

AN EXAMINATION OF THE FEASIBILITY OF A DRUG TREATMENT
COURT IN HALIFAX

AN OVERVIEW

BY

DON CLAIRMONT, DALHOUSIE UNIVERSITY

CAROLYN DAVISON, DEPARTMENT OF HEALTH, NOVA SCOTIA

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INTRODUCTION:

This Overview discusses, briefly, the drug treatment court (DTC) phenomenon and provides a summary of the four parts that constitute the authors' report on the feasibility of a DTC in metropolitan Halifax.

The DTC has been defined as an alternative sentencing structure within the criminal justice system (CJS) - some advocates characterize it as "smart sentencing" - that combines court supervision and substance abuse treatment to improve the health outcomes of drug offenders, rehabilitate them, and reduce crime. The DTC typically effects a team approach to the problems of addicted offenders, emphasizing the collaboration of CJS role players and of CJS and Treatment personnel. It brings much greater focus and holism to the official response to addicted offenders as well as closer monitoring of their behaviour and more immediate consequences (rewards and punishments) contingent on their behaviour during the time that they are participating in the program. The DTC path is an option voluntarily chosen by the addicted offenders.

The DTC clearly is one facet of the therapeutic jurisprudence or "problem-solving court" movement that has become increasingly popular in the USA, Britain, Australia, New Zealand and Canada over the past decade. Other facets would be domestic violence courts, mental health courts, and, in Canada, the Gladue court for aboriginal peoples. Observers contend that the specialty courts and fine tuning of the CJS approach to different issues and subgroupings are congruent with post-modernism in its proclivities and sentiments. The movement appears to advance a more proactive and invasive CJS and entails, even if more modest in practice than in rhetoric, some restructuring of roles within the CJS and between the CJS and welfare/health sectors. Its advocates advance a social construction of the addicted offenders and the CJS that is driven, like all social constructions, by a combination of knowledge, pressures and interests. Typically, it

is argued that the addicted offender requires a different CJS approach in principle, that the current CJS response is both inefficient and ineffective, and that the extant power/authority of the courts can effectively coordinate a positive rehabilitative context. The social constructions of DTC advocates, in characterizing the current approach, highlight the fragmentation of the CJS-Treatment response to the addicted offenders, the "aloofness" of the judge, and the limited collaboration, if not adversarial relations, between prosecution and defence and between treatment providers and CJS monitors. In the DTC, by contrast, the judge presumably acts more as a team leader who facilitates the sharing of information and coordinated focus, and whose personal interaction with the addicted offender is deemed to have considerable symbolic significance. The DTC's advantage is also argued to be a function of close monitoring of, and bringing immediate consequences to bear on, the behaviour of DTC participants. The participant in the DTC option regularly reports to court and is involved in an intensive and long-term treatment program.

Not surprisingly, the DTC, and the "problem-solving court" in general, have generated some controversy. Some criticism has focused on the changed role of the judge (team leader? the "scripting" entailed in pre-court sessions?) while other has been directed at the sharing of information with the prosecution by defence counsel and treatment providers or the equity of giving priority, in terms of resources and access to programs, to offenders who are addicted to hard drugs. Still other criticism focuses on the concept of therapeutic jurisprudence and whether it represents a new progressive horizon or a throwback to an earlier era of administrative justice. Perhaps the biggest policy issue has been whether the DTC claims for its greater effectiveness and efficiency have validity.

The accessible literature - theoretical, descriptive and evaluative - on DTCs is largely American, not unexpected since most DTCs are to be found in the USA. Certainly the DTC movement

in the USA has underwent considerable growth over the past decade. While precedents for it, in terms of judicial style and Justice-Treatment linkages, can be observed in the 1970s and even in the 1950s, the first formally designated DTC was established in Miami in 1989. By 2002, there were over 1200 DTCs scattered throughout the USA. The American literature depicts a DTC approach that is characterized by great variety in terms of the scale of the operations (e.g., number of clients, number and full time / part-time status of designated Justice and Treatment role players), the extent to which the DTC is differentiated from the rest of the criminal court system (e.g., designated role players, different facilities), the targeted clientele (e.g., adults, youth, minorities), the type of addiction focused upon (e.g., soft drugs, hard drugs, alcohol as well as drug addiction), the structure of the court (e.g., types of roles and linkages), the status of the treatment service providers (e.g., governmental, non-profit, private business), and the funding arrangements. Still, there are basic features that appear to be found everywhere, especially the team approach among CJS role players, the close Justice-Treatment linkages, the intensiveness of the treatment, the "invasiveness" of the CJS, the emphasis on immediate meaningful consequence for participants' actions, and the strategic use of coercion and rewards. A review of the literature does not reveal profound differences in the substance of the treatment provided, though some modest differences in how the treatment program is arranged and facilitated have been noted.

On the whole, the evaluation literature has yielded a very positive assessment of the DTC experience in the USA. Correlates of successful participation have been identified; for example, males, older addicts, crack/cocaine users, those with much previous exposure to treatment, resiliency of participants' social networks, less involvement in a criminal milieu, among other factors, have been shown to be highly and positively related to retention in the program and retention past thirty

days has been strongly related to successful completion of the treatment program. Other potential significant factors such as race/ethnicity, and type of treatment delivery (out-patient versus residential) have not been found to correlate with success. Successful outcomes have been generally defined as the participant becoming drug-free and having low levels of criminal recidivism. Typically, favourable comparisons are drawn on salient outcome measures between participants and non-participants in the DTC option, and especially between graduates of the DTC experience and other groupings of addicted offenders. Typically, too, the evaluation studies suggest that the costs-benefits of the DTC are far more favourable to the public purse than the current mainstream practices. Offenders' assessments of the DTC have emphasized the value of the coercive strategy and the 'power of the robe" in facilitating their rehabilitation. The positive findings are tempered by the realization that self-selection considerations and lack of sophisticated "controls", as well as the need for appreciating more long-term effects, may be contaminating the results. Nevertheless, the outcomes and efficiency claims have been impressive. There remains much lively discussion in the literature concerning the processes, outcomes and larger policy implications of the DTCs. Given the positive assessments, it is not surprising that there has been a discernible evolution in DTCs whereby they are increasingly targeting a clientele of more serious offenders with significant criminal records.

In exploring the feasibility of a DTC in metropolitan Halifax, several research strategies were employed. First, it was considered crucial to review the literature in order to place the DTC phenomenon in context and identify its main features, the policy issues it raises, and the findings of recent evaluations. Secondly, the Canadian experience to date was closely examined through multiple site visits to Vancouver and Toronto and single visits to Ottawa and Saint John; e-mail and telephone contacts supplemented the site visits. In order to appreciate the scale of

the hard drug abuse problem in the Halifax area and its linkage to other criminal activity, multiple secondary data sets were analyzed as well as prosecution, police and health records. A large number of in-depth, one-on-one interviews (76 in all) were conducted with judges, prosecutors, defence counsel, probation officers, police officers, Justice administration officials, treatment specialists and community activists/service providers. Such interviews provided insights into the various social constructions that exist concerning the drug-crime nexus, current and alternative strategies to deal with the associated problems, the scale of the problems, and the desirability and possibilities regarding a DTC initiative in this area. Finally, various options were advanced and assessed, based on the findings that emerged from these research strategies.

Conclusion from Each Section of Study

The main conclusions from each of the major parts of the feasibility report are reproduced below.

PART ONE: AN OVERVIEW OF THE CANADIAN EXPERIENCE

This part of the report deals with the experience to date of the drug treatment court movement in Canada. It consists of thirty-eight pages which deal, in sequence, with an introduction to the DTC in Canadian context, an account of the Toronto and Vancouver DTCs, and a review of preliminary DTC developments in Ottawa and Saint John. The section ends with a conclusion of the Canadian experience to date. Included here in this "Overview" are the Introduction and Conclusion to Part One.

THE DTC IN CANADA: AN INTRODUCTION

The first DTC in Canada was initiated in Toronto in 1998. Three years later the Vancouver DTC was launched. In both instances the major project multi-year funding was provided by the Justice Canada's National Crime Prevention Centre (NCPC). In the winter of 2003 an Ottawa DTC proposal was developed and its

advocates are awaiting word on their funding request via NCPD. Several different metropolitan areas are in the planning stages for DTCs, including Halifax and Calgary. As in USA, the federal government's advocacy and funding has been significant. In May/June 2003 federal officials - Justice and Health - announced that \$23 million would be provided to expand the DTC program, funding projects over the next five years; the news release referred to support for ongoing DTCs at Vancouver and Toronto and for as many as three new sites. There is also much to be learned from a closely related problem-solving court development, namely the mental health court (MHC), of which, currently, there are two in Canada, in Toronto and Saint John respectively (Toronto was first MHC in Canada).

