institute, Oakville, Ontario.

Canadian Pharmaceutical Association, Toronto, Ontario.

Canadian Psychiatric Association, Ottawa, Ontario.

Canadian Rehabilitation Association, Ottawa, Ontario.

Canadian Student Liberals, Toronto, Ontario.

Canadian Welfare Council, Montreal, Quebec.

Catholic School Commission of Montreal, English Section, Montreal, Quebec.

CEGEP de Sherbrooke, services aux étudiants, Sherbrooke, Quebec.

Centre d'accueil pour alcooliques et autres toxicomanes, Shawinigan, Quebec.

Centre d'orientation, Montreal, Quebec.

Charlottetown Inter-Faith Group and The Priests' Senate of the Diocese of Charlottetown, Charlottetown, Prince Edward Island.

Charlottetown Jaycees, Charlottetown, Prince Edward Island.

Charlottetown Public School Board, Superintendent of Schools, Charlottetown, Prince Edward Island.

Charlottetown School Principals, Superintendent of Schools, Charlottetown, Prince Edward Island.

Children's Aid Society, Vancouver, British Columbia.

Christian Reformed Church Ladies Society, Ottawa, Ontario.

Church of Jesus Christ Latter-Day Saints, Etobicoke, Ontario.

City of Niagara Falls, Niagara Falls, Ontario.

City of Vancouver, Vancouver, British Columbia.

City of Windsor, Civic Committee on Drugs, Windsor, Ontario.

Civil Liberties Association of British Columbia, Vancouver, British Columbia.

Clinique de l'enfant et de la famille, Montreal, Quebec.

Clinique de réadaptation pour alcooliques, Pointe-du-Lac, Quebec.

CODA Inter-Service Club Council, Kingston, Ontario.

College of Physicians and Surgeons of British Columbia, Vancouver, British Columbia.

Collège des pharmaciens de la province de Québec, Montreal, Quebec.

Comité conjoint, Alerte à la drogue, Three Rivers, Quebec.

Committee on the Misuse of Drugs and Narcotics, Human Resources Development Authority, Edmonton, Alberta.

Committee Representing Youth Problems of Today (CRYPT), Winnipeg, Manitoba.

Community Services Organization, St. Paul's Avenue Road United Church, Toronto, Ontario.

Community Welfare Planning Council, Winnipeg, Manitoba.

Council on Drug Abuse, Toronto, Ontario.

Crisis Centre & House of Dawn Hostel, Regina, Saskatchewan.

Dames Champlain, Habitation Marguerite d'Youville, Fort-Coulonge, Quebec.

Dawson College, Westmount, Quebec.

Department of the Attorney General, Province of Prince Edward Island, Charlottetown, Prince Edward Island.

Department of Education, Province of Nova Scotia, Halifax, Nova Scotia.

Department of Education and Justice, Province of Prince Edward Island, Charlottetown, Prince Edward Island.

Department of Education, Province of Alberta, Edmonton, Alberta.

Département de Pharmacologie, Université Laval, Quebec, Quebec.

Department of Public Welfare, Halifax, Nova Scotia.

Department of the Solicitor General of Canada, Ottawa, Ontario.

Drop-In Centre, Thunder Bay, Ontario.

Drug Advisory Council, University of Calgary, Calgary, Alberta.

Drug Aid, Montreal, Quebec.

Drug Alert Committee, Edmonton, Alberta.

Drug Habituation Committee, British Columbia Medical Association, Vancouver, British Columbia.

Drug Information Centre, Calgary, Alberta.

Drug Information Centre, Thunder Bay, Ontario.

Drug Sub Committee, Policy Committee of the Toronto and District Liberal Association, Toronto, Ontario.

Dufferin-Peel County Roman Catholic Separate School Board, Dufferin-Peel County, Ontario.

Eastview Secondary School, Business Education Department, Barrie, Ontario.

Edmonton & District Council of Churches, Social Action Committee, Edmonton, Alberta.

Edmonton Public School Board, Edmonton, Alberta.

Elizabeth Fry Society, Kingston, Ontario.

Elizabeth Fry Society, Toronto Branch, Toronto, Ontario.

Elizabeth Fry Society of British Columbia, Social Action Committee, Vancouver, British Columbia.

Environmental Health Laboratory, Winnipeg, Manitoba.

Federated Women's Institutes of Canada, Tupperville, Nova Scotia.

Fédération des Unions des Familles Inc., Montreal, Quebec.

First Portsmouth (Kingston, Ontario) Cub and Scout Group, Kingston, Ontario.

First United Church, Port Alberni, British Columbia.

Fortune Society of Canada, Winnipeg Branch, Winnipeg, Manitoba.

Greater Kamloops Chamber of Commerce, Kamloops, British Columbia.

Greater Moncton Committee on Non-Medical Use of Drugs, Moncton, New Brunswick.

Greater Vancouver Youth Communications Centre, (Cool-Aid), Vancouver, British Columbia.

Greater Victoria Association on Alcoholism, Victoria, British Columbia.

Greater Victoria School Board, Special Educational Services, Victoria, British Columbia.

Group (The), Saint John, New Brunswick.

Halifax Youth Communications Clinic, Halifax, Nova Scotia.

Halifax Youth Communications Society, Scotia Square, Halifax, Nova Scotia.

Hamilton Academy of Medicine, Hamilton, Ontario.

Hamilton Conference of the United Church of Canada, Kitchener, Ontario.

Hamilton Local Council of Women, Hamilton, Ontario.

Hamilton Presbyterian United Church Women, Hamilton, Ontario.

Heads & Hands, Montreal, Quebec.

Hoffman-LaRoche Ltd., Montreal, Quebec.

Hope Reformed Church, Vancouver, British Columbia.

Howe Sound Citizens' Committee, Squamish, British Columbia.

Humanist Association of Canada, Montreal, Quebec.

Humanist Association of Ottawa, Ottawa, Ontario.

Information Troupe, Toronto, Ontario.

Institut de cardiologie de Québec, Université Laval, Quebec, Quebec.

Interdepartmental Committee on Drug Abuse of the Province of New Brunswick, Fredericton, New Brunswick.

Inter Service Club Council, Kiwanis Club of Kingston, Operation Drug Alert, Kingston, Ontario.

Jaycettes, Delta, British Columbia.

Jeune Chambre de Trois-Rivières Inc., Three Rivers, Quebec.

Jewish Family and Child Service of Metropolitan Toronto, Trailer Project, Toronto, Ontario.

Jewish General Hospital, Institute for Family and Community, Department of Psychiatry, Montreal, Quebec.

John Howard Society of Ontario, Toronto, Ontario.

John Howard Society of British Columbia, Vancouver, British Columbia.

Kangaroo Court, Willowdale, Ontario.

Kiwanis Club of Edmonton, Edmonton, Alberta.

Kiwanis Club of Lake St. Louis, Montreal, Quebec.

Kiwanis Club of Stamford Inc., Operation Drug Alert Programme, Niagara Falls, Ontario.

Kiwanis Ontario-Quebec-Maritime (and Carribean) District, Casa Loma, Toronto, Ontario.

Knights of Columbus, Charlottetown Council No. 824, Charlottetown, Prince Edward Island.

Knox United Church, Agincourt, Ontario.

Knox-Metropolitan United Church Women, Regina, Saskatchewan.

Law Students' Association, Faculty of Law, University of British Columbia, Vancouver, British Columbia.

Legalize Marihuana Committee, London, Ontario.

Local Council of Women of Toronto, Willowdale, Ontario.

London Board of Education, Research Division, London, Ontario.

Manitoba Association for Children with Learning Disabilities, Winnipeg, Manitoba.

Manitoba Medical Association, Committee on Drug Abuse, Winnipeg, Manitoba.

Manitoba Psychiatric Association, Winnipeg, Manitoba.

Mayor's Committee on Youth, Ottawa, Ontario.

McGill University Health Service, Montreal, Quebec.

Memorial University, Students' Union, Committee on Drugs, St. John's, Newfoundland.

Mental Health Clinic, Saint John West, New Brunswick.

Merri-Go-Round, Youth Group, Halifax, Nova Scotia.

Mississauga St. Patrick's Catholic Women's League, Mississauga, Ontario.

Mississauga University Women's Club, Mississauga, Ontario.

