FACTORS AFFECTING THE DRUG ADDICTS TREATMENT INVOLVEMENT

A Preliminary Exploratory Study

by

David Lloyd George Dryden
Nerissa Oi-Sim Lo
Edward Milligan
Helene Ann Sawchuk
Edward Earl Sibbald
Mabel Po-Mee Wong

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Department of Social Work

The University of British Columbia
Vancouver 8, Canada

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ABSTRACT

Since the Narcotic Addiction Foundation of British Columbia opened its doors in 1958 it has been successful in contacting a large number of drug addicts in the Vancouver area. There has, however, been some concern expressed by the agency treatment staff over the high ratio of patients who discontinue treatment after the first few contacts. The authors of this exploratory study have undertaken the task of determining some of the factors which might influence the drug addict's continued treatment involvement at the Narcotic Addiction Foundation. This study sets the base for a projected three year study of the stated problem.

The study was divided into two phases. The first is the retrospective study which utilizes the Paulus Study (55) conducted in 1964. Though pursued for different reasons, this study provides a convenient and suitable sample of 105 addicts (50 male and 55 female) for the present research. The immediate aim of this retrospective study is to identify certain factors which are discernible at the time the addict presents himself for treatment and to relate them to the addict's subsequent treatment involvement.

The second phase, a longitudinal study, will utilize the specific factors which emerge from the retrospective study as being significantly related to the addict's continued treatment involvement. The longitudinal study, to further prove the validity of each factor, has been projected to cover a twelve month period from the time the addict first presents himself for treatment.

The results of the study point out some of the difficulties and areas of concern regarding the treatment of the drug addict and some recommendations pertaining to follow-up studies of this kind. While the drug addict exhibits
some characteristics similar to clients of any agency, he is unique in many ways. The factors discerned in this study clarify some of this uniqueness and, it is hoped, (using the significant factors brought out,) that they will eventually lead to better prognostication of the addict's future success for continued treatment involvement. It should prove to be especially helpful to the staff of the Narcotic Addiction Foundation and other agencies geared to treating the drug addict in guiding changes in the treatment program and organization.
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CHAPTER I

INTRODUCTION

In Canada, the publicity attendant upon the criminal activities of narcotic addicts suggest that, though relatively few in number, their collective involvement with the courts and correctional institutions constitute a social problem. A report issued by the Federal government in 1966 shows that there were 3,592 known addicts in Canada of whom 2,068 or 57 per cent were to be found in British Columbia. These criminal activities have been perceived as a threat to societal values and society's reaction has been to take such steps as were deemed necessary to safeguard those values. In the past these steps have been mainly in the area of legislation implemented and maintained by law enforcement officials, but as the futility of such punitive measures has become increasingly apparent, efforts have been made to set up some form of rehabilitative treatment program. The addictive substance is mainly heroin, and the rising costs of the drug which is available only illegally was, allegedly, commensurate with the rising incidence of crime in the area. Public concern resulted in the establishment of a Narcotic Addiction Foundation in British Columbia and the Clinic was opened in December, 1958. Initially it comprised an outpatient clinic but later a small residential treatment centre was instituted.

While those responsible for the implementation of the treatment have been successful in contacting a large number of the addicts, concern is being expressed over the high ratio of patients who discontinue treatment after the first few appointments. As one solution to the social problem initially stated, the clinic can claim only limited success.
HISTORICAL BACKGROUND

Historical evidence indicates that drug addiction has been known to every civilization on record. (41) In the 19th century many Chinese emigrated to North America and among them were opium smokers who introduced this habit to the Western people. However, the marked increase in the prevalence of addiction has been attributed to the discovery of the powerful derivatives of opium, the invention of the hypodermic needle, and the widespread use of opiates in patent medicines. In North America there is a strong taboo against drug addiction stemming from the belief that drug abuse contributes to the physical, psychological and social decay of the individual and is hence a threat to society. It has further been shown that drug addiction is of major concern to the general population because of its association with crime. It is interesting to note that during the 19th century, when narcotics were available at pharmacies, drug addiction was not especially linked to crime as it is today. Rather, addicts at that time were viewed much as alcoholics are at present.

According to O'Donnell: "The nature of the addiction problem is not determined only by the effects of drugs on the persons who use them. It changes and the characteristics of addicts change with variations in the way society perceives and tries to control the problem." (52, p.VII) In spite of the prevalence of drug addiction surprisingly little is known about the specific causal factors. A review of the literature has revealed a paucity of reliable studies in this area.

DEFINITIONS OF DRUG ADDICTION

Drug addiction has been defined in various ways. One of the most popular definitions used has been formulated by The Expert Committee of the World Health Organization which defines drug addiction as being
"A state of periodic or chronic intoxicification produced by consumption of a drug, natural or synthetic. It's characteristics are four in number:

(1) there is an overpowering desire, need or compulsion to continue taking the drug and to obtain it by any means;

(2) a tendency to increase the dose;

(3) a physical and generally, a psychological dependence upon the effects of the drug; and

(4) an effect detrimental to the individual and to society." (49, p. 3)

This definition has been subject to some criticism as noted in the Stevenson Report. (69, p. 3) A similar definition has been proposed by Dr. Abraham Wikler who states that, "for clinical purposes, 'drug addiction' in general may be defined as the compulsive use of chemical agents which are harmful to the individual, to society, or to both." (71, p. 3)

A valuable definition in terms of describing physical and psychological characteristics is proposed by Goodman & Gilman who define drug addiction as:

"A behavioural pattern of compulsive drug use characterized by an overwhelming involvement with the use of the drug, the securing of its supply and a high tendency to relapse after withdrawal." (22)

Inasmuch as the definitions identify certain characteristics of drug addiction they become essential in terms of implications for treatment.

For addicts, the drugs produce euphoria (a 'kick', a 'high' sensation, which may be explained by the reduction of anxiety associated with fear of pain. (15, p. 522) Whatever the sensation achieved by the initial use, the regular user develops tolerance to the drug; he requires more frequent or larger doses, or both, to recapture the original effect.
Regular dosage leads to physical dependence; if dosage is markedly reduced or ended, symptoms of withdrawal will result.

MAJOR EXPLANATIONS OF DRUG ADDICTION

Three major explanations of drug addiction which dominate the literature are (1) Psychological (2) Sociological and (3) Social-Psychological.