Certainly this DTC development fits well, in strategies and sentiments, with the broader therapeutic jurisprudence or the problem-solving court movement which has become widespread in North America and beyond. All the Canadian project groupings are headed by committed moral entrepreneurs and virtually all officials involved are very enthusiastic about what they are doing, rather messianic in their viewpoints, and quite interested in assisting other potential DTCs in all respects (e.g., distributing their funding proposals, talking with their role counterparts etc). The problem-solving court movement is alive and well in Canada. At the same time, there may well be special challenges for the DTC in Canada. For example, as compared to the United States, Canada has less severe sentencing for most criminal offenses and certainly for possession of and trafficking in hard drugs. Conditional sentences have become quite widespread too, and drug addiction is apparently considered to be a mitigating factor in sentencing. Under these circumstances, given the invasive character and long duration of the typical DTC program, it could be expected that DTC participants here would be what the DTC literature would label, "tough to rehabilitate clients with many social problems". Offenders opting for the DTC program presumably would mostly be persons who would be facing

remand and some incarceration for their offenses. Still, the DTC evaluation literature indicates that the DTCs have experienced significant success with this type of addicted offender. Although there are some major methodological issues concerning these evaluation studies (especially the self-selection problem), the general results indicate that, compared to other groupings, DTC participants, and especially DTC graduates, exhibit both less recidivism and more positive social behaviour.

CONCLUSION: THE CANADIAN EXPERIENCE TO DATE

The Toronto and Vancouver DTCs at this point in time represent the DTC presence in Canada. They share many features, including similar offender/participant profile, similar eligibility rules (e.g., only CDSA offenses for "track two" eligibility), similar protocols with participants, parallels in DTC structure and functioning (e.g., designated CJS and Treatment role players, team approach, similar sanctions, pre-court "scripting" sessions) and treatment format (e.g., outpatient emphasis, substance of their treatment programming). They differ in several respects, especially in terms of the treatment provider (non-profit, governmental versus private sector), some aspects of the treatment strategy (e.g., in Vancouver there is apparently more emphasis on a psycho-biological approach which emphasizes, among other things, physical care and sound diet) and the involvement of police and community organizations (it is more formal and extensive in Toronto). Both DTCs, at this writing, are carrying about the same number of active, "in good standing", participants (roughly 35), a smaller number than initially anticipated for this stage in their development. In both programs there have been almost no "track one" participants, that is, less serious offenders (e.g., women facing prostitution charges) who could readily secure bail and who could have had their charges withdrawn in the event they completed the DTC program. In other words, both programs have been dealing with what has been labelled in the DTC literature as "some of the toughest clients".

Overall, and among all those accepted into the program, the success rate appears to be roughly 15%. Both programs report significant success among participants who are retained in the program for more than thirty days. Both programs feature highly motivated CJS and treatment personnel who typically have remained enthusiastic about the DTC initiative. Indeed, the CJS role players in each DTC expressed a strong wish to have less restrictive eligibility criteria and a more expansive program.

Apart from Toronto and Vancouver, there is a DTC recently launched in Saint John (with one participant at this writing) and others being advanced in other large Canadian cities, Ottawa being the most likely to begin operations soon. As noted elsewhere, the Ottawa and Saint John DTC models differ from that of Toronto and Vancouver most significantly, but not only, in having a broad base of eligibility, being open to addicts with serious criminal records and charged with serious criminal code infractions. Some key Toronto and Vancouver DTC officials, in addition to seeking a broader-based eligibility, have indicated a wish to expand their programs into other addictions (e.g., Vancouver and alcohol addiction) or social groupings (e.g., Toronto and youth). The number of Canadian DTCs, along the continuum from drawing board to launching to maturing, is growing. This development is congruent with the Government of Canada's policy of encouraging the DTC approach and will provide competition for the significant funding that it has made available. In early summer 2003, the major federal initiative to expand DTCs in Canada was announced, involving collaboration between Health and Justice with program management being carried out by NCPC (Justice). As of October, 2003 apart from Vancouver and Toronto, NCPC had received eight "expressions of interests" from centres throughout Canada.

PART TWO: THE SCALE OF THE PROBLEM IN THE HALIFAX AREA

This section of the report assesses the extent of the "hard drug" problem in metropolitan Halifax as it relates to the criminal justice system (CJS). In addition to culling estimates and patterns from numerous interviews with CJS role players, treatment officials and informed community influentials, a variety of data sources were accessed. These latter included federal prosecutions data, monthly and annual reports from the Halifax Police Drug Squad, three Nova Scotian CJS secondary data sets (i.e., Community Corrections, Custody Admissions, and Court Appearances), and referral data from Addiction Prevention and Treatment Service, Department of Health, Nova Scotia. All data sets covered a three-year period. Part Two is twenty-eight pages in length and contains fifteen tables. The brief conclusion for this chapter is included in this Overview.

HOW BIG IS THE PROBLEM: CONCLUSION

Through accessing a variety of data sources it has been possible to characterize the possible clientele base for a DTC in Halifax. It seems clear from federal prosecutions data and reports of the Halifax Drug Squad that pertinent CDSA charges - the basis for entry into Toronto and Vancouver DTCs - would constitute a very limited pool of eligibles. The 'hard drug' charges averaged about 7 a month in recent years which translate into 5+ distinct individuals and this figure, discounted for non-addicted traffickers, becomes 2 or 3 offenders per month; based on DTC experience elsewhere, less than half these offenders in turn would opt for the DTC and only 10% to 15% of those who did opt for it would graduate.

Analyzing data from the secondary data sources, namely custody admissions, JOIS and community corrections (conditional sentences and probation), it is clear that there are many offenders who appear to have a hard drug addiction among those convicted of criminal code offenses; indeed, the figures suggest

that the proportion of such addicted people might well be greater than among those charged with the salient CDSA offenses. These data sets also point up the strong linkage between drug addiction and crime (multiple repeat offending). The number of hard drug addicted persons either on probation or parole or in extant NSLA caseloads appears to be roughly 200 a year, not a huge number compared to Toronto or Vancouver but perhaps constituting an adequate pool for a modest DTC initiative in Halifax that remained entirely focused at least initially on hard drug addicted offenders (i.e., did not include those with other addictions such as alcohol or gambling). Given the host of factors encouraging or limiting participation, the funnelling (from charges to eligibility) noted above, and the experience of Vancouver and Toronto, it would appear that over a period of several months a client base of perhaps a dozen persons could be developed.

Data from treatment sources, basically APTS client data, dovetails well with the estimates of Corrections and Parole interviewees, namely that there are about a hundred or so convicted hard drug addicts in metro Halifax under supervision and in the Capital District treatment programming. The addiction problem is well distributed throughout Nova Scotia but the cocaine/crack addiction is more concentrated in the Capital District, especially for women. The APTS data and other sources (e.g., Directions 180) indicate quite clearly that there is much addiction to hard drugs which may never manifest itself in the criminal justice system; for example, an indication of this larger phenomenon is that in the Capital District, there are some 265 persons receiving regularly prescribed methadone, 132 from public organizations (Directions 180 and APTS) and 133 from private physicians.

PART THREE: STAKEHOLDER VIEWPOINTS

This section, some fifty-eight pages, presents the views and perspectives of CJS and Treatment officials as well as some knowledgeable community people providing services to those with an addiction to "hard drugs". Seventy-six persons were interviewed over a twelve month period, virtually all one-on-one, sometimes on multiple occasions. Their views were obtained on the extent of the drug abuse problem, current CJS processing of offenders who are addicted to hard drugs, the CJS-Treatment linkages, alternative possibilities and, usually after describing the DTC approach and experience to date to them, the DTC option. Fifty-nine of the seventy-six respondents were CJS role players, namely judges (six), crown prosecutors (seventeen), defence counsel (eleven), probation officials (seventeen), police officers/officials (six), and senior Justice officials (two). In addition, six treatment/health professionals were interviewed and eleven community influentials. The views of each of the CJS subgroups as well as the treatment and community subgroups are presented separately in the text. Included in this Overview are the conclusion for the CJS views, a very brief conclusion of treatment and community views, and the four major conclusions regarding the DTC option that emerged from virtually all the interviews.