Montreal Police Department, Youth Division, Montreal, Quebec.

Montreal YMCA, Montreal, Quebec.

Moose Jaw Council of Women, Moose Jaw, Saskatchewan.

Mouvement des femmes chrétiennes, paroisse Ste-Famille, Sherbrooke, Quebec.

Municipality of the District of Digby, Digby, Nova Scotia.

Mysterious East, Fredericton, New Brunswick.

Nanaimo Youth Crisis Centre, Nanaimo, British Columbia.

Narcotic Addiction Foundation of British Columbia, Vancouver, British Columbia.

National Council of Jewish Women of Canada, Vancouver, British Columbia.

National Council of Women of Canada, Ottawa, Ontario.

National Film Board, Ottawa, Ontario.

National Parent-Youth Alert Inc., Ottawa, Ontario.

New Brunswick Federation on Alcohol Drug Problems, McAdam, New Brunswick.

New Brunswick Pharmaceutical Association, Drug Abuse Program, Rothesay, New Brunswick.

New Brunswick Teachers' Association, Fredericton, New Brunswick.

New Glasgow United Church Women, Charlottetown, Prince Edward Island.

Newfoundland Medical Association, St. John's, Newfoundland.

Newfoundland Pharmaceutical Association, St. John's, Newfoundland.

Newfoundland Teachers' Association, St. John's, Newfoundland.

North Shore Unitarian Church, Social Action Committee, North Vancouver, British Columbia.

North Toronto Youth Project, Toronto, Ontario.

Northland Presbytery, Manitoba Conference, United Church of Canada, Lynn Lake, Manitoba.

Nova Scotia Federation of Home and School Associations, Truro, Nova Scotia.

Nova Scotia Task Force on the Non-Medical Use of Drugs, Halifax, Nova Scotia.

Office de la prévention et de traitement de l'alcoolisme et des autres toxicomanies (OPTAT), Quebec, Quebec.

Ontario Department of Education, Toronto, Ontario.

Ontario Federation of Home and School Associations, Ottawa, Ontario.

Ontario Medical Association, Toronto, Ontario.

Ontario Progressive Conservative Student Association, Toronto, Ontario.

Operation Crime Check, Montreal, Quebec.

Ottawa-Carleton Committee on Drug Abuse, Ottawa Board of Education, Ottawa, Ontario.

Ottawa Roman Catholic Separate School Board, Ottawa, Ontario.

Ottawa United Church Women, Ottawa, Ontario.

Oxford Presbytery (Ontario), United Church of Canada, Toronto, Ontario.

Parents Anonymous of British Columbia.

Parents Anonymous of Vancouver, North Vancouver, British Columbia.

Parents of Drug Abusers, Kingston, Ontario.

Peel County Task Force on Drugs, Cooksville, Ontario.

Peel County Task Force on Drugs, Port Credit, Ontario.

People's Youth Clinic, Montreal, Quebec.

Penny Farthing Victorian Coffee House, Toronto, Ontario.

Penticton Parents Anonymous, Vancouver, British Columbia.

Pharmaceutical Manufacturers Association of Canada, Ottawa, Ontario.

Premier's Task Force, Charlottetown, Prince Edward Island.

Presbyterian Church in Canada, Board of Evangelism and Social Action, Don Mills, Ontario.

Prescription Services Incorporated, Windsor, Ontario.

Primrose Conservative League of British Columbia, Vancouver, British Columbia.

Prince Edward Island Department of Education and Justice, Charlottetown, Prince Edward Island.

Prince Edward Island Federation of Home & School Associations, Charlottetown, Prince Edward Island.

Prince Edward Island Federation of Labour, Charlottetown, Prince Edward Island.

Prince Edward Island Nurses Association, Charlottetown, Prince Edward Island.

Probation Officers' Association of Ontario, Toronto, Ontario.

Protestant School Board of Greater Montreal, Montreal, Quebec.

Provincial Council of Women of British Columbia, Vancouver, British Columbia.

Provincial Council of Women of British Columbia, Vancouver, British Columbia.

Provincial Council of Women of Edmonton, Alberta.

Provincial Council of Women of Ontario, Toronto, Ontario.

Quakers (Western Half Yearly Meeting of Friends), Argenta, British Columbia.

Quebec Federal Liberal Association, Policy Commission, Beaconsfield, Quebec.

Radicals for Capitalism, Toronto, Ontario.

Regina Board of Education, Regina, Saskatchewan.

Regina Special Committee on New Approaches to Drug Abuse, Regina, Saskatchewan.

Riverside United Church, Ottawa, Ontario.

Rochdale College, Board of Directors, Toronto, Ontario.

Royal Canadian Mounted Police, Ottawa, Ontario.

St. Andrew's River Heights, United Church of Canada, Winnipeg, Manitoba.

St. Andrew's United Church Women, Edmonton, Alberta.

Saint John District Council of Home and School Associations, Saint John, New Brunswick.

Saint John Medical Society, Saint John, New Brunswick.

Saint John School Board, Saint John, New Brunswick.

Saint Lawrence College, Quebec, Quebec.

Saint Thomas University, Students' Council, Fredericton, New Brunswick.

Salvation Army, Toronto, Ontario.

Sargeant Park Home and School Association, Winnipeg, Manitoba.

Saskatchewan Association of Social Workers, Saskatoon, Saskatchewan.

Saskatchewan, the Department of Attorney General, Regina, Saskatchewan.

Saskatchewan Federation of Home and School Associations, Regina, Saskatchewan.

Saskatchewan Hospital, North Battleford, Saskatchewan.

Saskatchewan Hospital Auxiliaries Association, Shellbrook, Saskatchewan.

Saskatchewan Province, Regina, Saskatchewan.

Saskatchewan Provincial Council of Women, Regina, Saskatchewan.

Scarborough Don Mills Inter Church Committee on Drug Abuse, Scarborough, Ontario.

School of Social Work, University of Windsor, Windsor, Ontario.

Social Action Committee, First Baptist Church, Edmonton, Alberta.

Social Planning Council of Metropolitan Toronto, Toronto, Ontario.

Social Workers of the Mauricie Region, La Tuque, Quebec.

South Shore Protestant Regional School Board, St. Lambert, Quebec.

Spera Foundation, Rawdon, Quebec.

Squamish District Council, District of Squamish, City Hall, Squamish, British Columbia.

Students' Council of Carleton University, Ottawa, Ontario.

Student Counselling Services, University of Alberta, Edmonton, Alberta.

Students' Union, University of Saskatchewan, Regina, Saskatchewan.

Study of Non-Medical Use of Drugs Committee, Hamilton and District Council of Women, Hamilton, Ontario.

Sudbury Y.M.C.A., Sudbury, Ontario.

Sûreté municipale de la Ville de Montréal, Montreal, Quebec.

Swift Current Local Council of Women, Swift Current, Saskatchewan.

Swift Current Ministerial Association, Swift Current, Saskatchewan.

Tell-It-As-It-Is, Board of Directors, Montreal, Quebec.

Temple Rodeph Shalom, Social Concern Committee, Montreal, Quebec.

Thirteenth Floor Cooperative, Community for Participants of the Utopian Research Institute, Rochdale College, Toronto, Ontario.

Thomas Merton Clinic, Magog, Quebec.

Toc Alpha, Don Mills, Ontario.

Toronto Board of Education, Toronto, Ontario.

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Toronto & District Liberal Association, Toronto, Ontario.

Toronto Free Youth Clinic, Toronto, Ontario.

Toronto Stake of the Church of Jesus Christ of Latter-Day Saints, Etobicoke, Ontario.

Trust, Edmonton Youth Emergency Society, Edmonton, Alberta.

Unitarian Service Commission, Charlottetown, Prince Edward Island.

United Church of Canada, Board of Evangelism and Social Service, Toronto, Ontario.

United Nations Association, Montreal, Quebec.

University Chaplain's Association, University of Calgary, Calgary, Alberta.

University Women's Club of North York, Toronto, Ontario.

University Women's Club, Victoria, British Columbia.

Vancouver Board of Trade, Vancouver, British Columbia.

Vancouver City Police Department, Vancouver, British Columbia.

Vancouver District Women's Christian Temperance Union, Vancouver, British Columbia.