Psychological Explanation

Psychiatrists and psychologists point to the almost universal existence of personality defects, most often traits of inadequacy and dependency among addicts. (15, 9, 50) This view holds that there is a large reservoir of 'addiction prone' personalities in any population, and that when accidental factors make narcotics available to these persons, many become addicted. (15, 7) Authorities such as Brill (26) and Chein (9) indicate that, since there has never been any real maturing on the part of the addict, there is a conflict of sexual role and identification resulting in homosexual impulses and variations in sexual roles and function at different times.

Gerard and Kornetsky (20) found that the personality patterns of adolescent addicts were more abnormal than those of their unaddicted friends drawn from the same environment. While this suggests that personality problems antedated addiction it is far from conclusive. (52, p. 65)

As noted in the Stevenson Report (69, p. 48) personality types are not peculiar to addicts alone. Except for 'medical' addicts, patients who have never used narcotic drugs can be found in any psychiatric clinic who would certainly fall into one or the other of the classifications commonly assigned to addicts. This is not to say that there is no basis
for discussing narcotic addicts collectively in these terms. Indeed, the preponderance of evidence involving psychological factors is in sufficient proportion to be seriously considered when attempting to examine the causal factors which determine why the majority of addicts drop out of treatment after a few interviews.

Sociological Explanation

Studies in this area point to the exceptionally high rates of addiction among minority groups; to the much higher rates for males; and to the fact that in the larger metropolitan areas which have been studied most cases of addiction come from the poorest, most deprived, most underprivileged areas. (15, 50, 8) The inference is that social pressures toward addiction must be operating, perhaps producing addicts among relatively 'normal' persons. (9)

Adding to the problems of reaching out and working with addicts are their different values and attitudes. (57) Complications in relation to treating lower socio-economic groups have been observed in connection with categories of mental illness where patients also evidence considerable apathy and resistance and who have difficulty accepting help. One such attitude is their markedly different outlook on life, as in questioning the usefulness of doing something about their current problems in order to achieve distant goals. Their inability to articulate problems and develop insight in the manner of middle-class patients offers additional obstacles to rehabilitation. (26, p. 185)

Other factors such as lack of stability in the home, living in crisis situations and sacrificing long-range plans for immediate gratification are characteristic of the working class but are reflected in a distorted way in the addict. (26, p. 186) Chein found that in almost all addict families (97 per cent), there was a disturbed relationship between
the parents, as evidenced by separation, divorce, open hostility, or lack of warmth and mutual interest. In these conditions Chein reports that the mother usually became the most important parent figure in the life of the youngsters. (19, p. 274)

Most addicts start using drugs before the age of twenty-five (55, p. 62); accounting for the fact that most studies in the drug addiction field deal with the adolescent population. An interesting study was conducted by Dr. Charles Winick (75) who concluded that a substantial (two-thirds) concentration of addicts became inactive in their thirties. Brill suggests that these results make it possible to speculate that addiction may be a self-limiting process for perhaps two-thirds of the addicts. (26, p. 187) The apparently significant relationship of age to addiction is an area which presents itself for detailed consideration and this is a factor which will be given marked attention in our study.

Socio-psychological Considerations

This approach focuses on the process of becoming an addict, the learning involved, the gradual withdrawal from the wider culture, increased integration into a deviant subculture and the giving up of old and the formation of new values and attitudes. (15, p. 523) As authors Eldridge (14) and Lindesmith (39) suggest, both personality and environmental factors must be considered if we are to make any progress toward helping the addict.

The proponents of this approach argue that, given the fact that drugs are, or can be made available, then the question of the etiology of dependence concerns itself mostly with the personality of the individual who chooses to use the drug. (23)

On the basis of studies and clinical reports of the personality
of the addict Chein has concluded that the potential male addict suffers from (a) a weak ego structure, (b) defective superego functioning, and (c) inadequate masculine identification. In addition, the typical young addict's attitude usually involves (d) a lack of realistic orientation toward the future and (e) a distrust of major social institutions.

(9, p. 255) In a study "Translation of Personality Characteristics into Hypothetical Early Environments" (9, p. 271) Chein found that family experiences play an important role in the etiology of addiction. He maintains that the environment does influence behaviour and that even when some aspects of this role are obvious they are not necessarily simple. It has been generally accepted that poor family relationships in the early life experience promote a lack of trust in one's fellow beings, a sense of everyone's being out for himself, a sense of futility, of not really belonging etc., Placing a disrupted family in a deteriorated neighbourhood would merely serve to reinforce this effect.

In light of the foregoing, the view has been expressed that heroin and its related subculture give the addict a sense of well-being and of social acceptability and participation. (52, p. 140) Thus, in some measure the addict's perception of himself and his desire to modulate that perception are areas of concern directly related to our research efforts.

TWO MAIN APPROACHES TO THE PROBLEM OF DRUG ADDICTION

Law Enforcement:

The major attempt to solve the problem in the United States, and Canada too, has been legislation against the manufacture and sale of opium. The earliest efforts, therefore, were toward blocking access to narcotics. (56) In the 19th century, narcotics were freely imported
and could be bought without prescription. Physicians prescribed them freely and medical treatment, unacceptable by today's standards, produced a large proportion of addicts. (52) Sporadic attempts were made at State and local levels to control the distribution of narcotics but it was the enactment of the Harrison Act (66) which marked the embarkation upon a totally new approach to the narcotics problem. That approach can best be described as an effort which set out to control the non-medical use of narcotics and evolved into the prohibition of non-medical uses and the control of medical uses. (14, p. 9) Any appreciation of the relationship of addiction to crime must also take into account the legal structure which has forced narcotics traffic into the underworld. (14, p. 27) Since the adoption of the Harrison Act there has been but one approach in the United States, namely, that of criminal sanction applied to all offenders against the narcotic laws. (14, p. 47, 6)

Society has made a judgment that indulgence in narcotics is wrong and supports this judgment with laws. Perhaps the most significant basis for the judgment lies in the ethical and philosophical foundations of our religious and moral culture which mistrust rule of the senses. (14, p. 13) This attitude found expression in the laws and subsequent approach toward the addict. This leads us to the stereotype of the "drug fiend" and "drug maniac" - a myth exposed thirty years ago but one which has, nevertheless, been very slow in dying. (5, p. 227) Other myths, i.e. that the addict is a "sex menace" etc. have also been exposed, largely due to increased knowledge regarding the addict from psychological, sociological, medical and psychiatric sources.