CJS VIEWS: CONCLUSION

Among the CJS role players interviewed in this project there was widespread support for implementing a DTC in metro Halifax. Almost everyone agreed, for practical and fairness reasons, that eligibility should be based on an offender's addiction to hard drugs, whether the offence charged be a CDSA or a criminal code infraction. There was a widespread, though not unanimous, agreement that the current ways of responding to the addicted criminal were inadequate from the point of view of dealing effectively with the offender and in reducing the harm of his/her actions for society at large. It was contended that there were

serious shortfalls concerning the linkages between treatment programs and CJS prescriptions and actions, and that the sanctions for breaches were, for one reason or another, ineffectual. The strengths of a DTC approach were seen to be (a) getting more at the roots of the offenders' actions, and (b) effecting a team approach between Health and Justice prescriptions and actions, and (c) using coercion effectively to enhance rehabilitation. Other strengths were seen to be the immediate consequences, both positive and negative, for the addicts' behaviour, and the holistic focus that a DTC brings to bear on the addicts' attitudes, behaviours and social situations. The potential weaknesses of a DTC were seen as most likely at the implementation level (e.g., will there be consequences for violations?) but there were occasional concerns raised about expending scarce resources on this particular grouping of offenders and some uncertainty about the motivation of the offenders opting for the DTC. In all role categories of the CJS sample, the central position was that the resource requirements for a DTC were not huge and, for a modest-sized DTC, perhaps could be largely directed to treatment and coordination. Similarly, in all role categories, there was a common view that some colleagues would be appropriate and eager to be seconded to the DTC. The characteristics of the local offenders driven by addiction to hard drugs, as identified by the CJS sample, were, with the exception of criminal record and roots in a criminal milieu, the features found in evaluations of DTCs to be associated with participants' success in the program (e.g., crack/cocaine addiction, older persons, males, past treatment experience, and resilient positive social networks). There was important variation within and between the CJS role categories but also a significant commonality that favoured a DTC being established in Halifax.

TREATMENT AND COMMUNITY PERSPECTIVES: CONCLUSIONS

Overall, the Treatment respondents appreciated the

shortfalls of the existing CJS-APTS efforts in responding to the repeat and serious offenders who are addicted to hard drugs. Most, and especially the APTS staffers, welcomed the opportunity to work more effectively with these clients, and saw the DTC approach as possibly allowing that to happen.

Overall, the community stakeholders in this small sample saw merit in a DTC initiative while the level of their enthusiasm varied for a number of reasons, but perhaps most especially depending on how much importance they attached to having a highly structured, strategically coercive combination of enforcement and treatment to respond to the offender with an addiction to hard drugs. Respondents from community-based organizations appeared to be more supportive of the DTC approach than the agency-based respondents because they emphasized such a need. All respondents considered that a metro Halifax DTC would have to be, and should be, offender-based. All agreed, too, that there was a strong linkage between addiction to hard drugs and widespread criminality.

STAKEHOLDERS' VIEWPOINTS: OVERALL CONCLUSION

There appear to be four major conclusions from the many interviews of CJS Officials, Treatment Staffers and Community Activists discussed above, namely

(a) The interviewees were generally quite favourably disposed to seeing a DTC in metro Halifax. Defence counsel were unanimous and enthusiastic in their assessments. There was more diversity among the other CJS role players (judges, prosecutors and probation/parole officers) in their philosophical approach to Justice matters and in their priorities for Justice initiatives but, aside from a very few respondents, the general response was that a DTC initiative would be "worth a try"; indeed for a good number, there was enthusiastic support for a DTC. Respondents on the treatment side were also generally positive and reported themselves ready to be involved. They appeared to envisage the DTC as an opportunity to bring more focus to, and engage

in more intensive treatment of, their clientele of CJS-referred hard drug addicts. There was diversity in the views of community activists but most of these respondents considered the DTC concept interesting and likely to have a beneficial impact on hard drug addicts and by implication the drug-crime linkage; those most in support of a DTC appeared to more closely involved with the day to day lives of "hard drug" addicts.

(b) The DTC was seen to be of potential value for effectively responding to hard drug addicts who commit crimes, because of several of its chief features, especially (1) bringing focus and an holistic approach to dealing with the addicted offender; (2) having a team approach between Justice and Treatment which makes more likely that the response will be appropriate and enforced; (3) close monitoring and effective supervision (case management) of the DTC participant; (4) having immediate consequences for behaviour, both positive and negative; (5) having dedicated or designated personnel in all roles whose knowledge of the addicts and addiction will increase with experience. It was generally considered that the DTC thrust was needed and justified by the evident difficulty of rehabilitating these offenders or deterring their criminal activity through regular punishment, and by the clear, strong linkage between addiction to hard drugs and extensive criminal behaviour.

(c) Virtually everyone believed that eligibility for a DTC in Halifax should be offender-based with restrictions only for serious violent crimes and other offenses repugnant to the public (e.g., anything involving harm to children). This view was partly based on practical factors, essentially that there would be an insufficient pool of eligibles if a person had to be charged with a drug offense. But, more than that, most respondents believed that an offender-based model was the ethically-appropriate response and would best get at the

problem of addicts and crimes. A large number of respondents across the groupings interviewed held that other addictions should be considered too, especially once the DTC initiative has proven itself and become institutionalized; clearly, alcohol addiction was seen as the number one addiction problem both from a purely "numbers" point of view and with respect to the addiction-crime linkage.

(d) There was widespread agreement that a fully implemented DTC in Halifax would at a minimum require a shoring up of treatment capacity since a key dimension of it is more intensive and long-term treatment. Whether CJS, Treatment or Community based, respondents identified this resource requirement. Of course how much resources would have to be marshalled would depend chiefly on the number of DTC participants. Respondents from the CJS and Treatment milieus generally considered that a project coordinator would also be necessary since the DTC program by its nature is holistic and multi-dimensional, drawing upon and connecting a wide range of professional and community personnel and services. There was much uncertainty as to the resource requirements for the different CJS functions. Certainly virtually everyone anticipated that there should be a designated judge, duty counsel, federal and provincial prosecutors, and probation officer but whether these positions could be filled through secondments and scheduling and translate into minimal new resource requirements was too complex to be assessed in the interviews; given existing workloads for these roles, and given the modest expectations concerning the number of DTC participants, no one suggested that the positions were full-time slots. Community activists were concerned about the implications for their resources should they be significantly involved, but at this point the nature of their possible participation was quite unclear.

PART FOUR: A HALIFAX DTC?

Here the entire short section on possible future directions for Halifax is included in this Overview.

FUTURE DIRECTIONS FOR HALIFAX: OPTIONS AND ISSUES

The literature on DTCs indicates that there are basic features that identify a DTC such as voluntarism (e.g., offenders must opt for the DTC), an extensive and intensive, phased treatment program, significant collaboration between treatment and CJS role players (e.g., a team approach), close supervision of DTC participants and regular monitoring of their compliance with DTC rules, timely utilization of rewards and punishments, an holistic approach to the participants' addiction and related problems, and a more personalized relationship between CJS officials and the addicted offender. At the same time, there is considerable variation in DTCs in terms of the scale of their operation (e.g., number of participants, frequency of court sessions), the targeted groupings (e.g., youth, adults, minorities, track one or track two offenders), eligibility criteria (e.g., type of offending highlighted), structural linkages (e.g., whether the treatment services are provided by regular governmental programs or contracted out to private or non-profit organizations, types of coordinating roles), treatment format (e.g., out-patient or residential emphasis), formalization of CJS distinctiveness (e.g., whether designated and exclusive CJS role players, and new, detailed protocols and waivers), and addiction focus (e.g., hard drugs or soft drugs, whether other addictions are eligible). In addition, as noted in the chapters above, there are many policy issues raised by the DTC approach, such as changing role expectations for treatment and CJS role players (especially perhaps for treatment professionals, defence counsel and judges), equity concerns (e.g., justification of the allocation of scarce resources to the targeted population), and the extrapolation possibilities for other regions and other

addictions. Of course, a fundamental issue, and the one most stressed in the DTC literature, is whether the DTC approach is effective (i.e., significantly rehabilitates the drug addict offender) and efficient (i.e., is a good investment considering costs and benefits). While there are many methodological caveats associated with the DTC project results to date, evaluation reports have generally found the DTC initiatives to be both effective and efficient, especially when comparisons are drawn between, on the one hand, "graduates" and those participants retained for at least thirty days in the DTC, and, on the other hand, early drop-outs, eligibles who did not opt for the DTC, and other convicted offenders with an addiction to hard drugs.