Vancouver Inner-City Service Project, Vancouver, British Columbia.

Vancouver Jaycettes, Vancouver, British Columbia.

Victoria Voice of Women, Victoria, British Columbia.

Victoria Free Clinic, Victoria, British Columbia.

Victoria Youth Council, Victoria, British Columbia.

Wesleyan Methodist Church of America in Canada, Trenton, Ontario.

West Island Social Action Committee, Youth Clinic, Montreal, Quebec.

West Point Grey Liberal Policy Committee, Quadra Constituency Association, Vancouver, British Columbia.

Windsor Civic Committee on Drugs, Windsor, Ontario.

Women's Christian Temperance Union of British Columbia, Victoria, British Columbia.

Women's Christian Temperance Union, Winnipeg, Manitoba.

Women's Institute of Prince Edward Island, Charlottetown, Prince Edward Island.

X-Kalay Foundation Society, Vancouver, British Columbia.

Young Lawyers' Conference of the Alberta Section of the Canadian Bar Association, Calgary, Alberta.

Young Men's Christian Association, Halifax, Nova Scotia.

Young Men's Christian Association, Committee on Youthful Drug Use, Hamilton, Ontario.

Young Men's Christian Association, Board of Directors, Montreal, Quebec.

YM-YWCA Drop-In Centre, Ottawa, Ontario.

Young Women's Christian Association of Canada, Toronto, Ontario.

INDIVIDUALS

Aimers, Mr. John L., Young Progressive Conservatives of Canada, Montreal, Quebec.

Aldous, Dr. J. G., Dalhousie University, Halifax, Nova Scotia.

Amaron, Mr. Robert, Renfrew, Ontario.

Anderson, Dr. R. L., University of Alberta, Edmonton, Alberta.

Arehson, Mr. Kenneth, Winnipeg, Manitoba.

Asselstine, Mrs. Asta, Winnipeg, Manitoba.

Assimi, Dr. A., Lakehead University, Thunder Bay, Ontario.

Astin, Mrs. M., New Westminster, British Columbia.

Banik, Dr. Sambhu N., University Hospital, Saskatoon, Saskatchewan.

Banville, Mr. R., Sept-Îles, Quebec.

Barclay, Mr. J. F., University of Alberta, Edmonton, Alberta.

Baron, Mr. Jonathan, McMaster University, Hamilton, Ontario.

Barootes, Dr. E. W., Regina, Saskatchewan.

Beach, Dr. Horace D., Dalhousie University, Halifax, Nova Scotia.

Beaulieu, Professor Claude, University of Quebec, Montreal, Quebec.

Bennett, Mr. Peter, Alcoholism Committee of Saskatchewan, Regina, Saskatchewan.

Bennett, Mr. Wayne, Regina, Saskatchewan.

Bertrand, Lieut. Elzear, Police Department, Quebec, Quebec.

Blewett, Dr. Duncan, Regina, Saskatchewan.

Boddie, Dr. Charles, Memorial University of Newfoundland, St. John's, Newfoundland.

Boden, Reverend Robert, Church of the Nazarene, Fredericton, New Brunswick.

Boyce, Dr. Murray, University of Western Ontario, London, Ontario.

Brady, Mr. John, University of Western Ontario, London, Ontario.

Brand, Mr. Robert H., Burlington, Ontario.

Briggs, Dr. Robert, Queen's University, Kingston, Ontario.

Bruce, Mr. R., Guidance Specialist, Scarborough, Ontario.

Buckner, Professor T., Sir George Williams University, Montreal, Quebec.

Burditt, Dr. A. M., Saint John, New Brunswick.

Burke, Dr. H. C., Mount Allison University, Sackville, New Brunswick.

Burton, Rev. A. J., Edith Ave. United Baptist Church, Saint John, New Brunswick.

Butler, Mr. Phillip, Vancouver, British Columbia.

Campbell, Mr. Brian, Vancouver, British Columbia.

Cargo, Mr. John, McMaster University, Hamilton, Ontario.

Caron, Mr. Fernand, University of Quebec, Three Rivers, Quebec.

Carter, Dr. Robert E., Sir George Williams University, Montreal, Quebec

Cathcart, Dr. L. M., University of British Columbia, Vancouver, British Columbia.

Cashen, Mrs. M. I., Ottawa, Ontario.

Cayouette, Mr. Richard, Ministère de l'Agriculture et de la Colonisation, Quebec, Quebec.

Chalmers, Mr. N. A., Q.C., Department of Justice of Canada, Toronto, Ontario.

Chapman, Mr. Bruce, Mount Allison University, Sackville, New Brunswick.

Chiles, Mr. Vernon K., Sarnia Pharmacy, Sarnia, Ontario.

Christie, Miss Norma, Q.C., Department of Justice of Canada, Vancouver, British Columbia.

Christopherson, Mr. C. J., Vancouver, British Columbia.

Clarkson, Mr. Reginald, Victoria, British Columbia.

Clarkson, Professor Stephen, University of Toronto, Toronto, Ontario.

Clement, Mr. Wilfrid C., Toronto, Ontario.

Cloud, Professor Jonathan, York University, Downsview, Ontario.

Cody, Mr. Howard, Vancouver, British Columbia.

Cohen, Dr. M., Children's Hospital, Buffalo, New York.

Cohen, Dr. S., Regina, Saskatchewan.

Colby, Mr. Dennis, Toronto, Ontario.

Cook, Dr. David, University of Alberta, Edmonton, Alberta.

Cook, Mrs. Shirley J., University of Toronto, Toronto, Ontario.

Copley, Mr. D. R., Markham, Ontario.

Corey, Dr. Margaret, Dalhousie University, Halifax, Nova Scotia.

Cornil, Professor Paul, University of Montreal, Montreal, Quebec.

Could, Miss Rebecca, Sackville High School, Sackville, New Brunswick.

Coulombe, Mr. Roland, Montreal, Quebec.

Craig, Dr. David, Edmonton, Alberta.

Crawford, Mr. Brian, Sackville, New Brunswick.

Cundill, Mr. G., Calgary, Alberta.

Cunningham, Mr. Kenneth, Confederation College, Thunder Bay, Ontario.

Danis, Mr. Armand, Westgate High School, Thunder Bay, Ontario.

Davidson, Mr. Robert, University of Alberta, Edmonton, Alberta.

Decarie, Professor M. G., University of Prince Edward Island, Charlottetown, Prince Edward Island.

Delaney, Dr. J. A., City Coroner, Fredericton, New Brunswick.

Dessureault, Professor Jacques, University of Quebec, Three Rivers, Quebec.

Devlin, Mr. Terry, Vancouver, British Columbia.

Donovan, Mr. Greg, Nova Scotia Youth Agency, Halifax, Nova Scotia.

Douyon, Professor Emerson, University of Montreal, Montreal, Quebec.

Dunlop, Mr. Michael, Vancouver, British Columbia.

Dunsworth, Dr. F. A., Halifax, Nova Scotia.

Ellenberger, Dr. Henri F., University of Montreal, Montreal, Quebec.

Evans, Mrs. Phyllis, Rexdale, Ontario.

Falardeau, Professor Jacques, University of Quebec, Three Rivers, Quebec.

Fattah, Professor M. E., University of Montreal, Montreal, Quebec.

Faulkner, Mr. John, Edmonton, Alberta.

Fenske, Reverend T., Department of National Defence, Halifax, Nova Scotia.

Flight, Mr. Harvey, St. John's, Newfoundland.

Floyd, Mr. and Mrs. Stan, University of British Columbia, Vancouver, British Columbia.

Forestell, Mr. Francis, Department of Justice, Fredericton, New Brunswick.

Foulks, Dr. James G., University of British Columbia, Vancouver, British Columbia.

Fowells, Mr. Gavin, Ottawa, Ontario.

Frank, Dr. George B., University of Alberta, Edmonton, Alberta.

Freedman, Mr. Bernard, Saint John, New Brunswick.

Gagné, Mr. Denis, University of Montreal, Montreal, Quebec.

Gagnon, Mr. Claude, Institute of Medieval Studies, University of Montreal, Montreal, Quebec.

Gander, Mrs. Lea, Ottawa, Ontario.

Gaussiran, Mr. Michel, University of Montreal, Montreal, Quebec.