Recent years have seen legislation that has markedly increased the severity of penalties imposed on such offenders. (60, p. 3) These
increased penalties were aimed at the sellers of narcotics. However, they are difficult to trace and it is ultimately the addict who suffers as he is fairly easy for the police to detect because his need for drugs brings him into the open and into the company of known addicts and sellers. As Lindesmith has noted: (40, p. 231)

"Laws have become increasingly cruel and inflexible and are now, to a considerable extent, designed in the interests of police expediency rather than of justice. In this whole process, the forgotten man has been the addict."

The advocates of the punitive approach (law enforcement officials and supporters), regard the use of drugs as an offshoot of the addict's other criminal tendencies.(58) There has been some change in attitude recently by police authorities toward the addicts. He is now defined as, "an abnormal individual whose addiction is primarily due to his underlying mental instability." (64, p. 201) They recommend enforced committal and control. The underlying philosophy is that drug addicts are criminals first and drug addicts second and therefore should not be accorded special treatment apart from the non-addict. It would seem that although there is a beginning trend for law enforcement officials to accept addiction as a disease, they still regard addiction to narcotic drugs as an activity within the realm of police concern.

In a recent study in Lexington, Kentucky (53; 9, p. 62) evidence is presented that the increase in crime after addiction is not a direct effect of drug use, but is due to the way of life which becomes necessary in many, but not all cases, to obtain narcotics. Other current research in Vancouver, Canada points out that 50 per cent of a sample of 176 addicts seeking voluntary treatment at the Narcotic Addiction Foundation, had no criminal record before they became addicted, but 50 per cent have had some
criminal activity. (55) It has further been shown that crimes are associated with utilitarian violation and are seldom crimes of sex and violence as is commonly believed. (14, p. 24)

One could speculate as to the effectiveness of law enforcement agencies when considering the increase in the number of addicts. Statistics show that in British Columbia the number of known addicts increased from 1,906 in 1965 to 2,068 in 1966. (16) Authorities at the Narcotic Addiction Foundation in Vancouver believe that there are many more who are unknown.

Insofar as treatment is concerned, little has been done for the addict in the prison setting. Treatment efforts consisted mainly of abrupt withdrawal known as "the cold turkey" method. Rehabilitation, which has long been recognized as the key problem in the treatment of addicts was virtually ignored in this setting.

Legal and Medical Views

It can be stated that, generally, the legal and medical authorities are agreed that existing legislation and law enforcement are unsatisfactory and that drug addiction is a condition properly within the area of medical concern and jurisdiction. (48) The basic premise here is that drug addiction is a disease for which punishment is inappropriate. The argument is presented that many addicts become criminals in order to sustain their habit and, in fact, have no alternative to a criminal existence. (14, p. 24) Dr. Halliday, past director of the Narcotic Addiction Foundation of British Columbia has stated:

"It is more and more recognized and accepted that the narcotic addict is a sick person, and that his addiction is a symptom of some disturbance or conflict which he cannot resolve or cope with in an adequate way." (25, p. 85)

Some authorities in the field believe that the kinds of people
who are addicts appear to have been fertile subjects for drug use, for in narcotics they find relief from their multiple problems in adjusting to life. These people have tried since their formative years to adjust to the formidable problems of economic, psychological and social depression. (15, p. 404) As a consequence, workers in the medical, psychological and social sciences in recent years have devised new approaches to the treatment of drug addiction. For the addict who has experienced a long history of being treated as a criminal the notion of being treated as a sick person is difficult to accept. Addiction is a part of the way of life which he has chosen or fallen into as a result of his associations. It would appear that most of them have little sympathy with the aims of treatment if that means life without drugs sooner or later. (60) From this it would appear that there may be a discrepancy between the aims and objectives of treatment personnel and the addicts themselves. Clearly, the recognition of such disparities is of paramount importance when the problem of the continuing or discontinuing of treatment of the addict is under consideration.

TREATMENT METHODS

United States:

It has generally been accepted that the treatment of addiction may be divided into three phases: (1) the withdrawal of drugs, (2) Physical and mental rehabilitation, (3) follow up treatment.(52, p. 72)

The first concerted effort to treat drug addiction was made in Lexington, Kentucky in 1935, followed by a federal hospital in Fort Worth, Texas in 1938. These two psychiatric hospitals were intended to treat addicts, do research on addiction, and to make available to state and local agencies the knowledge gained from their experience and research.(52, p.174) They had some success and the problem of withdrawal from narcotics, once
regarded as a major problem, was solved. It was recognized from the start that the problem was not to get the addict off drugs but to keep him off.

Unfortunately not enough has been done in the past in the way of research into an understanding and treatment of the addict's manifold problems to bring this situation under control, with the result that society has continued to pay a very high price for its failure in this regard. (47)

In the 1950's the states of New York and California experimented with programmes that combined treatment of the addict with an element of compulsion. These programmes were set up for parolees released from state prisons who could be required to co-operate. The success of these programmes has led recently to increased support for the concept of civil commitment and compulsory after-care for patients at the two federal hospitals. It has also contributed to the establishment of half-way houses on an experimental basis to ease for the treated addict the transition from the institution to life in the community. (52, p. 177)

Experimental clinics, such as the one operated by Nyswander and her associates, were established as outpatient clinics were addicts come for voluntary treatment. Nyswander feels that the only way to get addicts out of the sub-culture is to give them drugs and, in her experiment, Methadone. (28) According to Nyswander, much more research will have to be done on addicts getting their drugs legally in order to plan intelligently for their rehabilitation.

Synanon, a unique experiment in the group living method was pioneered in California in 1958. (71, 76) This centre is staffed and run by addicts themselves. The aim is to attempt to create an extended family with a strong father-figure who dispenses firm justice combined with warm concern and who extols inner-directed convictions about the virtues of
honesty, sobriety, learning and hard work. This attempt has received wide acclaim as a more positive approach to addiction treatment and has enjoyed some success. It is interesting to note that a project patterned on the Synanon programme was instigated in 1964 by the Probation Department of the Supreme Court of New York. (67)

Canada:

Approaches to treatment in Canada include institutionalization (hospitals, prison etc.) and Narcotic Addiction Foundations located in Toronto and Vancouver. In British Columbia the federal institution at Matsqui for the compulsory treatment of drug addicts was opened in 1966. Treatment methods include group sessions, educational and vocational training and an intensive work programme. Much criticism has been levelled at this approach by various authorities in the field. (9) Ausubel has stated that:

"Federal drug addiction hospitals acquire an unmistakable prison atmosphere which not only subtly influences the attitudes of physicians and attendants toward the patients, but also focuses undue attention upon the security and custodial aspects of treatment. Little hope for attitudinal improvement can be anticipated when society adopts a punitive approach toward victims of a behaviour disorder and treats them as criminals." (52, p. 197)

Some voluntary programmes have emerged, such as Teen Challenge, which is essentially a religious approach to the problem. The Half-Way House programme is, basically, a self-help method where addicts try to help themselves without the aid of professionals. (73) One of the treatment centres in Canada is the Narcotic Addiction Foundation of British Columbia in Vancouver, founded in 1955. (48)

It would seem that that crucial problem in the treatment of addicts will continue to be how to effect their rehabilitation in the community. According to O'Donnell (52, p. 197), the problem is similar
to that which exists for the prostitute or criminal. In each instance a behavioral pattern has been established and the person is enmeshed in an antisocial subculture which supplies some satisfactions, group support and frequently an income level the deviant person could not achieve legitimately. It also resembles the problems faced by some alcoholics and mentally ill in their rejection by the wider society. In many cases the deviant pattern was established so early in life that there never was a period of reasonably satisfactory adult adjustment to which the person might be returned. It is not known why an addict frequently returns to drug use after a 'cure'. Presumably the factors which initially produced his addiction retain their effect. Other factors produced or accentuated by the addiction may have conditioned him to relapse.

There has been an increasing awareness among treatment personnel that success or failure in the treatment may include more than the apparent motivation of the patient, the degree of the pathology and skill of the therapist. What happens in treatment may, to a significant degree, be a function of the patient's social class position in the community. Individuals from different classes undergo different experiences, have different frames of reference for human relationships or differing kinds or orientations for acting with others. (27, p. 163) The converse of this problem exists for the middle-class helping person who fails to understand the way of life and goals of persons from lower socio-economic groups so that communication between them is frequently blocked (30) and who manifests judgmental attitudes which create an impediment to treatment. (26, p. 186)

One useful way of shedding light on this important and little understood area is to examine the addict in treatment; to try to discern the factors which lead people into drug addiction and, more specifically,
the factors which keep some addicts in a treatment situation and those which impel others to leave it. Inasmuch as the purpose of our study is to give consideration to factors which would appear to affect treatment as conceived and practiced by the N.A.F., special consideration is given to this agency setting.

EXPERIENCE OF THE NARCOTIC ADDICTION FOUNDATION OF BRITISH COLUMBIA

The Annual Report states that it was initially the intention that the Narcotic Addiction Foundation should be a pilot project primarily concerned with research and education, with treatment and rehabilitation programmes restricted to those addicts from whom the professional staff could obtain meaningful data. The Foundation, although designed for this purpose, had to abandon this role in view of increasing appeals from addicts for help, from the medical profession for advice and assistance in the dispensing of medication, and from the public for information.

(48, p. 39) The aim of the Narcotic Addiction Foundation as outlined by the Paulus study is to:

(1) Detoxify the addict and teach him to function properly without the aid of drugs.
(2) Enable him to secure or maintain work in an appropriate occupation.
(3) Have him desist in his criminal activities.
(4) Change his associations from drug users to non-users.
(5) Teach him to act responsibly in his family of orientation or procreation or both, where applicable.

(55, p. 14)

"The philosophy of the Foundation is that a change can occur in a self-induced and self-perpetuated destructive process once the patient
knows the underlying causes of the disease for which the use of drugs is a symptom". (49, p. 8) The clinic team, combining the skills of psychiatrists, physicians, social workers and psychiatric nurses, tries to treat these causes. The aims of treatment are the same for all addicts. However, for some older addicts functioning without drugs might have become impossible and the treatment programme has fallen into two groups since 1963: (1) Regular withdrawal and (2) Prolonged withdrawal, especially for the older addict. (73) Treatment at the Foundation is voluntary and offers ambulatory and in-patient treatment. Worthy of note is that in 1960 the N.A.F. commenced using the synthetic narcotic Methadone in its treatment programme and this, along with the initiation of a prolonged withdrawal programme in February, 1963 was a 'first' in the treatment field in North America. (49)

The N.A.F. has recognized the need to study the addict in his own environment, to discover something of the epidemiology of his condition, and the sequence of events which lead to addiction and its maintenance. The literature reveals a paucity of reliable studies in this regard. Outside the Paulus study (55) little has been done in the area of empirical research on the addict population of Vancouver which contains the largest proportion of addicts in Canada namely, 53.34 per cent of the national total. (48, p. 5) Descriptive reports such as the Mobilization for Youth (61) and empirical studies such as those by Chein (9) deal with addiction among Negroes and Puerto Ricans in New York and other large American cities. The value of this research has limits for our study as it is questionable whether these findings are applicable to the Vancouver scene where the addict population is comprised of 45 per cent native born, 49 per cent from other provinces and 6 per cent from other countries. Many had experimented with, or were addicted to a narcotic
drug before moving to this area. (48, p. 6) This suggests that Vancouver is one of the centres which attracts 'fringe' members of society because there is an established 'sub-culture' which allows these fringe members to flourish. (48, p. 22)

The principles and aims of the N.A.F. are in line with current thinking of leading authorities in the field of drug addiction. The Foundation is however experiencing limited success with addicts continuing in treatment. According to the Paulus study overall rates in rehabilitation are not affected by the kinds of withdrawal medication a patient receives. (55, p. 72) This finding is supported by results of other treatment approaches such as those used in Synanon and in institutional settings. Both use the 'cold turkey' method of withdrawal but Synanon claims a higher degree of success. One difference is that where withdrawal in institutions is compulsory, Synanon uses this method for proof of intention. As Holzinger (32) points out addicts who are willing to submit and succeed in this method make a psychological investment of which they can be proud. One could speculate as to whether factors other than the method of withdrawal influence the outcome of treatment.