The evidence - statistical and qualitative - indicates that there is a significant "hard drug addiction - crime" pattern in Nova Scotia and in metropolitan Halifax. It seems, also on these grounds, that, with some exceptions, most notably perhaps at the federal corrections level, the current CJS-Treatment approach to this problem is neither effective nor efficient. There appears to be nothing about the metropolitan Halifax situation that would suggest that a DTC could not be implemented here and achieve the kind of success that DTC projects have had elsewhere under similar as well as different conditions. There are many precedents reported upon in the DTC literature. The characteristics of the addicted offenders, the type of hard drug addiction, the apparent resiliency of the offenders' social networks, housing conditions and social programming - all are congruent with the thresholds that the American and Canadian DTC experience indicate to be associated with success. There may be a few negative correlates of success that are applicable, such as the age distribution of the targeted population and the extent to which the eligible offenders have been thoroughly embedded in a criminal milieu. Additionally, on the plus side, as summarized in the last section, there tends to be general support for a DTC initiative in the metropolitan Halifax area among CJS officials, treatment professionals and community stakeholders.

There are three issues that merit especial scrutiny in the Halifax context, namely scale, treatment capacity and moral entrepreneurship. While acknowledging a significant hard drug and crime pattern, it is unclear what the scale of a Halifax DTC would be. That would depend on the eligibility criteria as well as on whether eligible offenders would opt for a program that is quite invasive and of significant duration. Alternatives, such as the increasingly common conditional sentences, might well be much preferred by most offenders, save those who want the structure and coercive support of a DTC. A DTC program based on solely CDSA offence eligibility would not appear to be an efficient initiative in metropolitan Halifax (see below). A DTC program, based on the offender's hard drug addiction (i.e., an offender-based, not offence-based eligibility) appears to be more appropriate here though it would still be uncertain how many offenders would opt for it (see below). As noted, DTCs in North America have varied much in terms of scale so a Halifax DTC, whether having a handful of participants or as many as twenty-five, could be justified; of course, as a pilot project, a Halifax DTC could have implications, too, for subsequent expansion to other regions and to other addictions.

Treatment capacity is a salient consideration given the intensive and extensive character of the DTC treatment programs and the uncertainty as to the size of participant pool. As noted above, current treatment programming (e.g., CORE) and special facilities (e.g., beds) are limited in relation to CJS-directed drug treatment. Still, knowledgeable professionals believe that with some new funding for designated treatment providers (possibly funding up to two positions were the DTC active pool to be projected as fifteen or so clients) and other, modest service delivery costs, a DTC could readily be mounted. Given these additional resources, there appears to be widespread - and reasonable - confidence that an out-patient type of treatment program, complemented by some "detox" and residential programming on an "as required" basis, could be effected in the present

context; this is the format followed in many other Canadian and American DTCs. It is unclear, but quite possible according to some informants, whether treatment could be provided outside the government-based APTS framework, by contracting private treatment services.

A common characteristic of successful DTCs appears to be their having strong "champions", or what sociologists refer to as moral entrepreneurs, in the CJS. Committed advocates, pushing the initiative along within and beyond the CJS, and often taking on responsibilities additional to their usual, impressive workloads, have been crucial to the DTCs' achievements. There does not appear to be a dominant voice for a DTC in the Halifax CJS context but, as reported above, there certainly are advocates at all levels of the CJS able and eager to mobilize and commit for such a project. To facilitate implementation and coordination among CJS personnel, treatment providers and community stakeholders and support agencies, a strong case can be made for having a full-time project coordinator, as in Toronto and Vancouver DTCs; the diffuse advocacy pattern in the Halifax area CJS would seemingly underline the value of such a position here.

Overall, then, it would appear that a Halifax area DTC, broad in eligibility criteria but still likely to be modest in scale, could be readily mounted with good prospects for successful achievement of the usual DTC objectives. Some new resources would be required to ensure those prospects, especially additional resources on the treatment side, and some resources for project coordination. On the CJS side, it is unclear whether significant new resources would be required, at least until the DTC participant pool increased beyond a handful; at present, a strong case could be advanced for some funding to relieve Nova Scotia Legal Aid or to contract the part-time services of private defence counsel. It would appear wise for a proposed DTC project, in its first phase, to focus on adult offenders addicted to hard drugs and committing diverse offenses. In the second phase, and in the long-run, issues of extrapolation to youth, to other

regions and to other addictions (especially alcoholism) should be considered for equity reasons, if not for concerns of effectiveness and efficiency.

A BRIEF NOTE ON THREE OPTIONS

OPTION ONE: VANCOUVER AND TORONTO ELIGIBILITY CRITERIA

As noted, in both the Toronto and Vancouver DTCs, eligibility, for all intents and purposes, is limited to those charged with possession or trafficking in hard drugs (CDSA offenses) and subject to federal prosecution. Federal Prosecution and HRPS data for the Halifax area show (a) an average number of seven persons charged and prosecuted per month, yielding perhaps an average of five distinct persons per month since a person may be charged several times in the course of a year (not to speak of recidivism over different years); (b) since at least 75% of the charges in the case of hard drugs are for trafficking and since at least 50% of the traffickers would not be likely to meet the addiction criteria, the five per month becomes perhaps a little more than two distinct persons a month; (c) since only about half of the eligibles could be expected to opt for the DTC (the experience in Toronto and Vancouver and elsewhere concerning "track 2" eligibles) and since some offenses may be ineligible, the net pool for a Halifax DTC might be as low as one candidate a month.

A program based on such small numbers could be viable as witness the Saint John experience discussed above and some American projects. However, given the few participants and the probable success rate of roughly 15% -20% for track 2 participants, a DTC would be problematic for efficient resource allocation and for the enthusiasm of its advocates; pressures to get successes would be great (would the tail be wagging the dog?). Additionally, such a DTC initiative would alienate potential treatment and CJS supporters who see little logic or fairness in having a program based on

such limited eligibility criteria.

OPTION TWO: BROAD-BASED OR OFFENDER-BASED ELIGIBILITY

Of course there would probably be some restrictions on the offenses that could permit eligibility, but including addicted offenders charged with a wide variety of criminal code offenses, as well as those subject to federal prosecution, could yield a modest sized DTC for metropolitan Halifax. Multiple interviews at different points in the CJS have indicated a fair consensus that, at this point in time, there are some 200 plus persons who might qualify for a DTC - i.e., addicts committing crimes in large part driven by their addiction to hard drugs. Estimates from Probation, Parole and NSLA concerning the number of "hard drug" addicts among the overall agency caseload yield approximate numbers of 50 each for Probation and Parole and 100 for NSLA. This 200 figure dovetails well with the estimates of HRPS drug squad officers. It could possibly yield, after six months to a year, an on-going active DTC clientele of fifteen to twenty persons and, after a start-up period, a success rate perhaps of four or five graduates a year. Could there be more? There may well be many more people addicted to hard drugs as suggested by local sources (e.g., Directions 180 and Department of Health statistics) but, given that the DTC process begins with a criminal offense and that it would probably attract only "track 2" accuseds (i.e., those with a high probability of being remanded and subsequently receiving a sentence of some incarceration), the estimates seem appropriate and, perhaps, even generous. Recall that Vancouver and Toronto DTCs with their much larger addict populations have an active current clientele of only roughly thirty-five persons (of course, on the other hand,

eligibility is restricted in both cases, as noted above). The numbers would justify a DTC program and down the road perhaps one could consider alcohol and/or gambling addictions - addictions which appear to be susceptible to the similar treatment and therapeutic jurisprudence approaches.

OPTION THREE: USING THE CONDITIONAL SENTENCING FORMAT

As noted above, a number of prosecutors and probation officers have suggested that the objectives of a DTC might well be otherwise attained by putting more resources into - beefing up - conditional sentencing where the offender has an addiction to hard drugs. By such a strategy, there might be more supervision, more mandated treatment, more frequent testing for drug use, and so on. Data indicate that conditional sentencing has become quite common in cases involving drugs in Nova Scotia. There have been 2,852 conditional sentences rendered in Nova Scotia between September 1996 and September 2002; 16% of these went to offenders convicted for drug offenses (there may have been other charges but in the JOIS data system, the drug charge was deemed to be the most serious offence), approximately eighty per year. A conditional sentence is a jail sentence which is subsequently set aside in lieu of an offender being required to meet certain conditions of house arrest. Those offenders receiving a conditional sentence must serve full-term, and a conditional sentence can be considered for any sentence less than two years with a few exceptions (e.g., crimes carrying a minimum sentence such as robbery with a firearm).