Ghan, Mr. Leonard, Regina, Saskatchewan.

Gibseghen, Mr. Hubert, Centre d'orientation, Montreal, Quebec.

Golden, Mr. Allan, Windsor, Ontario.

Gordon, Mr. John M., Peterborough, Ontario.

Grant, Dr. Sydney, Fredericton, New Brunswick.

Green, Mr. B., Toronto, Ontario.

Grindstaff, Mr. Carl, University of Western Ontario, London, Ontario.

Grossman, Professor Brian, McGill University, Montreal, Quebec.

Gurevich, Mr. Howard, Winnipeg, Manitoba.

Gustin, Dr. Ann, University of Saskatchewan, Regina, Saskatchewan.

Hagen, Dr. Derek L., Fredericton, New Brunswick.

Hall, Miss Dorothy, Vancouver, British Columbia.

Hansen, Dr. E. S., Acadia University, Wolfville, Nova Scotia.

Hastie, Mr. J., Willowdale, Ontario.

Hatfield, Mr. Richard, Fredericton, New Brunswick.

Hawboldt, Mrs. L. S., Halifax, Nova Scotia.

Henderson, Mr. Harry, Charlottetown, Prince Edward Island.

Henley, Mr. Steve, St. John's, Newfoundland.

Herren, Dr. Steven, University of Saskatchewan, Regina, Saskatchewan.

Hill, Mr. Terry, Toronto, Ontario.

Hill, Mr. J., Vancouver, British Columbia.

Hoffer, Dr. A., Saskatoon, Saskatchewan.

Holland, Reverend D., Gonzaga High School, St. John's, Newfoundland.

Hoskin, Mr. H. F., Vancouver, British Columbia.

Howell, Mrs. Sheila, Kingston, Ontario.

Jamha, Mr. Roy, Edmonton, Alberta.

Jamieson, Dr. W. R. E., Fredericton, New Brunswick.

Jobson, Mr. K. B., Dalhousie University, Halifax, Nova Scotia.

Jones, Mr. R. C., Department of Social Development, Edmonton, Alberta.

Julien, Professor M., University of Alberta, Edmonton, Alberta.

Kirkham, Mr. Tim, Penticton, British Columbia.

Kitz, Mr. Leonard, Q.C., Halifax, Nova Scotia.

Kositsky, Mr. J., Winnipeg, Manitoba.

Kuropatwa, Mr. Ralph, Winnipeg, Manitoba

Kushner, Dr. Wilkie, Halifax, Nova Scotia.

Lake, Mr. B. U., Ottawa, Ontario.

Lalonde, Dr. Pierre, University of Montreal, Montreal, Quebec.

Lambert, Mr. Dave, Fredericton, New Brunswick.

Lamrock, Mr. Leonard, Mount Allison University, Sackville, New Brunswick.

Landry, Mr. L. P., Q.C., Department of Justice, Montreal, Quebec.

Languirand, Mr. Jacques, Westmount, Quebec.

LaPointe, Mr. John, Toronto, Ontario.

Lapointe-Michaud, Mrs. Blanche, Ottawa, Ontario.

Laud, Mr. J. H., Vancouver, British Columbia.

Laverty, Professor S. G., Queen's University, Kingston, Ontario.

LeBel, Mr. Bernard, University of Montreal, Montreal, Quebec.

LeBlanc, Dr. J., Clinique de réadaptation pour alcooliques, Pointe-du-Lac, Quebec.

Lee, Mr. Terry, McMaster University, Hamilton, Ontario.

Leon, Dr. Wolf, Provincial Department of Health, Charlottetown, Prince Edward Island.

Leslie, Mr. David F., Vancouver, British Columbia.

Levesque, Mrs. Blandine, Hôpital du Christ-Roi, Quebec, Quebec.

Levin, Mr. George, Mount Allison University, Sackville, New Brunswick.

Levine, Dr. Saul, Hospital for Sick Children, Toronto, Ontario.

Lewis, Mr. W. G., Harrow, Ontario.

Linde, Mr. Gary, University of British Columbia, Vancouver, British Columbia.

Ling, Dr. George, University of Ottawa, Ottawa, Ontario.

Lorimer, Mr. R. M., Simon Fraser University, Burnaby, British Columbia.

Love, Mr. D., Calgary, Alberta.

Low, Professor Kenneth, Calgary, Alberta.

Luka, Mr. Leslie B., Don Mills Collegiate Institute, Don Mills, Ontario.

Lundell, Dr. F. W., Montreal, Quebec.

Lynch, Mr. Thomas, London, Ontario.

Lyon, Mr. Israel, University of Manitoba, Winnipeg, Manitoba.

MacGill, Mr. Neil W., University of New Brunswick, Fredericton, New Brunswick.

MacKenzie, Professor K. R., University of Calgary, Calgary, Alberta.

MacLean, Reverend Ian, United Church of Canada, Fredericton, New Brunswick.

Macneill, Miss Isabel, Mill Village, Queen's County, Nova Scotia.

McAlister, Mr. Alexander, Toronto, Ontario.

McAmmond, Professor D., University of Calgary, Calgary, Alberta.

McBay, Mr. T. P., Vancouver, British Columbia.

McCuaig, Reverend Malcolm, Church of St. James, Charlottetown, Prince Edward Island.

McDonald, Dr. Angus, Clarke Institute of Psychiatry, Toronto, Ontario.

McDonald, Mr. Brian R., Edmonton, Alberta.

McDonald, Dr. Lynn, McMaster University, Hamilton, Ontario.

McGaw, Mr. David, Fredericton, New Brunswick.

McKillop, Mr. D. B., Thunder Bay, Ontario.

McLaughlin, Mr. Donald R., Montreal, Quebec.

McLeod, Miss Illette, Vancouver, British Columbia.

McLeod, Dr. Neil, Fort William Clinic, Thunder Bay, Ontario.

McRae, Mr. E. D., Vancouver, British Columbia.

McWhirter, Mr. K. G., Edmonton, Alberta.

Mahaffy, Mr. Bry David, Ottawa, Ontario.

Mahoney, Mr. Michael, Kingston, Ontario.

Malloy, Brother Kevin, Brother Rice High School, St. John's, Newfoundland.

Mansfield, Mr. N., Vancouver, British Columbia.

Marier, Professor Gérard, University of Quebec, Three Rivers, Quebec.

Martin, Dr. Douglas, Toronto, Ontario.

Mason, Mr. Ian, University of Toronto, Toronto, Ontario.

Mechoulam, Dr. Raphael, Hebrew University of Jerusalem, Israel.

Medill, Mr. James, Surrey, British Columbia.

Meehan, Mr. Michael R., District of Sudbury Federal Prosecutor, Sudbury, Ontario.

Milton, Mrs. P. B., Saint John, New Brunswick.

Mitchell, Mrs. Ellen, St. John Fisher Church CWL, Bramalea, Ontario.

Moghadam, Dr. Hossein K., University of Toronto, Toronto, Ontario.

Moore, Mrs. Gerald, Truro, Nova Scotia.

Morin, Dr. Yves, Institut de cardiologie du Québec, Quebec, Quebec.

Morley, Professor Gregory, University of Western Ontario, London, Ontario.

Morrison, Dr. William, University of Winnipeg, Winnipeg, Manitoba.

Morton, Dr. A., Nova Scotia Mental Hospital, Dartmouth, Nova Scotia.

Mouledoux, Professor Joseph, Sir George Williams University, Montreal, Quebec.

Mountenay, Dr. Donald, Regina, Saskatchewan.

Munro, Mr. Robert, London, Ontario.

Munroe, Miss I. A., University of Alberta, Edmonton, Alberta.

Murray, Mr. David, Stoney Creek, Ontario.

Naidu, Dr. S. B., University of Moncton, Moncton, New Brunswick.

Nash, Dr. John C., University of Waterloo, Waterloo, Ontario.

Neamta, Miss Gertrude, Montreal, Quebec.

Nelson, Mrs. Sally, Montreal, Quebec.

Nevin, Mr. W. H., North Vancouver, British Columbia.

Newton-Smith, Richard and Sheila, Windsor, Ontario.

Nicholson, Mr. Jack, Charlottetown, Prince Edward Island.