SUMMARY

An attempt has been made to show how society's attitude toward drug addiction reflected in the laws led to the ultimate degradation of the addict. This was compounded by the punitive treatment approaches and attitudes of law enforcement officials. The addict's incarceration in institutions had specific meaning which he finds reflected in the attitudes toward him by members of the non-addict society. This conception of self as a criminal becomes internalized as he begins to apply criminal argot to his activities and institutional experiences. (59)
It is only in recent years that the notion that the addict is somehow psychologically inadequate has gained support. This, along with new knowledge of the social and cultural environment of the addict, would appear to indicate that they are socially as well as psychologically deprived. It was found that the literature which supports these views was comprised largely of theoretical discussions as well as impressionistic analyses. More empirical research in this area seems warranted before regarding this evidence as conclusive. Perhaps our projected exploratory study could be an initial effort toward defining some of the factors which may affect the continuing contact of the addict with his treatment agency.
CHAPTER II

PROBLEM IDENTIFICATION AND FORMULATION

The impressions retained after reviewing the literature are perplexing. Theories of causation are mainly speculative and are supported by no conclusive evidence other than that indicating a multiplicity of contributory factors. The differences in social attitudes toward the problem have their corollary in the conflicting modes of dealing with it. As with any social illness we are faced with treating the symptoms because of their immediacy before attempting to determine the source of the infection. Drug addiction is no exception. The difficulties have been compounded by the widely differing concepts of what drug addiction is and how the addict should be dealt with. The expression 'dealt with' is used advisedly as it is only until comparatively recently that social attitudes have permitted the possibility of viewing the addict as a sick person and addiction as a social illness, the casual factors residing within society itself.

Despite indications of a slightly rising incidence in the numbers of addicts in Canada, they represent only a small fraction of the population: approximately .0007, (48) and massive social reform is not likely to ensue in order to accommodate them other than, perhaps, in the area of legislation and the control of drugs. The fact remains that until more enlightened laws, themselves a reflection of the public's attitudes, are in effect, we are faced with treating the addict in such a manner that he can, hopefully, be helped to occupy a status and function in society more rewarding to himself and consequently of greater benefit to the community.

It is to the terms of treatment that we narrow the purpose of
this study in the hope that an exploratory consideration of some of the possible causal factors which affect the addict's treatment involvement may be determined.

Statement of the Problem

Embodied in our introductory remarks is the statement that the problem under consideration is the high percentage of drop-outs from treatment. The degree of concern expressed by the treatment personnel at the Narcotic Addiction Foundation of British Columbia is illuminated in their 10th Annual Report (1965). (48) In this report there arises an interesting comparison appropos continuance in treatment in the preliminary stages when medication is being prescribed to alleviate the distress occasioned by the withdrawal syndrome. Even at this stage the dropping from treatment averages 32.25 per cent of the outpatients and 46.75 per cent of those in residential treatment. (48, pp. 43-44) There are indications here that the 'conditions' of treatment, i.e. residential or outpatient, and not treatment per se may have some significance.

This expressed concern regarding the discontinuance of contact both during and after the medicational phase of the treatment programme has been a contributory factor in the identification and formulation of the problem under study. Recent research by Ingeborg Paulus (55, p.6) infers that all patients drop from treatment before the programme is completed. The goals of the therapeutic team are hardly likely to be realized if the patient makes himself unavailable and, in fact, the nature of addiction may lend itself to the suggestion that strong external controls are required to help the addict remain in treatment and that what is necessary is broad legislative revision comparable to that related to mental and public health disorders. (48, p. 11)
Our immediate concern however, is a consideration of the situation as it presently exists and the intention is to apply ourselves to the problem of the voluntary patient who presents himself for treatment but fails to pursue it, not only in the initial, medica­
tional phase but also at the later stages of psycho-social therapy for as long as is considered necessary on the assessment of the ther­apeutic team. (48, p. 11) The precise boundaries of the treatment span for the purpose of this study will be discussed under the operational definition of terms.

This leads to the consideration of the possible disparity in goals of the addict and the agency through its instrument of service, the therapeutic team. While it may be a relatively simple matter to define the aims of the agency under review it is feasible to propose that the goals of the patient are not consonant with those of the agency or, that though they initially have much in common, the thera­peutic encounter may have within it elements which distort or negate the original purposes of both contracting parties and which lead to the breach of contract by the addict which is giving rise to our present concern.

Assumptions

A proposition which presents itself and bears examination is that the patient's treatment involvement (longitudinally, and not to be confused with or considered to be synonymous with actual use of service) is determined by his motivation, capacity and the opportunities afforded him by both his environment and agency.

Casework theory postulates that the client with appropriate and adequate motivation and adequate capacity to whom the services offered are appropriate and supplied in an adequate manner makes use of case-
work help provided forces outside of agency or client are not too restrictive and unmodifiable. At the other extreme along the continuum it is suggested that the client who is poorly and inappropriately motivated, who lacks capacity and to whom the services are inappropriate or poorly supplied does not make use of casework help. In other words, in the terms of our study, he severs the treatment contract. As continuance in treatment is a necessary antecedent to the use of treatment our efforts will be to attempt to specify those factors or elements to which the addict appears subject.

It seems valid to propose that, as the addict's initial contact with the agency is normally on an entirely voluntary basis there is reason to assume that it is his initial intention to pursue the treatment made available. Similarly, it can be assumed that the institution of a service or an agency designed to meet the needs of these same addicts formulates policy and treatment designed to attain those ends. If such efforts on both sides fail to come to fruition one could further assume that if the agency is able to identify some of the factors which appear to be significant obstacles to the pursuance of treatment, steps could be taken to modify them in order to facilitate the addict's continuance in treatment.

Hypotheses

It appears therefore, that three major hypotheses present themselves at this stage;

A. There are factors discernible in the addict at the time he presents himself for treatment which affect his treatment involvement.

B. There are factors in the agency which affect the addict's treatment involvement.
C. There are factors in the treatment which affect the addict's treatment involvement.

In pursuit of this reasoning it is logical to hypothesize that if hypotheses A, B & C are supported and any or all of the detrimental factors which are subject to modification are modified, the addict's treatment involvement would be enhanced. At this stage of the study, however, it is considered imperative to confine ourselves to an examination of those factors referred to in hypotheses A, B & C.

Dependent and Independent Variables

Since the purpose of this exploratory research is to address itself to the question of the addict's continuance or discontinuance in treatment, hereafter referred to as 'treatment involvement', this will be viewed as the dependent variable.

Those factors possibly influencing the addict's contact could be of infinite variety and endless permutation, but those which are separable and measurable and of seeming significance will be termed the independent variables and our efforts will be toward recognizing and delineating them.

We have already made reference to the cultural differences attendant upon narcotic addiction in the U.S.A. and Canada. Since many of the studies we have discussed have been pursued in the United States they have little direct reference to the Canadian narcotic addict's subcultural environment. Undeniably, the Canadian addict pursues an existence fraught with misery and hazard but he is freer from the additional pressures of ethnic and the more extreme and complex economic deprivations than his American counterpart. It can be reiterated then, that the area of concern of this particular study is confined to the geographic locale of Greater Vancouver - the residential milieu of the
majority of Canadian addicts - and it can be speculated that the main consumers of the possible outcome of these particular research efforts would be the Narcotic Addiction Foundation of British Columbia.