DTC proponents, while not discounting the possible value of a 'beefed up" conditional sentencing program, emphasized that even with more resources it would not

be based on the principles that account for the successes of the DTCs, such as the close teamwork between CJS personnel and treatment providers, the proactive and continuous role of the court, and the court-monitored multi-faceted and holistic approach to the addicted offenders' shortfalls and problems. Certainly the symbolic significance (i.e., status, power, authority) of the court and the judge - so often cited by DTC participants as crucial to their overcoming their addiction - would unlikely be as effectively conveyed by a probation officer. Others have contended that the structure and processes of the DTC facilitate much more the effective utilization of immediate rewards and punishments contingent on the offender's behaviour. Defence counsel have suggested that there would be little incentive for the offender to deal with his/her addiction in conditional sentencing and. like other informants, argued that the fact that the sentence is delayed in the DTC format provides a major incentive for the participants to meet the DTC conditions tied to the interim judicial release (i.e., post-conviction bail). These arguments in support of the DTC option appear to be quite persuasive. None of the Canadian DTC projects cited above (Toronto, Vancouver, Ottawa and Saint John) considered that conditional sentencing could achieve their DTC objectives. It would clearly be interesting, however, as part of the evaluation of a Halifax DTC project, to use the extant conditional sentencing program as a comparison.

PART ONE: THE DTC IN CANADA: AN OVERVIEW

INTRODUCTION

The first DTC in Canada was initiated in Toronto in 1998. Three years later the Vancouver DTC was launched. In both instances the major project multi-year funding was provided by the Justice Canada's National Crime Prevention Centre (NCPC). In the winter of 2003 an Ottawa DTC proposal was developed and its advocates are awaiting word on their funding request via NCPC. Several different metropolitan areas are in the planning stages for DTCs, including Halifax and Calgary. As in USA, the federal government's advocacy and funding has been significant. In May/June 2003 federal officials - Justice and Health - announced that \$23 million would be provided to expand the DTC program, funding projects over the next five years; the news release referred to support for ongoing DTCs at Vancouver and Toronto and for as many as three new sites. There is also much to be learned from a closely related problem-solving court development, namely the mental health court (MHC), of which, currently, there are two in Canada, in Toronto and Saint John respectively (Toronto was first MHC in Canada). All four Canadian programs - Toronto, Vancouver, Ottawa and Saint John - have been discussed at length above.

Certainly this DTC development fits well, in strategies and sentiments, with the broader therapeutic jurisprudence or the problem-solving court movement which has become widespread in North America and beyond. All the Canadian project groupings are headed by committed moral entrepreneurs and virtually all officials involved are very enthusiastic about what they are doing, rather messianic in their viewpoints, and quite interested in assisting other potential DTCs in all respects (e.g., distributing their funding proposals, talking with their role counterparts etc). The problem-solving court movement is alive and well in Canada. At the same time, there may well be special challenges for the DTC in Canada. For example, as compared to the United States, Canada has less severe sentencing for most criminal offenses and certainly for possession of and trafficking in hard drugs. Conditional sentences have become quite widespread too, and drug addiction is apparently considered to be a mitigating factor in sentencing. Under these circumstances, given the invasive character and long duration of the typical DTC program, it

could be expected that DTC participants here would be what the DTC literature would label, "tough to rehabilitate clients with many social problems". Offenders opting for the DTC program presumably would mostly be persons who would be facing remand and some incarceration for their offenses. Still, the DTC evaluation literature indicates that the DTCs have experienced significant success with this type of addicted offender. Although there are some major methodological issues concerning these evaluation studies (especially the self-selection problem), the general results indicate that, compared to other groupings, DTC participants, and especially DTC graduates, exhibit both less recidivism and more positive social behaviour.

THE TORONTO DRUG TREATMENT COURT

INTRODUCTION

The Toronto Drug Treatment Court (DTCT) began in the winter of 1998/99. It was the first of its kind in Canada but there were precedents, many of course in the United States as discussed in the previous section, but also in Toronto itself, there was a Mental Health Court that had some similar features. The moral entrepreneur behind the DTCT was a provincial court judge who was aware of these precedents and who was sharply critical of the ineffective and inefficient way that addicted offenders charged with non-violent property and social order crimes were dealt with. In the several courtrooms that made up the provincial court at Toronto's "old city hall", the different judges had to contend with a plethora of such cases and there was reportedly considerable frustration with the perceived "revolving door" situation. This perception was congruent with the facts as statistics show that recidivism to custody has been highest among those with drug problems. Under those circumstances, the idea of concentrating such cases in one court and responding to them in a different, more proactive and problem-solving way - what has been conceptualized by the DTC advocates as "smart sentencing" - proved to be quite acceptable at the court level.

In advancing the concept of a DTC, the judge as moral entrepreneur linked up early with other CJS role players and with treatment providers. The linkage with federal prosecutions which handles the CDSA prosecutions was readily achieved; however, despite his urgings, provincial prosecutions did not "come aboard", insisting that serious criminal code offenses (e.g., break and enter, theft over, as well as violent crime) had to be processed via provincial prosecution in regular criminal court. One senior provincial official commented: "Judge Bentley visited us for discussions; the province might have been willing to go along with minor charges being waived or deferred to the drug charges but was not willing to allow serious or major criminal code offenses to 'downplayed'". There was also some concern expressed at the provincial prosecutions level concerning the appropriateness and constitutionality of the DTC practice of deferring sentence for up to a year or more subsequent to the defendant having pleaded guilty. The result then was that offence eligibility for the DTCT, from the outset, was largely restricted to drug charges (i.e., possession of and trafficking in hard drugs). Collaborative links with the

government-based Centre for Addiction and Mental Health (CAMH) were put in place in 1997 as that body assisted in the development of the DTCT proposal to Justice Canada (NCPC) and became the designated treatment provider for the DTCT, assuming responsibility for the treatment program as well as for the liaison functions with the DTC court. CAMH staff strongly identifies with the DTCT and properly perceive the CAMH as having played a pivotal role in getting the program off the ground.

The judge, federal prosecutor and the CAMH personnel, all specially designated for the DTCT, formed the core of the program, with the prosecutor being charged with the responsibility for initial determination of eligibility (i.e., the gate-keeper role). Defence counsel assumed an important role since the program hinges on the informed voluntary consent of the defendant (i.e., required access to legal counsel to fully inform) and defence counsel's positive recommendation has been deemed crucial for eligibility. Subsequent to the client's opting for the DTCT, the duty counsel's role is a mix of advocacy and DTC team player. From the beginning there was also a half-time probation officer role providing information to the DTC and complementing the case management activity performed by CAMH liaison personnel. In some American DTCs, the probation officer is the major CJS role player ("runs the court", a key informant noted) but in DTCT, "the province was not at the table" so initially the probation officer's responsibilities were more limited than in most DTCs. Initially, too, police presence was minimal in the DTC though police had participated in early discussions and have been represented on the DTC steering committee. Two years into the program, the need for better harnessing of police information on potential DTC candidates, expediting bench warrants for participants, quickly relaying information on new charges to the DTC, and obtaining more "buy-in" at the field level among officers, was acknowledged with the establishment of a full-time court liaison officer (a detective constable from The Metropolitan Toronto Police Service). The officer does not attend the DTCT team's important pre-court meetings, presumably because "information shared at that meeting could be information he may have to act on as a police officer".

The DTCT began in late 1998, receiving core funding of 1.6 million dollars over a four year period from NCPC; additional funding was provided by CAMH and via subsequent secondments (e.g., the designated liaison officer from Toronto's Metropolitan Police Service). As the official DTCT evaluators noted, it has been modeled on the USA drug courts with respect to

emphasis on abstinence not harm reduction (though, while abstinence is the goal, there is much acknowledgment of it representing "a long road with many relapses"), designated CJS roles, scope of roles, and treatment-justice linkages. While Canadian and American sentencing patterns differ substantially in their severity for drug offenses, "the hammer of bail and the break at sentence" is seen as a real incentive for participants in Canada as well. The DTCT has been designed for non-violent offenders who have serious hard drug addictions and are charged with drug offenses.