Nickerson, Dr. Mark, McGill University, Montreal, Quebec.

Nixon, Mr. Gary, Vancouver, British Columbia.

Norman, Mr. Charles, Winnipeg, Manitoba.

Ogden, Mr. Frank, Montreal, Quebec.

Olsson, Mrs. Staig, Saint John, New Brunswick.

Page, Mr. Harold J., Victoria, British Columbia.

Paterson, Mr. J. Craig, University of Western Ontario, London, Ontario.

Pearce, Dr. K. I., University of Calgary, Calgary, Alberta.

Pelletier, Mr. D., Montreal, Quebec.

Peltier, Mr. Louis L., Jr., Thunder Bay, Ontario.

Pendergast, Reverend Arthur J., Saint Lawrence College, Quebec, Quebec.

Penner, Professor Rolland, University of Manitoba, Winnipeg, Manitoba.

Peters, Mr. Kenneth Gordon, Education Resources Centre, Sudbury, Ontario.

Phillips, Mr. D. L., Victoria, British Columbia.

Pinard, Mr. Pierre, Three Rivers, Quebec.

Pitts, Reverend F. J. H., Christ Anglican Church, Kitchener, Ontario.

Poliquin, Mr. J. J., Three Rivers, Quebec.

Porter, Professor James, York University, Toronto, Ontario.

Potts, Mrs. Lynda, Windsor, Ontario.

Pownall, Mr. & Mrs. Steve, Windsor, Ontario.

Radouco-Thomas, Dr. C. and Dr. S., Laval University, Quebec, Quebec.

Rakoff, Dr. Vivian, Clarke Institute of Psychiatry, Toronto, Ontario.

Reed, Mr. Jerry, Vancouver, British Columbia.

Reich, Dr. Carl J., Calgary, Alberta.

Reiffenstein, Professor R. J., University of Alberta, Edmonton, Alberta.

Richardson, Dr. D. W., Queen's University, Kingston, Ontario.

Richmond, Dr. R. E. G., Department of the Attorney General, Vancouver, British Columbia.

Rittenhouse, Mr. J. E., Vancouver, British Columbia.

Robertson, Professor A. H., University of New Brunswick, Fredericton, New Brunswick.

Robins, Dr. Lee, Washington University, St. Louis, Missouri.

Roper, Dr. Peter, Montreal, Quebec.

Ross, Mr. Daniel, University of Western Ontario, London, Ontario.

Ross, Mr. Peter, Sherbrooke, Quebec.

Rothwell, Dr. A., Calgary, Alberta.

Roxburgh, Dr. P., University of Calgary, Calgary, Alberta.

Rush, Professor G. B., Simon Fraser University, Vancouver, British Columbia.

Rutman, Professor Leonard, University of Winnipeg, Winnipeg, Manitoba.

Ryan, Professor Stuart, Queen's University, Kingston, Ontario.

Samuels, Mr. Jeffrey, York University, Toronto, Ontario.

Saulnier, Mr. Maurice, Maisonneuve University, Montreal, Quebec.

Schafer, Mr. Reuben, Toronto, Ontario.

Schlegel, Assistant Professor R. P., University of Windsor, Windsor, Ontario.

Schumiatcher, Dr. Morris C., Q.C., Regina, Saskatchewan.

Schwartz, Dr. Conrad J., University of British Columbia, Vancouver, British Columbia.

Scott, Dr. George, Canadian Penitentiary Service, Kingston, Ontario.

Segal, Dr. Mark, Dalhousie University, Halifax, Nova Scotia.

Sharpe, Mr. Robin, Vancouver, British Columbia.

Shaw, Mrs. Ellen, Richmond, British Columbia.

Shragge, Mr. Sherve, Regina, Saskatchewan.

Shuster, Mr. Bernard, Montreal, Quebec.

Siegel, Dr. Ronald K., Dalhousie University, Halifax, Nova Scotia.

Silverman, Dr. Saul, Prince Edward Island University, Charlottetown, Prince Edward Island.

Simms, Mr. Thomas M., Saint Thomas University, Fredericton, New Brunswick.

Simons, Mr. Sidney, Q.C., Vancouver, British Columbia.

Skirrow, Professor J., University of Calgary, Calgary, Alberta.

Slaughnwhite, Mr. Bradley, Sackville High School, Sackville, Nova Scotia.

Smith, Mr. G. Brian, Sackville, New Brunswick.

Solomon, Professor David, York University, Toronto, Ontario.

Solursh, Dr. L. P., Toronto General Hospital, Toronto, Ontario.

Solway, Mr. Jeff, Downsview, Ontario.

Spector, Dr. Malcolm, McGill University, Montreal, Quebec.

Spellman, Dr. J. W., University of Windsor, Windsor, Ontario.

Stein, Mr. Allan, Spruce Grove, Alberta.

Stein, Dr. Samuel, Jewish General Hospital, Montreal, Quebec.

Steinhart, Mr. James, Ottawa, Ontario.

Stennet, Mr. R. G., Addiction Research Foundation, London, Ontario.

Suthers, Mr. D., Burlington, Ontario.

Suzuki, Dr. D., University of British Columbia, Vancouver, British Columbia.

Szabo, Dr. Denis, University of Montreal, Montreal, Quebec.

Taylor, Mr. G., Calgary, Alberta.

Therien, Mr. Marcel M., Three Rivers, Quebec.

Thompson, Mr. Lloyd, Saskatoon, Saskatchewan.

Thurlow, Dr. John, University of Western Ontario, London, Ontario.

Timovrian, Mr. J. G., University of Alberta, Edmonton, Alberta.

Topping, Professor C. W., University of British Columbia, Vancouver, British Columbia.

Trivett, Reverend D. F. L., Dalhousie University, Halifax, Nova Scotia.

Trottier, Mr. Michel, Clinique pour l'aide à l'enfance, Quebec, Quebec.

Tylke, Mr. Donald H., Toronto, Ontario.

Unwin, Dr. J. Robertson, Allen Memorial Institute, Montreal, Quebec.

Upfold, Mr. Michael, McMaster University, Hamilton, Ontario.

Vikander, Professor Nils, Saint Thomas University, Fredericton, New Brunswick.

Villeneuve, Dr. Andre, Hôpital St-Michel-Archange, Mastaï, Quebec.

Voft, Mrs. Ruth, Regina, Saskatchewan.

Wachna, Dr. Anthony, Windsor, Ontario.

Walker, Mr. Eddy, Winnipeg, Manitoba.

Watt, Mrs. Donna, Vancouver, British Columbia.

Watt, Mr. F. B., Ottawa, Ontario.

Watt, Mr. James W., Sarnia Pharmacy, Sarnia, Ontario.

Wayman, Mr. Ted, Fredericton, New Brunswick.

Westmiller, Mr. W. J., Kingston, Ontario.

Weston, Reverend Hugh, Saskatoon, Saskatchewan.

Whealy, Mr. Arthur, Toronto, Ontario.

Whitehead, Professor Paul C., Dalhousie University, Halifax, Nova Scotia.

Whitney, Miss Beverley, London, Ontario.

Wilson, Mr. Ray, McMaster University, Hamilton, Ontario.

Wilson, Mr. S. L., Sackville, New Brunswick.

Wood, Mr. John N., St. John's, Newfoundland.

Wood, Dr. J. K. Saskatoon, Saskatchewan.

Wright, Miss Jane E., Toronto, Ontario.

Wybranowska, Mr. A. M., Vancouver, British Columbia.

Wytrwal, Mr. John, Kitchener, Ontario.

Yeudall, Mr. Lorne, University of Alberta, Edmonton, Alberta.

Yonge, Dr. Keith, Edmonton, Alberta.

Zlotkin, Mr. N. K., Toronto, Ontario.