In summary, if there are factors which are discernible when the addict presents himself for treatment which appear to affect his treatment involvement it is conceivable that the demonstration of the association of such factors with treatment involvement would materially affect the whole approach to the problem of the treatment of narcotic addiction from medical and psycho-social therapy to the broader aims of agency policy and development and its interpretation. This, in itself, is sufficient justification for the pursuit of those factors which may have direct or indirect bearing on the treatment aims and their planning and implementation at the Narcotic Addiction Foundation of British Columbia.

OPERATIONAL DEFINITIONS

As noted in the review of the literature there are many and varied stated definitions of the terms used in discussing addicts, addiction, treatment, etc. For the purposes of this study the key terms as stated in the hypotheses are defined as follows:

Addict

A person, who, not requiring the continued use of a drug for the relief of the symptoms of an organic disease, has acquired as a result of repeated administrations, an overpowering desire for its continuance and in whom withdrawal of the drug leads to definite symptoms of physical and mental distress or disorder. (66, p. 2)
Addiction

No truly comprehensive definition of addiction has yet been formulated. The Stevenson Report questions the full definition put forward by the World Health Organization and specifically that portion which states that the addict "will obtain it by any means".

The physical and psychological properties are best described by a reformulation of the definitions put forward by Goodman and Gilman and the World Health Organization. (22, 69)

Drug addiction is a state of periodic or chronic involvement with the consumption of a drug, the securing of its supply, and a high tendency to relapse after withdrawal. It's characteristics include an overpowering desire or need to continue taking the drug, a tendency to increase the dose, and a psychic (psychological) and sometimes a physical dependence on the effect of the drug.

Addiction if thus viewed as an extreme along the continuum of drug use and refers in a quantitative rather than qualitative sense to the degree to which the drug use pervades the total life activity of the user.

Treatment

Throughout the literature it is apparent that there is much conflict regarding the most effective methods of treating the addict, depending on how the addict is seen. Those who favor the legal methods feel the addict needs only to be free of drugs while serving a sentence imposed by the courts. Others feel the addict can be treated
only in an institutional setting but utilizing professional staff administering psycho-therapy and/or casework counselling and/or vocational retraining. There are some advocates of treatment such as Marie Nyswander, who feel that medication such as methadone must be included and that the addict can best be treated on an outpatient basis.

The philosophy underlying the treatment of the addict who applies for service at the Narcotic Addiction Foundation of British Columbia is that "change can occur in a self-induced and self-perpetuated destructive process for which the patient seeks to alleviate the pains associated with physical withdrawal from drugs, while the treatment team seeks to treat the underlying causes for which the taking of drugs is but a symptom." (56)

In this study the definition of treatment as employed by the Narcotic Addiction Foundation of British Columbia will be used. The Foundation employs the following treatment procedures on an outpatient basis:

1. Social work counselling
2. Medical examination
3. Psychiatric assessment and counselling
4. Community, physicians and other resources
5. Social casework

In a broad sense the treatment approach can be classified under two main headings:

1. The alleviation of physical distress occasioned by the onset of the withdrawal syndrome.
2. Rehabilitative measures implicit in the psycho-social therapy offered.

Treatment Involvement

This will be defined as having had, on an outpatient basis, more than 10 social casework and/or psychiatric interviews, whether or not the withdrawal period was completed. This is the definition used in the Paulus study and is utilized here to ensure correlation with the agency's drop-out statistics.

Agency

The agency referred to in this study is the Narcotic Addiction Foundation of British Columbia, 2524 Cypress St., Vancouver 9, British Columbia.
CHAPTER III

RESEARCH DESIGN

The task of determining some of the variables which appear to be of significance to the addict's treatment involvement is visualized in two phases. In the first phase attention will be concentrated upon delineating those factors which lend themselves to examination by means of a retrospective study. In the second phase those variables which emerge from the retrospective study as significant and measurable will be used further in a longitudinal study. This would necessitate the application of the variables to current and projected treatment over a specified period of time. Variables of proven validity could then be used as tools for prognostication.

FIRST PHASE - THE RETROSPECTIVE STUDY

We have already determined that the locale of our research will be the Narcotic Addiction Foundation of British Columbia. The data available for collection and analysis are limited because of the addict's propensity to pursue an existence which is of an erratic and transient nature. Records at the Foundation go no further back than 1959 and the opportunities to assemble a sample for study which is large enough to be considered representative are circumscribed by these facts. Fortunately, the Paulus Study, though pursued for reasons different from ours, provides us not only with a study sample of reasonable proportions, (105 addicts, 50 males and 55 females), from which we can select the majority of our subjects, but also with a collection of data some of which are of immediate relationship to our factors. It should be explained at this stage that the Paulus Study was designed to examine the difference in
change between two groups of addicts, one group on the regular withdrawal dosage of medication, the other on prolonged or maintenance dosage. Our concern is directed solely toward those addicts on regular dosage of medication and the data assembled by the Paulus Study will be separated, extracting only the information which is pertinent to the regular group.

It has to be constantly borne in mind that what we are determining at this stage is a composite diagnosis or assessment of the addict at the time he presents himself for treatment. The immediate aim is to separate certain factors which are discernible at this point and test them to determine if they influence his treatment involvement.

Factors - The Rationale

The following factors were developed from the literature in general, the Paulus Study in particular and from N.A.F. records as well as the personal experiences of members of the research team who have been involved in the treatment of narcotic addicts.

No. 1. Drug Use Pattern

By drug use pattern is meant the characteristics of the use of drugs. The types or forms of drugs (alcohol, barbiturates, opiates), the varying periods of addiction and the corresponding periods of being 'clean'; the activities engaged in to support the habit and reasons for abstinence. All will be used to define a pattern of drug use, a continuum along which the addict's position may be related to treatment involvement.

No. 2. Work Pattern

In view of the formidable difficulties which face the addict when he attempts to resume his position as a working member of the community it is reasonable to assume that his previous work experiences directly influence
his efforts at rehabilitation. The appropriateness of his education, training and abilities to the jobs available, and the lengths of employment or unemployment are important elements of the rehabilitative process. A measurement of his success and difficulty prior to treatment would probably provide an indication of his chances of success in the projected undertaking of seeking abstinence and independent functioning.