In the DTCT model, there are two tracks for eligible addicted offenders. Track One is for the less serious offenses (e.g., simple possession) and offenders who usually would be able to avoid remand and/or any significant "jail time" in the event of a conviction. Such accused persons by taking responsibility for the offence (but not entering a plea of guilty), and opting for the DTC, can expect to have their charges withdrawn upon completing the DTC program. For them, there is no bail to be revoked in the event of non-compliance. Addicted persons charged with prostitution offences, a grouping initially targeted by the DTCT, might well be possible track one candidates (research has shown that most Toronto street prostitutes are addicted to hard drugs and that, while the drug use did not get them on the streets, it intensified that life style). Track Two is for those addicted offenders charged with more serious CDSA offenses, likely also repeat offenders, who face remand and the prospects of at least several months incarceration if convicted. Such persons, were they to plead guilty, secure bail (i.e., interim judicial release), enter and complete the DTC program, can expect a probation term upon returning to the court for sentencing. Graduation from the DTCT, by the initial protocol, requires that the participant be free of hard drugs use for several months, free of soft drug use for at least a few weeks and has achieved some social stability.

As conceptualized, the DTCT has two "levels" or distinct phases. Level one is when the participant is subject to the direct control of the DTCT and, for track two participants, can have his/her bail revoked for non-compliance with the rules and conditions agreed to upon entry to the DTCT. As noted below, level one can be decomposed into evaluation and assessment, diverse treatment phases and graduation/ treatment completion. Level two begins when the participant graduates/completes treatment, returning to court for sentencing which would be probation and usually several explicit conditions. Usually, in level two, the offender is expected to make some

monthly returns to the drug court to report on his/her progress, to attend treatment perhaps once a week, and, of course, to meet at least monthly with the probation officer and to refrain from using hard drugs. At level two, there are no urine screens and attendance at the treatment centre is not mandatory. DTCT graduates are encouraged to stay involved with the DTCT by engaging in alumni type behaviour (e.g., presenting DTCT t-shirts to new graduates at the graduation ceremony).

STRUCTURE AND PROCESS

There are three main groupings that characterize the DTCT. The core group of the DTCT is the "team" that represents, better concretizes, the collaboration of the CJS and treatment professionals and which meets prior to the twice-weekly court sittings to discuss the active cases and consider possible strategies for dealing with the different DTC participants later in court - the latter activity has been referred to by one judge as "scripting the court scene". The key members of this team are the judge (the "chair" who goes through the files at hand, gets the verbal reports of the CAMH court liaison staffers and probation officer, solicits views and articulates the consensus), the federal prosecutor, the defence counsel, the CAMH liaison / case managers, and the probation officer. Several administrative aides - court clerks and a paralegal - regularly attend. Usually the DTCT project evaluator also attends both the pre-court and court sessions. Other important DTCT groupings are the steering committee which meets every three months and includes a wide spectrum of CJS and Treatment role players, and a community advisory committee which reportedly represents approximately seventy community groups and agencies.

All the CJS roles get interpreted differently in the DTC context. There are three DTCT judges, the principal judge (the DTCT is formally a two day per week assignment) and two backup judges. The judge's role in a DTC focuses much on providing leadership and cohesion vis-à-vis the other officials, facilitating an in-depth agreement on how best to deal with the participants and assist their rehabilitation, and having direct communication (of limited duration but powerful symbolic impact) with the DTC participants. As one DTCT judge observed, the problem is that the treatment people do not understand the law and he is unsure what he understands about therapy; also he acknowledged that he was, and still is, "uncomfortable to be

scripting the court at the pre-court session". The judges all seemed to have coped well with the new nuances of their role and were very positive about the DTCT. The prosecutor role and the police role, on the surface, seemed less altered in the DTCT format but clearly there are different sentiments at play and a different approach to the offender and any infractions or non-compliance (e.g., the expectation of relapses, the priority of rehabilitative goals); in the DTCT the chief prosecutor and the police court liaison officer both are strong advocates of the program and active promoters of it, especially, and on a broader scale, the prosecutor. There are at least two federal prosecutors and a division of labour has emerged among them; one prosecutor deals with operations, screening candidates and attending pre-court and court sessions, while the other focuses more on managing the program, and working on funding issues related to the institutionalization of the DTCT.

Three other roles are quite interesting for their reconfiguration in the DTCT. The DTCT duty counsel is a multi-year contract position with Legal Aid Ontario - two days a week formally though, as in the case of the judge, in practice more like three days since there is an expectation of much more informal contact with participants in the DTCT. The duty counsel acknowledged that the adversarial - collaboration dimensions of the role "are not easily explained". Acting in the best interests of the client - the obligation of defence counsel - in the DTCT context, means taking the conventional adversarial role until the person pleads guilty and signs the DTCT contract, fully informing the client of DTCT rules and the ramifications of breaching the conditions of bail, and following the instructions of the client and defending the client with respect to non-compliance issues (sometimes contacting other defence counsel on specific charges). At the same time, defence counsel is a member of the DTCT team and since the client has voluntarily agreed to be a participant, and the DTCT is seen as in the best interests of the client, there is, in the duty counsel's eyes, an obligation to make sure that the client does the program successfully, "to assist in the person's recovery" (to use the words of different CJS role player referring to the job of the duty counsel). The current duty counsel has been in the position for four years and is quite comfortable with the role's nuances; as one judge noted, "the challenge will occur when a new duty counsel is appointed and the reorientation must occur again".

Another interesting DTCT role is that of case manager. As noted, in many DTCs the case manager (officially titled Community/Court Liaison Worker in the DTCT) is rooted in probation

services but in the DTCT the two case managers are full-time CAMH staff, rooted in treatment services and with some counseling responsibilities (and especially, apparently, being involved in preparation for group sessions), even while their central functions are to liaise on client matters between treatment professionals and CJS role players, and to directly assist clients (in a myriad of ways such as in housing needs) and oversee their behaviour in the DTCT program (doing front-end screening as well regarding substance abuse, relationships, needs etc). Observation indicates that the case managers are major information conveyers at both the pre-court and court sessions. The case manager is a complicated, demanding role and would clearly be affected by caseload considerations. While informants on the treatment side strongly believed that case managers should be rooted in treatment services, the unique role developed the way it did in the DTCT in large part, according to key informants, because initially "the province was not at the table" and so probation services did not assume a major role. The probation officer in the DTCT complements the work of the case manager, acting as a resource person for the DTCT, providing information on the clients and their background, advising regarding community services and educational/employment programs, and monitoring compliance with DTCT rules.

The role, DTC coordinator, was not originally funded in the DTCT but developed in response to project needs. It is now a full-time position and the key functions are bringing in community resources, communications and liaison with the larger community (community groups, agencies, other treatment providers). The coordinator prepares and dispenses the public documentation for the DTCT, handles public relations, is preparing its web site, lobbies at the community level and among the levels of government, and generally focuses upon the DTCT environment. The coordinator does not attend either the pre-court or court sessions and his office is at the CAMH facility. He is in contact with some seventy community organizations, frequently attends their meetings as a quid pro quo, and regularly reports feedback and recommendations to the DTCT steering committee.

As noted, in the DTCT, treatment services are basically provided by the CAMH. There are nine key positions here, namely the two case manager roles discussed above, five therapists involved full-time in individual and group counseling, a part-time nurse and a doctor hired on a consultant basis who is responsible for all drug testing (basically urine analysis). Other personnel become involved on an occasional basis. Over 80% of the DTCT participants have been treated

as crack cocaine addicts. Initially, it was expected there might be a larger number of heroin (and other opiates) addicts and there were two somewhat different treatment programs advanced. There may well be continuing differences in prescribed treatment (e.g., use of methadone for opiate addicts) but the experience of the DTCT has reportedly been that the type of addiction makes little difference.