Appendix Q

Schedule of the Commission's Public Hearings

TORONTO	St. Lawrence Hall	Oct. 16, 1969
	York University	Oct. 16, 1969
	St. Lawrence Hall	Oct. 17, 1969
	University of Toronto	Oct. 17, 1969
	Penny Farthing Coffee House	Oct. 17, 1969
	St. Lawrence Hall	Oct. 18, 1969
VANCOUVER	Queen Elizabeth Playhouse	Oct. 30, 1969
	Hotel Vancouver	Oct. 30, 1969
	Queen Elizabeth Playhouse	Oct. 31, 1969
	University of British Columbia	Oct. 31, 1969
	Bistro Coffee House	Oct. 31, 1969
VICTORIA	City Hall Council Chambers	Nov. 1, 1969
MONTREAL	Queen Elizabeth Hotel	Nov. 6, 1969
	McGill University	Nov. 6, 1969
	University of Montreal	Nov. 6, 1969
	Queen Elizabeth Hotel	Nov. 7, 1969
	Sir George Williams University	Nov. 7, 1969
	Back Door Coffee House	Nov. 7, 1969
	Queen Elizabeth Hotel	Nov. 8, 1969
WINNIPEG	Norquay Building	Nov. 13, 1969
	University of Manitoba	Nov. 13, 1969
	Norquay Building	Nov. 14, 1969
	Civic Auditorium	Nov. 14, 1969
	University of Winnipeg	Nov. 14, 1969
OTTAWA	National Library	Dec. 12, 1969
	University of Ottawa	Dec. 12, 1969
	Carleton University	Dec. 12, 1969
	National Library	Dec. 13, 1969

HALIFAX	Lord Nelson Hotel	Jan. 29, 1970
	Queen Elizabeth Auditorium	Jan. 29, 1970
	Lord Nelson Hotel	Jan. 30, 1970
	Dalhousie University	Jan. 30, 1970
ST. JOHN'S	Newfoundland Hotel	Jan. 31, 1970
	Memorial University	Jan. 31, 1970
FREDERICTON	Lord Beaverbrook Hotel	Feb. 19, 1970
	University of New Brunswick	Feb. 19, 1970
MONCTON	Harrison Trimble High School	Feb. 20, 1970
	University of Moncton	Feb. 20, 1970
SACKVILLE	Mount Allison University	Feb. 20, 1970
CHARLOTTE-TOWN	Centennial Centre	Feb. 21, 1970
	University of Prince Edward Island	Feb. 21, 1970
KINGSTON	City Hall	Mar. 5, 1970
	Queen's University	Mar. 5, 1970
QUEBEC	Chateau Frontenac	Apr. 3, 1970
	Laval University	Apr. 3, 1970
	CEGEP de Linoilou	Apr. 3, 1970
	Chateau Frontenac	Apr. 4, 1970
REGINA	Hotel Saskatchewan	Apr. 9, 1970
	University of Saskatchewan	Apr. 9, 1970
SASKATOON	Centennial Centre	Apr. 10, 1970
	University of Saskatchewan	Apr. 10, 1970
CALGARY	The Calgary Inn	Apr. 16, 1970
	University of Alberta	Apr. 16, 1970
EDMONTON	Edmonton Public Library	Apr. 17, 1970
	University of Alberta	Apr. 17, 1970
SUDBURY	Sudbury Public Library	May 7, 1970
THUNDER BAY	Royal Edward Hotel	May 8, 1970
HAMILTON	Board of Education Building	May 14, 1970
	Board of Education Building	May 15, 1970
LONDON	Hotel London	May 22, 1970
	London Public Library	May 22, 1970
WINDSOR	City Hall	May 23, 1970

THREE RIVERS	CEGEP de Trois-Rivières	Oct. 15, 1970
	University of Quebec	Oct. 15, 1970
	Auditorium of the Seminary	Oct. 15, 1970
SHERBROOKE	CEGEP de Sherbrooke	Oct. 16, 1970
	Sherbrooke University	Oct. 16, 1970
	Wellington Hotel	Oct. 16, 1970
LENNOXVILLE	Bishop's University	Oct. 17, 1970
HALIFAX	Queen Elizabeth High School	Oct. 23, 1970
ST. JOHN'S	Newfoundland Hotel	Oct. 24, 1970
TORONTO	St. Lawrence Market	Oct. 29, 1970
	St. Lawrence Market (evening)	Oct. 29, 1970
MONTREAL	Queen Elizabeth Hotel	Oct. 31, 1970
SEPT-ÎLES	Sept-Îles Hotel	Nov. 5, 1970
	Sept-Îles Hotel (evening)	Nov. 5, 1970
SAINT JOHN	Holiday Inn	Nov. 5, 1970
BAIE COMEAU	Caravelle Hotel	Nov. 6, 1970
CHARLOTTE-TOWN	Charlottetown Hotel	Nov. 6, 1970
WINNIPEG	Fort Garry Hotel	Nov. 12, 1970
REGINA	Saskatchewan Centre	Nov. 13, 1970
EDMONTON	Holiday Inn	Nov. 19, 1970
VANCOUVER	Vancouver Hotel	Nov. 20, 1970
	Vancouver Hotel (evening)	Nov. 20, 1970
OTTAWA	Skyline Hotel	Feb. 19, 1971

Appendix R

Commission Research Projects

The following list of projects reflects the major areas of our research and the general division of labour among Commission research personnel. In addition to these studies, there were numerous other miscellaneous investigations and writing tasks which were not formally classified as research projects. Many studies were carried out in collaboration with independent scientists on contract in universities and other institutions, but most of the research program was conducted by the full-time Commission staff in Ottawa. The names and addresses of the contract researchers and consultants are listed separately in Appendix O. Full-time staff members with the Commission during the preparation of this *Final Report* are presented in Appendix N; former members of the staff, whose work contributed primarily to earlier Commission reports, are listed in those publications.

The research projects varied considerably in scope and in the form of their end products. Some were relatively limited pilot or preliminary studies which were terminated after the initial data gathering or inquiry stage. Certain projects focussed on specific subjects in a way which led to complete working papers or study reports. In many instances a particular project entailed only a specific limited study and is not indicative of the overall examination of the topic by the Commission. Other projects included rather massive continuing investigation and monitoring of broad areas. These efforts typically resulted in a regular flow of information to the Commissioners and senior staff members involved in the drafting of the Commission reports, rather than in specific finished papers; much of the material in these studies was continuously up-dated and revised as new data became available. Often there was direct input of the primary information from research to Commission report drafts, without the intervening stage of separate and complete project reports. As far as possible the Commission has attempted to convey the essentials of its research in its published reports. Many studies were completed to the extent necessary for the preparation of the official Commission reports but have not been exhaustively exploited from a broader scientific standpoint. Further analysis and independent publication of information from certain Commission studies may be done by individual researchers after the release of

this *Final Report*. However, there will not be any further analysis or publication of technical reports by the Commission.

For the purpose of this appendix, the projects have been grouped into ten general categories according to principal area of reference, as follows: (A) Drug Effects; (B) Chemical and Botanical Aspects; (C) Sources and Distribution; (D) Extent and Patterns of Use; (E) Motivation and Causal Factors; (F) Law and Law Enforcement; (G) Medical Treatment and Related Services; (H) Information and Education; (I) Mass Media; and (J) Miscellaneous. Many of the projects have provided material related to more than one topical area, but for the sake of simplicity in this presentation we have attempted to minimize duplication and cross-references.

A. Drug Effects

1. Critical review of research on drug effects.
   (R. Miller, R. Hansteen, J. Brewster, P. Oestreicher, B. Hemmings, Z. Amit, M. Corcoran, P. Thompson, L. Wright, D. Thompson, R. Paterson, B. Anthony, & M. Willinsky)

28 Investigation of cannabis psychosis.
   (R. Miller, J. Brewster, J. Anderson, & T. Ridley)

62a. Drug-induced poisoning and death in Canada: An analysis of government statistics.
   (R. Miller, & B. Hemmings)

62b. Survey of provincial coroners regarding drug-related deaths.
   (B. Hemmings, R. Miller, E. Bild, & P. Thompson)

64. Survey of Ottawa-area physicians regarding the non-medical use of drugs.
   (R. Miller, J. Brewster, B. Leathers, & B. Hemmings)

65. Survey of LSD researchers in Canada.
   (B. Hemmings, & R. Miller)

74. The effects of cannabis and alcohol on some automobile driving tasks.
   (R. Hansteen, L. Lonero, R. Miller, B. Jones, J. Brewster, M. Elliott, & H. Stankiewicz)

77a. A comparison of the effects of Δ^9 THC and marijuana in humans.
   (R. Miller, R. Hansteen, C. Adamec, J. Brewster, J. Bijou, S. Dayken, C. Farmilo, D. Hamilton, S. Link, R. Siegal, M. Willinsky, R. Mechoulam, & C. Moiseiwitsch)

77b. The effects of marijuana on visual signal detection and the recovery of visual acuity after exposure to glare.
   (L. Theodor, R. Miller, J. Glass, R. Hansteen, & S. Dayken)

78. The effects of cannabis and alcohol on psychomotor tracking performance.
   (L. Reid, R. Hansteen, R. Miller, N. Wexler, P. Muter, & M. Awasthy)

90. Drug use and non-drug crime.
   (F. Hughes, M. Green, R. Miller, & L. McDonald)

107. Non-medical drug use as a factor in hospitalization: A survey of Canadian psychiatric hospital diagnostic records.
(B. Hemmings, R. Miller, & E. Bild)

See also: (B)103; (C)112; (D)92, 105b; (E) 45, 58, 75.