No. 3. Delinquency Pattern

There are varying conclusions drawn from studies pertaining to the criminal activities of the addict prior to and after addiction. The Stevenson Report (69,p.21) states that, "practically all addicts had convictions prior to their contact with narcotic drugs". In contrast, only 57 per cent of Paulus' regular group are so designated. (55,p.53) The paucity of studies in this area coupled with the fact that juvenile records are not available for inspection adds confusion to the issue. It is further believed that if the addict was addicted prior to any criminal activity his chances of positive change are better than if vice versa. (55,p.52) These are important considerations in connection with treatment involvement because, as we have already intimated, continuance in treatment is a necessary antecedent to use of treatment, by which, presumably, change is effected.

No. 4. Family History

We assume that the addict's discomfort arising from his problem and his total life situation motivates him toward treatment. Further, as the addict is present-oriented it is reasonable to suppose that most of his discomfort arises from his immediate and continuing close family and social network. Ripple (78) in her study on continuance in casework service found
that the patient who is rated as having low discomfort about his problem and in his life situation rarely continues. Finlay (77) posits a reinforcing thesis. If it can be determined at the outset what the addict's actual (not merely legal) situation in relationship to spouse, family and wider network the conclusions drawn from the Ripple and Finlay studies could be applied to the specific nature of a particular problem; namely, addiction.

No. 5 Male - Female Comparisons.

The ratio of male to female addicts presenting themselves for treatment at the Narcotic Foundation is 70 per cent males to 30 per cent females. (55,p.12)* If it can be established that differing proportions continue in treatment this would be a significant factor for prognosticating treatment involvement.

No. 6. Age

An important aspect of the addict's desire for narcotics is that it appears to undergo change with age. Paulus comments (55,p.47) upon the striking differences in response to treatment of differing age groups, alluding to her findings that the older addicts appear to be more rehabilitative. In the U.S. Charles Winick (75) suggests that a 'maturing-out' of narcotics addiction takes place for perhaps two-thirds of the addicts. He

* This closely parallels the figures for criminal addicts reported by the Division of Narcotic Control for 1964. (72% M to 28% F). (55,p.12)
speculates that as the stresses of adolescence become less insistent and
the drug user feels less threatened by the need to respond to such stresses
he tends to stop taking narcotics. If the relationship of age to treatment
involvement can be determined it would be a clear-cut factor to aid prog-
nostication.

No. 7. Stated Reasons for Seeking Treatment.

Assessment of motivation, especially when one also takes into
account its unconscious aspects is, at best, unreliable. Nevertheless,
working on a conscious level the addict's stated reasons (presuming he is
truthful), may be a measurable factor relative to his continuance in treat-
ment. Considering the voluntary nature of his initial attendance the source
of his anxiety or his discomfort which he states propels him toward seeking
some amelioration of his condition may have indications directly related
to his treatment involvement.

No. 8. Previous Treatment Involvement with N.A.F.

The repetitive-compulsive nature of the addict's behaviour lends
itself to examination in connection with treatment involvement if it can
be studied over a period of time to determine if a definite pattern exists.
From T1 to T2* in the Paulus Study the number of contacts for withdrawal by
some addicts range as high as 10+. If it can be determined that a relation-
ship exists between the number and duration of treatment attempts and the
final successful completion of the treatment programme it may or may not be
a significant factor discernible at the time an addict presents himself for

* Symbols used in the Paulus Study to define points in time.
  T1 = Time First Sought Treatment.
  T2 = Time Research Interview took place. (55,p.11)
No. 9. Agency Staff.

In the therapeutic relationship the therapist’s sex, profession, training, experience, attitudes, personality and associated traits are important elements. Some are difficult or impossible to measure but those which are, (sex, profession, training, experience for instance), lend themselves for testing for their relationship to the addict's treatment involvement.

Data Collection.

At the outset it must be realized that the instruments of measurement described in the Paulus Study cannot, for our purposes, be used 'in toto'. Each has to be examined for validity and appropriateness. It has to be remembered that her enquiry was directed toward evaluating change in two comparative groups of addicts during and after different types of treatment, i.e. prolonged or regular dosages of medication. Our concern is focussed upon discerning particular factors at a specific point in time namely, when the addict presents himself for treatment. Consequently, our use of the Paulus data will be mainly extracting information relevant to our enquiry and pertaining only to the group designated as the regulars.

As an illustration of this, when pursuing factor No. 8 (Previous Treatment Involvement with the N.A.F.) we will collect from Table 22 (55,p,58) data confined to the number of N.A.F. withdrawals, ignoring all other information detailed therein. As the method of data collection for each factor is discussed, such adaptations, where necessary, will be indicated.
The primary source of our information will be the interview schedule, questionnaire items and ratings devised by Miss Paulus to provide the source material by which she arrived at the T1 assessment for her comparative study. There will be one exception. When considering factor No. 9. (Previous Treatment Involvement with the N.A.F.), the period of her enquiry (T1 to T2) will be utilized. Miss Paulus' sources of information were Police Records, The Division of Narcotic Control, N.A.F. Records and structured interviews with the addicts.

Other sources of data for our study will be agency records (files, interview schedules etc.) as well as, where indicated, questionnaires designed to elicit information from present staff or past members of the staff if they can be located.

Factor No. 1. Drug Use Pattern.

Source of data will be the interview schedule items 041 and 042 used to assess the addict's drug use pattern at T1.

Factor No. 2. Work Pattern.

Source of data will be the interview schedule items 071, 072, 073, 074 and 075 used to assess the addict's work pattern at T1.

Factor No. 3. Delinquency Pattern.

Source will be the statistics determined from official sources which were used to support the T1 assessment of the addict's delinquency pattern.
Factor No. 4. Family History.

Source of data will be the interview schedule item 148 used to assess the addict's family history at T1.

Factor No. 5. Male-Female Comparisons.

Source of data will be the interview schedule item 007 which will be utilized by simply dividing the sexes and comparing them with treatment involvement.

Factor No. 6. Age.

Source of data will be the interview schedule item 008 extracting the simple statistics and instituting 'cutting points' where indicated.

Factor No. 7. Stated Reasons for Seeking Treatment.

Source of data will be interview schedule item 036. The table used by Paulus (55,p.54) will be utilized to group the specifics determined by the questionnaire and subsumed under the six broad headings of Drugs, Legal, Health, Work, Family and Other.