Treatment services in the DTCT involve the setting up of individual treatment plans where there are clearly defined phases with attached minimums or explicit required number of weeks/hours, namely six weeks (three two-hour afternoon sessions per week) in preparation, three weeks in intensive treatment (four mornings a week and two other sessions), three months in maintenance (twice weekly sessions), and then continuing or after care (one evening a week), for the remainder of level one and if directed in level two probation. There are no maximums. Participants, favorably assessed in the evaluation or preparatory phase, enter the DTCT with the information that the treatment would last for approximately one year. The treatment plan or model for cocaine users is a modification (for the DTCT context) of an established model developed by CAMH. The treatment is provided on an outpatient basis, though beds for "detox" and residential programs (when participants cannot otherwise get out of a heavy use pattern) are available on an as need basis; some informants claimed these facilities could be readily accessed while others mentioned waiting lists of several weeks. Treatment staff generally held that the outpatient mode is the superior option. For them the outpatient program is not primarily an issue of bed availability but an issue of treatment approach; residential programs are deemed to be jail-like milieus, artificial environments, which fail to generate the coping strategies necessary for successful rehabilitation in the real world.

The full-time therapists have limited interaction with their CJS partners. While the number of graduates in the DTCT has been modest, the therapists are usually each carrying a caseload of twelve to fourteen clients and the program is quite labour intensive and demanding. These therapists do not attend either the pre-court or the court sessions. They do though attend the DTCT retreats, reportedly every quarter, where issues and processes are discussed. Clearly the case managers' liaison is crucial to effective collaboration between CAMH and Justice role players. Both treatment and CJS informants indicated that establishing trust has been an important achievement of the DTCT and that there were significant hurdles to overcome.

Respondents from both sides noted that there was much early discussion about the different roles and the goal was advanced to have equal participation. Similarly, it was frequently noted that recommendations for leniency (e.g., curfew, required attendance) or the application of sanctions in dealing with non-compliance may just as readily come from one "side" as the other.

The DTCT process begins with a voluntary action on the part of defendants who must submit an application to the federal prosecutor, and be recommended by duty counsel/legal counsel. Input from police is sought as the crown considers eligibility (police are requested to complete and return a form received by fax from the prosecutor). Once deemed eligible by the prosecutor, the track two defendant must plead guilty, sign various waivers and agree to abide by what is labeled the Drug Court Conditions - nineteen conditions in all, ranging from "be honest with the court and treatment staff" to "sign such releases as necessary to allow DTC or CAMH to obtain or disclose information it deems necessary". Upon securing bail, the "track two" offender is placed in evaluation and assessment (roughly a thirty day period) and is subject to all the rules and conditions as set out and directed by the DTCT. The DTC team makes a final decision on eligibility (presumably there are police reports, case manager assessments and some in-depth therapeutic examination) and of course the offender can opt out during this time. In the subsequent routine of the DTCT, the participant, as noted above, engages the treatment program and regularly attends the DTCT court.

The treatment team itself meets regularly on Monday and Wednesday while the DTC team meets Tuesday and Thursday. The pre-court sessions on these latter days are pivotal to the DTCT concept. There, CJS and CAMH liaison staff review the progress of each file (all persons to appear later that day in court) and suggest strategies (i.e., rewards and punishments) aimed at furthering the rehabilitative prospects of the participant. There is an open discussion among team members, reports from the case managers and probation officer, and inputs from the prosecutor and duty counsel (especially of course if non-compliance or new charges are being considered). The judge exercises democratic leadership (there is no voting) and, at least in the sessions observed, is very sensitive to recommendations from treatment staff; for example in one instance, after a broad exchange of views, the judge commented, "if treatment says we should do it, we'll do it". The sanctions considered run the gamut from a few hours community service work for missing a treatment session to two or three days in jail for repeated, "unacknowledged"

failing of the urine analysis, while rewards also vary from extended curfew hours to reduced court appearances and words of praise. The latter is considered quite significant, in congruence with a general view in the DTC literature that "in the DTC the main focus is the communication between the offender and the court". The actual court scene is more informal than the conventional court but decorum is adhered to (e.g., the offender stands while his/her case is reviewed). The courtroom is usually crowded with DTCT participants, DTCT officials and others and in each case there is some direct communication between participant and judge on the person's progress to date. There appears to be no cross-examination and typically the process unfolds as scripted in the pre-court session.

In the event that the participant drops out or is expelled, the court strikes his/her plea and the person returns to the mainstream court system where he/she is processed in the normal fashion. The successful participant attends a formal graduation ceremony where the case manager, other DTCT officials and the participant address the court, often in very moving words; the participant then stands as the judge both praises him/her and renders the sentence of some probation and other conditions. As noted, graduation has taken on average at least one year of DTCT participation, though in the most recent graduation four of the five graduates had been in the program for only nine months. While there is no fixed amount of time for one to graduate from the DTCT, if, in the eyes of the DTCT officials, it is taking too long, the case will be reviewed. As noted below, some accommodation has been made for "substantial compliance".

OUTCOMES AND EVOLUTION

The DTCT numbers have varied over time. At one point there were eighty active participant files, well above the fifty to sixty said by most informants to be have been the targeted maximum at the outset. In the late summer of 2003, there were thirty-six active, in good standing, participants. Almost all DTCT participants, beyond the thirty day assessment period, have been 'track two', the more serious offenders with the more serious problems. Not surprisingly, most DTCT participants have backgrounds of low socio-economic status. All participants have been adults. Men have predominated and the average age has been around thirty-five years old. Afro-Canadian have been modestly over-represented. Aboriginal persons, a targeted group initially, have been rather under-represented, presumably, according to DTCT

informants, because they have tended to go to Toronto's Gladue court (i.e., Canada's only aboriginal-oriented criminal court).

The official evaluation of the DTCT, in a 2000 report based on the first eighteen months of the program, indicated that of 198 persons deemed eligible by the federal prosecutor, roughly 35% had either graduated (10) or were persisting in the program (59). It was noted that, for graduates, the results were as hoped for concerning less recidivism and more positive social behaviour (e.g., work. family ties). The least successful DTC participants - drop-outs or expelled - were women, younger addicted offenders and those with significant criminal records. The most successful, according to several informants, were those "who had a previous life" in the sense of family, social capital and work experience. There was a widespread view among the DTCT officials that women, usually prostitutes, did not fare as well with the DTCT "because in most cases they live with their pimps and the pimps want them to continue in the trade". Older addicts fared better than young ones presumably because "they are worn out; they've tried everything else and now want to get some of their life back". No difference in terms of success or failure has been associated with the primary type of hard drug addiction (crack cocaine or opiates), perhaps because the DTCT participants had histories of multiple substance abuse. In making the case for efficiency, it was argued that the DTCT was costing roughly \$4500. per year per participant while incarceration costs would have been \$47,000. per inmate per year.

Subsequent evaluation reports have not been accessible so it is difficult to specify percentages for graduates or active and continuing participants. A January 2001 report issued by the leading judge of the DTCT reiterated early claims that 50% of those participating in the program were either still active or had graduated but it is unclear whether the population base here is pre- or post- the initial thirty day evaluation/assessment period. In any event, the same document reported that "some of those who left say they got something out of it anyways" and presumably might be more likely to succeed in the future (remember that one strong finding of the DTC literature has been that previous treatment experience is an indicator of success in the DTC program). This latter view was also expressed by treatment professionals, one of whom expressed it this way, "client graduation is not the only success; it is also that the individuals in the program may not have graduated but have made gains in their lives". An internal police report prepared in 2003 by the court liaison officer referred to "a success rate of about twelve

percent which is considerable as the program is in its infancy"; it is also unclear what population base this percentage is drawn from. Perhaps as significant as the statistics are the personal testimonies of the DTC officials, all of whom reported themselves moved by the real transformation of certain participants.

It seems clear that over time there has been increasing recognition that social capital and supports in the community are paramount to successful completion of the DTCT program, in both its level one and level two phases (i.e., where the participant is an alumnus on probation). Concomitant with that recognition has been a shoring up of what might be called the outreach dimension of DTCT, namely having a program coordinator to liaise deeply with community groups, engaging the probation officer on a full-time basis, and having a designated liaison with the police service.

The DTCT initially was a pilot project but with the new federal funding package for DTCs in Canada it has moved more to a program, albeit with some uncertainty about the long-run and about the "buy-in" at the provincial government level. It has also evolved in terms of structure and process and there are plans to expand the DTCT in a variety of ways. It was noted above that the criteria for graduation in the DTCT program have been quite demanding. An issue has been what to do with the participant who seems to be trying but relapses regularly and is therefore ineligible for graduation. Recently, the DTCT has apparently developed a new category, "substantial compliant" for non-regular graduates who may still have some problems with substance abuse but have stopped using hard drugs.