B. Chemical and Botanical Aspects

60. An examination of street drug analysis needs and facilities in Canada.
(P. Oestreicher, R. Miller, R. Paterson, C. Farmilo, I. Stankiewicz, & L. Barash)

88. An historical review of hemp cultivation in Canada.
(L. Barash, C. Farmilo, R. Miller, R. Farmilo, & H. Stankiewicz)

96a. Chemical analysis of street drugs in Canada: Non-forensic aspects.
(R. Miller, P. Oestreicher, J. Marshman, H. Beckstead, R. Paterson, R. Berg, G. Larsson, B. Hemmings, M. Green, C. Farmilo, M. Willinsky, P. Cooper, L. Barash, & J. Brewster)

96b. Chemical analysis of police seizures in Canada.
(R. Miller, P. Oestreicher, H. Beckstead, R. Paterson, & C. Farmilo)

103. Chemical aspects of cannabinoids and their metabolites: A review of existing information.
(P. Oestreicher, R. Miller, C. Farmilo, B. McNaughton, D. Phelps, M. Willinsky, R. Mechoulam, & D. Thompson)

104. Botanical and agricultural aspects of cannabis.
(E. Small, C. Farmilo, R. Miller, P. Oestreicher, & L. Barash)

110. The effects of combustion on cannabis.
(K. Fehr, H. Kalant, R. Miller, & R. Hansteen)

See also: (D) 92; (J) 99.

C. Sources and Distribution

8. Illicit drug trafficking in Canada.
(M. Green, K. Stoddart, R. Solomon, M. Hollander, J. Hogarth, & P. Thompson)

19. Organized crime involvement in drug trafficking in Canada.
(J. Hogarth, R. Solomon, & M. Green)

34. Importation, production and marketing of psychotropic drugs in Canada.
(J. Kodua, M. Green, C. Farmilo, R. Miller, J. Moore, & A. Arda)

106. International aspects of heroin distribution.
(R. Solomon, J. Hogarth, & M. Green)

112. The history of the medical use and availability of cannabis in Canada.
(R. Miller, P. Oestreicher, L. Barash, & R. Farmilo)

See also: (B) 96a, 96b; (J) 99.

D. Extent and Patterns of Use

7. Participant observation study of street-level drug users in major Canadian cities, summer 1970.

   (M. Green, R. Aubin, H. Broomfield, C. Bussière, B. Darrough, A. Dudeck, D. Gagné, M. Gaussiran, B. Hemmings, M. LeBlanc, G. Letourneau, R. Manes, E. Marchuk, D. McLachlen, C. Murphy, M. O'Neill, K. Stoddart, B. Torno, & J. Woolfrey)

9. Participant observation study of suburban youthful drug users in the Montreal area.

   (M. O'Neill, & M. Green)

14. Participant observation study of street-level drug users in Toronto.

   (R. Manes, B. Torno, & J. Hogarth)

36. Alcohol consumption and alcoholism in Canada.

   (J. Kodua, & R. Miller)

41. Critical review of the international literature on the extent and patterns of amphetamine use.

   (M. Green, M. Hollander, J. Blackwell, & S. Sadava)

42. Mediating drug factors and use at rock festivals.

   (W. Clement, B. Chapman, M. Balker, & G. Della-Stua)

51a. The non-medical use of drugs and associated attitudes: A national household survey.

   (C. Lanphier, S. Phillips, N. Kuusisto, G. Smith, L. Thomas, & P. Craven)

51b. Secondary school students and non-medical drug use: A national survey of students enrolled in grades seven through thirteen.

   (C. Lanphier, S. Phillips, N. Kuusisto, G. Smith, L. Thomas, & P. Craven)

52. University students and non-medical drug use: A national survey.

   (C. Lanphier, S. Phillips, N. Kuusisto, G. Smith, L. Thomas, & P. Craven)

57. Coordination of sociological information on heroin with selected reviews.

   (J. Blackwell, R. Miller, M. Green, S. Goldner, & R. Solomon)

76. Synopsis of non-medical drug use surveys in Canada.

   (G. Smith, & B. Rogers)

86. Participant observation study of street-level drug users in London, Ontario.

   (R. Leth, & M. Green)

87. Historical, theoretical, and descriptive study of drug use in Amsterdam, Netherlands.

   (G. Letourneau)

89. Interviews with 'straight' adult cannabis users.

   (M. Green, B. Leathers, D. Ellis, M. Elliott, M. Hollander, E. Marchuk, S. Moss, K. Ouellette, & M. Stark)

92. Self-reporting of drug use patterns by regular cannabis users: A log book study.
(M. Green, B. Hemmings, R. Miller, R. Hansteen, & M. Hollander)

97. Review of sociological research on cannabis, hallucinogens, barbiturates, and volatile solvents.
(S. Sadava, J. Blackwell, M. Green, D. McLachlen, & L. McDonald)

98. Alcohol use among Canadian Indians.
(P. Trottier, G. Rushowick, J. Dewhirst, F. Walden, & W. Hlady)

102. Continuing participant observation study of committed drug users.
(M. Green, R. Aubin, B. Darrough, M. Hollander, M. O'Neill, K. Ouellette, & E. Smith)

105b. Comparative international study of alcoholism.
(M. Latchford, & L. McDonald)

109. Tobacco use in Canada: Epidemiological and treatment aspects.
(D. Andrews, F. Wake, J. MacLean, M. Green, P. Thompson, & R. Miller)

111. Continuing survey of sensitive observers in Canada: The final monitoring project.
(M. Green, J. Blackwell, B. Anthony, R. Aubin, M. Buriak, R. Farmilo, G. Letourneau, K. Martin, C. Murphy, & W. Spicer)

115. Relationships among the patterns of use of different drugs.
(G. Smith, R. Miller, C. Petch, J. Blackwell, & J. Brewster)

See also: (C)112; (E)a11; (J)99, 101.

E. Motivation and Causal Factors

13. A selective review of the sociological literature bearing on drug use with emphasis on policy.
(J. Hackler)

24. Social change, alienation, and youth: A sociological analysis.
(R. Crooke, & T. Buckner)

25. Sociological approaches to non-medical drug use and drug dependence: A non-critical review.
(B. Rogers, & M. Green)

43. Growing up in a new world: A sociological analysis.
(T. Buckner)

44. Drug use in contemporary society.
(M. Mouledoux)

54. Sociological aspects of non-medical drug use: A private Commission symposium, Montreal, December 1970.
(Commissioners, H. Becker, J. Blackwell, M. Bryan, C. Farmilo, M. Green, B. Hemmings, J. Hogarth, L. McDonald, R. Miller, J. Moore, T. Morris, M. Rioux, E. Schur, F. Walden, & A. Zijderveld)

58. Review of the psychological, psychiatric and pharmacological literature on drug use and drug dependence.
(Z. Amit, M. Corcoran, R. Miller, M. Elliott, & B. Hemmings)

75. Theories of drug use and addiction.
(L. McDonald)

See also: (A)107; (D)42, 57, 115; (G)63; (I)81; (J)99, 101.