Factor No. 8. Previous Treatment Involvement with the N.A.F.

Source of data will be interview schedule item 017 which gives numbers of contacts for withdrawal during the period from T1 to T2. The agency files will be used to identify those who, while in regular treatment eventually completed the programme (by the study definition of completion). Thus two comparative groups will evolve and a simple graph will be devised to illustrate the relationship, if any, between the number of times an
addict presents himself for treatment before he succeeds in finally completing the programme.

Factor No. 9. Agency Staff.

Sources of information pertaining to the therapists involved with the selected addicts would be derived from, initially, the addict's file to determine the therapist and then from the therapist's personal file to ascertain the details to be considered i.e. sex, profession, training, age in relation to patient's marital status and experience in the treatment of addicts. We will also devise a questionnaire and rating scale to elicit the expert judgment of the appropriate and available personnel regarding attitudes, (from permissive to authoritarian) and capacity for casework relationships of the treatment staff. Once the pertinent details are listed they can be cross-examined with the sex, age, marital status and treatment involvement of the addict to determine the co-relationships.

Data Analysis.

The data will be analyzed by separating the appropriate factors concerning those addicts in regular treatment and relating them to the addicts' treatment involvement. Thus, the factors will be pre-tested and those which survive will be further tested in a longitudinal study.

SECOND PHASE - THE LONGITUDINAL STUDY

Emerging from the retrospective study will be specific factors discernible at the time the addict presents himself for treatment, which, judged by evidence produced by the pre-testing appear to be significantly related to his treatment involvement. The next logical step will be to further prove the validity of each factor which has emerged in a fashion
which will reinforce, modify or discount the findings — by means of a longitudinal study.

The period of testing will be for twelve months, from the time the addict presents himself for treatment, when the initial assessment will be made to the time the review assessment will take place. To avoid confusion with the Paulus Study these points in time will be symbolized by F1 and F2.

F1 = Factors used in initial assessment.
F2 = Factors evaluated after 12 months.

All addicts who present themselves for treatment at the Narcotic Addiction Foundation for a period of six months from F1 will be assessed, using the questionnaires and rating scales devised for the retrospective study. The cutting-off point for addicts to be so studied will be six months after the commencement of the study, F1 + 6. Thus, the longitudinal study will take place over a period of eighteen months: F1 + 6 + 12.*

It will be seen, however, that evaluation of the factors and treatment involvement can commence at F2 (F1 + 12) as each subject will be examined as his twelve months period expires.

* Code for Symbols.

F1 = Factors used in initial assessment.
F2 = Factors evaluated after 12 months.
F1 + 6 = Six month period during which all addicts presenting themselves for treatment will be included in the study.
F1 + 6 + 12. Total period of study for all addicts.
Thus, those factors which originally emerged as significant in the retrospective study will be additionally tested under conditions of current treatment. Those which survive the longitudinal study will be of value not only prognosticative tools for treatment involvement but as indications of factors to be modified, where possible, in order to enhance the probabilities of the addict's continuance in treatment.

SUMMARY

The primary and often admittedly only goal of the narcotic addict seeking voluntary treatment at the Narcotic Addiction Foundation is withdrawal medication. However, the philosophy underlying the treatment offered to the narcotic addict is that change can occur in a self-induced and self-perpetuated destructive process for which the patient seeks to alleviate the pains associated with physical withdrawal from narcotic drugs, while the treatment team seeks to treat the underlying causes of the disease for which the taking of drugs is a symptom.

At the Narcotic Addiction Foundation the clinical approach to the treatment or drug addiction combines the skills of physicians, psychiatrists, social workers and psychiatric nurses. When a patient first arrives for withdrawal help, it is the function of the treatment team to involve the patient in treatment beyond the immediate relief of withdrawal discomfort.

Records at the Narcotic Addiction Foundation show that most patients attend the clinic more frequently during the period that medication is provided. However, as soon as the period of withdrawal under medication is completed the majority of addicts drop out of the treatment process. The degree of concern felt by the treatment personnel about the proportionately high percentage of patients dropping from the treatment process has led to
the identification and formulation of the problem for this study. The therapist's goals are hardly to be realized if the patient makes himself unavailable for continuing treatment. The primary concern of this study is to determine whether there are factors discernable at the time an addict presents himself for treatment which are associated with treatment involvement.

It became clearly evident from the review of the literature on drug addiction that there were conflicting views of narcotic addiction and treatment. This is indeed a most controversial field with a paucity of reliable studies. Most of the literature is based on impressionistic or theoretical material reflecting the bias or orientation of the author with little reliable evidence to substantiate the points of view expressed.

Basically, there appear to have been two main approaches taken by authors and individuals dealing with the problems of addiction and these reflect two divergent points of view about the nature of drug addiction. One approach considers drug addiction a social problem properly dealt with by the law enforcement agencies. The other approach, entertained by the legal and medical authorities, considers drug addiction a medical problem which should properly be dealt with by the medical authorities. While both views co-exist in our society the literature indicates a shift, over the course of the last few decades, from an emphasis on law enforcement, to treatment and rehabilitation.

The wide range of treatment approaches indicates the extreme complexity of the drug addiction problem. A variety of factors emerge from the literature which may affect the addict's treatment involvement. However, this area of research has no specific documentation to date.
Since our study is primarily concerned with the treatment of addicts at the Narcotic Addiction Foundation of British Columbia it is necessarily circumscribed by that agency. Several difficulties were encountered which required a refocusing of the study. While the Narcotic Addiction Foundation opened in December of 1958 it was only in 1965 that any systematic approach to data collection was devised. In the following year the agency published the findings of a research study on the problem of drug addiction using a pre-coded intake interview schedule which enabled them to get "statistically speaking" a picture of their treatment population.

Because of the lack of any earlier systematic collection of statistics on the epidemiology of drug addiction with regard to the Narcotic Addiction Foundation population it was necessary for the present research to utilize a retrospective design using some of the factors and categories of the pre-coded intake interview schedule used in the Paulus Study.

Thus, an exploratory retrospective study was formulated for instrument testing and a longitudinal study was prepared for the testing of the study hypothesis.

Recommendations

It is recommended that the factors and their measurement be further developed and tested by the Narcotic Addiction Foundation.

It is further recommended that research in the field of narcotic addiction be considered unsuitable for student research because there is a paucity of reliable studies and the field of narcotic addiction is both complex and controversial requiring considerable time for students to become familiar with its many aspects.
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