F. Law and Law Enforcement

2. Canadian federal drug prosecutors.
(J. Hogarth, & M. Kleiman)

6. Comparative study of foreign legislation respecting psychotropic drugs.
(S. Ryan, & S. Troster)

12. Economic implications of the current drug phenomenon.
(D. Szabo, S. Rizkalla, R. Fasciaux, & F. Gélinas)

15. The decision-making flow with respect to Canadian drug offenders.
(J. Hogarth, J. Prince, A. Kidd, M. Moriarity, J. Kodua, & A. Arda)

16. Demographic patterns of law enforcement in Canada.
(J. Hogarth, & R. Solomon)

17. Interviews with Canadian police officers.
(J. Hogarth, R. Solomon, & Y. Liljefors)

18. Participant observation with police forces in Canada.
(J. Hogarth, & R. Solomon)

20. Sentencing attitudes and practices with respect to drug offenders in Canada.
(J. Hogarth, J. Prince, A. Kidd, H. Kleiman, S. Kasman, Y. Liljefors, & R. Solomon)

21. The use of probation in dealing with drug offenders in Canada.
(J. Hogarth, G. Fields, & R. Solomon)

22. A study of certain correctional institutions with particular reference to their effect on drug offenders.
(J. Hogarth, L. McDonald, R. Solomon, & A. Caplan)

23. The handling of drug offenders in the criminal justice system of Quebec.
(J. Laplante, & J. Hogarth)

33. Study of U.N. conventions for the control of psychotropic drugs.
(C. Farmilo, & R. Miller)

37. The extent and patterns of drug-involved convictions and sentences in Canada.
(J. Hogarth, J. Kodua, J. Prince, P. Oestreicher, A. Arda, & G. Doherty)

39. A doctrinal study of law in relation to drug control.
(P. Weiler)

73. Entrapment and violence in the enforcement of drug laws.
(B. Anthony, J. Moore, R. Solomon, & M. Green)

85. Review of research on the psychological and behavioural effects of imprisonment.
(W. Mann)

93. Law enforcement practices with respect to drug offences in Canada: An analysis and summary of related projects.
(J. Hogarth, L. McDonald, R. Solomon and associates)

94. Law enforcement aspects of non-medical drug use: A private Commission symposium, Montreal, March, 1971.
(Commissioners, J. Ackroyd, J. Blackwell, M. Bryan, J. Edwards, M. Green, B. Hemmings, J. Hogarth, J. Kaplan, L. McDonald, R. Miller, H. Mohr, J. Moore, K. Paul, R. Quinney, M. Rosenthal, S. Ryan, L. Schwartz, R. Solomon, & P. Weiler)

105a. Comparative international study of drug law enforcement.
(M. Latchford, & L. McDonald)

113a. Civil commitment and compulsory treatment of drug users in Canada.
(M. Bryan, F. Brown, A. Lane, & B. Hemmings)

113b. Civil commitment and compulsory treatment of drug users in the U.S.A.
(M. Green, J. Blackwell, & R. Miller)

116. The Methadone Control Program of the Government of Canada.
(A. Lane)

117. Probation for heroin dependents in Canada.
(M. Bryan)

118. Parole of heroin dependents in Canada.
(M. Bryan)

See also: (A) 90; (B) 60; (C) 112; (G) 114; (J) 61, 99, 101.

G. Medical Treatment and Related Services

10. Study of innovative services in Canada.
(B. Rogers, N. Martin, R. Farmilo, M. Morin, & J. Anderson)

26. An analysis of selected addiction treatment programs.
(J. Anderson, & T. Ridley)

27. Review of approaches to the treatment of alcoholism.
(J. Anderson, & T. Ridley)

29. The treatment of chronic amphetamine users.
(J. Anderson, & J. Shaw)

30. Survey of community treatment services in Canada.
(J. Anderson, & T. Ridley)

31. Adverse reactions to LSD: Treatment and epidemiological aspects.
(J. Anderson, R. Miller, J. Brewster, T. Martin, T. Lee, & T. Johns)

32. A summary of treatment methods for medical problems associated with psychotropic drug use.
(T. MacFarlane, & J. Anderson)

38. Alternatives to psychotropic drug use.
(A. Wine, J. Anderson, T. Ridley, & R. Miller)

63. Treatment aspects of non-medical drug use: A private Commission symposium, Montreal, January 1971.
(Commissioners, J. Anderson, G. Bell, T. Bewley, J. Blackwell, H. Brill, M. Bryan, C. Farmilo, G. Gay, M. Green, R. Hansteen, B. Hemmings, J. Jaffe, R. Miller, J. Moore, J. Shaw, R. Smith, & L. Yablonsky)

83. A critical review of methadone therapy programs.
(J. Anderson, J. Shaw, M. Bryan, M. Green, J. Blackwell, R. Hansteen, & R. Miller)

91. Medical treatment: A summary of related projects.
(J. Anderson and associates)

114. The "British System": The treatment of opiate-dependent persons in the United Kingdom.
(B. Anthony, & J. Blackwell)

119. Treatment capacity in the provinces.
(A. Lane, M. Bryan, & B. Rogers)

See also: (A) 64, 107; (D) 42, 109; (F) 12, 113a, 113b, 116, 117, 118; (J) 99, 101.

H. Information and Education

5. Drug education, information, and services in selected Toronto schools.
(J. Solway, & H. Solway)

11. Documentation of scientific and technical information on psychotropic substances.
(C. Farmilo, R. Miller, E. Polasek, E. Hanna, A. Kerr, L. Barash, G. Larsson, I. Stankiewicz, & D. Thompson)

46. Community drug education programs.
(D. Hanley, & F. Walden)

53a. A brief review of the literature in the field of drug education.
(F. Walden)

53b. Drug education: An analysis and summary of related Commission projects.
(B. Myers)

59. Drug education in Canadian public schools.
(B. Myers, F. Walden, D. Hanley, & C. Lohoar)

67. An investigation of drug education efforts by large organizations.
(F. Walden, D. Hanley, & S. Gillean)

68. Drug education for professionals and others in universities and community colleges in Canada.
(S. Gillean, D. Hanley, & F. Walden)

71. A comparative study of drug education in selected foreign countries.
(B. Myers, F. Walden, C. Lohoar, & I. Stankiewicz)

84. Problems with government statistics.
(R. Miller, J. Kodua, M. Bryan, M. Green, B. Anthony, & A. Arda)

108. Students and drug education.
(F. Walden, B. Myers, H. Solway, & J. Solway)

See also: (F)12; (G)38; (I)81; (J)61.

I. Mass Media

81a. The media and the social context of drug use: General aspects and summary of related Commission studies.
(J. Taylor, J. Moore, F. Walden and associates)

81b. A survey of responses by Canadian daily newspapers and periodicals to non-medical drug use.
(C. Hénault)

81c. The underground press.
(M. Slack, J. David, & M. Green)

81d. Drugs and literature.
(J. Basile, & S. Fefferman)

81e. Drugs and music.
(M. Green, P. Goddard, & J. David)

81f. The role of advertising in promoting attitudes to the use of drugs.
(M. Callaghan)

81g. Drugs and Canadian film.
(M. Brûlé)

81h. Radio, TV and drugs.
(P. Watson, G. Constantineau, P. Goddard, & A. Sirois)

81i. Drugs and the plastic and environmental arts.
(A. Leblanc)

J. Miscellaneous Projects

50. Analysis of unsolicited letters to the Commission.
(D. Rebin, J. Moore, J. MacBeth, R. Miller, J. Kodua, & P. Oestreicher)

61. Analysis of Canadian policy on non-medical drug use research.
(R. Miller, P. Oestreicher, C. Farmilo, R. Hansteen, D. Thompson, R. Paterson, J. Moore, & L. Barash)

66. Current research on psychotropic drugs: A survey of major studies in progress in Canada and abroad.
(P. Oestreicher, R. Miller, R. Hansteen, C. Farmilo, J. Brewster, M. Willinsky, R. Paterson, G. Larsson, & B. Myers)

72. An examination of the attitudes and responses of religious, business, military, professional and other organizations to non-medical drug use.
(F. Walden, D. Hanley, & S. Gillean)

82. An analysis of *Interim Report* critiques.
(D. Rebin, R. Miller, J. Moore, N. Eddy, S. Cohen, & Z. Amit)

99. Coordination of tobacco information: Scientific and legal aspects.
(P. Thompson, & R. Miller)

101. Coordination of alcohol information: Scientific and legal aspects.
(F. Hughes, R. Miller, C. Petch, & P. Thompson)