DTCT officials virtually all want to expand the program to include youth as set out in a 1997 project proposal and currently are working on some plans to that effect. They do not see Canada's new youth justice strategy (i.e., the YCJA) as an obstacle. Similarly, there appears to be unanimity that eligibility should not require a drug (CDSA) charge but be open to more criminal code offenses. The DTCT officials are well aware of similar proposals being advanced elsewhere in Canada and have always wanted to have a more offender-based eligibility. There has been some program development; for example, the lesser success of those more immersed in the criminal milieu is being addressed in part by a special program on anti-criminal thinking advanced through the collaboration of treatment staff and probation services. DTCT officials have identified community resources as an important area for focus, especially the need for more

housing outside known drug areas. To that end they recognize the need to network and lobby at the community and governmental levels. The DTCT officials appear to be quite confident that the DTC approach has been worthwhile and can be made even more so. At all levels, judge, prosecutor, treatment, probation officer, police, they are active in spreading the DTC message. Largely at the initiative of the judge and prosecutor, a Canadian Association of Drug Treatment Courts is being launched to advance the approach in various circles and to exchange best practices.

IMPLICATIONS FOR A HALIFAX DTC

Notwithstanding the recent graduation ceremony (end of August 2003) where two of the five DTC graduates were female, the DTCT statistics clearly indicate that males have been more successful in the program than females, especially young female adults. This finding, also characteristic of the DTCV and fairly typical of the American experience, flags an issue for attention and perhaps suggests the need for special gendered programming. Little data were available on the DTCT concerning race and ethnic factors, apart from the fact that Afro-Canadians were well-represented among the participants. However, community linkages have been emphasized in the Toronto program in order to provide support for the participants, and liaising with and mobilizing those community linkages has been a major responsibility of the DTCT coordinator. Certainly, in the case of Halifax, given the race/ethnic patterns cited below, such ties would be quite important. Community linkages in general have to be encouraged, as the DTCT has discovered, to assist both in the successful rehabilitation of the participants (e.g., social support, housing, after-care) and in the recruitment of these participants (i.e., getting more eligible offenders to select the demanding DTC option). Organizationally, the DTCT indicates the necessity of designated CJS personnel and the value of an overall project coordinator. Police liaison has been important to obtain information about eligible persons, to ensure meaningful, immediate consequences for behaviour (e.g., DTC bench warrants are readily acted upon) and to encourage a proactive and perhaps sympathetic police response to the participants' behaviour and conditions. The DTCT experience clearly indicates as well that those opting for the program will virtually always be "track two" offenders, typically repeat offenders with many social problems;

in other words, the DTC demands much not only of the participants but also of its advocates and officials.

THE VANCOUVER DRUG TREATMENT COURT

Certainly the drug scene in Vancouver, the subject of numerous reports, documentaries, media attention of all kinds, and much academic/policy research, would represent a significant challenge for therapeutic jurisprudence. There may be no drug milieu in North America that rivals the "Downtown Eastside" for notoriety. Several DTC researchers have argued that DTCs receiving most favourable assessments may have been so evaluated, not because of any of their features, but because they are not dealing with "the toughest clients" (Curley, 2003) or "the chronic offenders with serious problems" (Anderson, 2001). Clearly, those qualifications could never be attached to the Vancouver DTC which is focused on the Downtown Eastside. Moreover, the challenge for a Vancouver DTC would reportedly be heightened by the widely perceived image of Vancouver courts as rendering lenient sentences, even by Canadian standards (Toronto DTC Workshop, 2001), to offenders who are hard drug addicts - the court threat presumably would be less effective!

The Vancouver DTC serves a fairly unique population and operates in a special social milieu. The court itself is housed in the Main Street courthouse in the heart of the Downtown Eastside, a kind of "combat zone" in police jargon, where thousands of hard drug addicts (informants generally estimated some 5000 addicts) concentrate ("shooting up", fencing stolen goods, and engaging in the prostitution business), where, annually, more people die of drug overdoses than in the whole of the rest of Canada outside British Columbia, and where a plethora of service organizations, shelters, "cheap" rooming houses/hotels, and food banks cater to the addicts' needs. It is a sociological mosaic where the most noticeable street-level dealers, apart from the addicts themselves, are recent immigrant youths and young men from Central America and where other ethnic groups dominate different aspects of the drug business (e.g., the Chinese and Vietnamese, white bikers, Indo-Canadians and East Europeans dominate the various levels of drug dealing, hotels and facilitative small "corner stores" respectively). The Vancouver DTC's treatment, monitoring, and medical / social services and activities are provided Monday through Friday in a facility housed in a large office building several kilometres outside the Downtown Eastside, easily accessible by foot or public transport. Vancouver is the most expensive city in

Canada for housing so, not surprisingly, accommodation has been identified by DTC staff as one of the most pressing problems for DTC participants.

Each week some fifty persons reportedly are charged in the Main Street court for possession of and/or trafficking in hard drugs (especially crack cocaine and heroin, sometimes taken together in "spitballs"). Repeat offenders are commonplace, if not the rule. The DTC participants could be expected to be tough to rehabilitate, "track two clients", typically persons who would not otherwise get bail because of previous administration of justice offenses, lifestyle etc. In the outpatient format of the DTC, it would be expected that many would continue to inhabit the Downtown Eastside milieu. The area has also been a magnet for many aboriginal people. Over the first year of the Vancouver DTC, aboriginal persons made up 70% of the DTC clientele but that percentage has declined over the past six months to roughly 50%. Aboriginal persons, while plentiful, constitute only a minority (perhaps 25% at most) of drug addicts in the Downtown Eastside and their greater involvement in the DTC apparently has, in large measure, to do with the presence at court of a native court worker, encouraging native offenders to use the DTC and referring cases to Justice officials.

The Vancouver DTC began in the winter of 2002 (officially in December 4, 2001). Reportedly, its moral entrepreneur had been a senior federal crown prosecutor, and its key operational planner, an ex-staffer with the Toronto DTC (involved as a therapist and also having a liaison role with the DTC) who has an MSW. The former, the prosecutor, has since moved to Ottawa but the latter remains as the project coordinator. with a salary partly drawn from the Department of Justice, Ottawa and partly from the province of British Columbia. The core funding for the Vancouver DTC comes from Justice Canada's NCPC (\$1,772,440. over four years) but additional resources are provided by the provincial government (largely in terms of secondments) and the federal prosecution service.

The Vancouver DTC essentially followed its Toronto predecessor in terms of eligibility criteria, the crown prosecutor determining eligibility, the "two track approach", the criteria for graduation and sentencing, and general DTC structures and processes. Candidates for both DTCs must have been charged with a serious drug offence (i.e., possession of or trafficking in hard drugs), a necessary and sufficient criterion, and cannot be solely charged with criminal code offences. In addition, there are other common eligibility criteria (e.g., evidence of drug addiction,

restrictions in terms of violent crimes, health status and psychopathology). It can be noted that pre-implementation discussions took place between federal and provincial Justice officials concerning eligibility criteria and, reportedly, a primary (though perhaps not sole) provincial position was that for constitutional reasons (i.e., violation of an offender's right to speedy justice resolution) it could not agree to refer criminal code violators to the DTC (save in the conventional practice of prosecutorial collaboration across jurisdictional levels). This position by the way is disputed by DTC CJS people, including the defence counsel, who contend that superior court decisions have ruled that there is no problem in delayed sentencing if the accused agrees to waive that right. According to DTC informants, a person, facing relatively serious criminal code charges where custody is possible, would be unlikely to be deemed eligible for the DTC on his/her drug charges. Minor charges, however, could be tried in the regular court system while the person is having his/her drug charges dealt with in the DTC. Some DTC informants held that since, in the Vancouver court system currently, trials are about eleven months after arraignment hearing, most criminal code crime, theoretically at least, would not prevent participation in the DTC provided the person is not in custody.

As noted, both Toronto and Vancouver DTCs have formally a two-track model, track one for minor, perhaps first-time accuseds, and track two for more serious and repeat offenders. In both courts virtually all participants in the DTC are "track two", that is, more serious offenders who typically would be remanded and who, theoretically, could face more severe sentencing (i.e., incarceration). Both DTCs also have similar criteria for acknowledging the graduation of the participants, namely a specified treatment period (made up of distinct phases) of roughly one year, some period of being drug-free (at least free of hard drugs) and some headway in transforming their lives as members of society. Sentencing subsequent to completion of the DTC program, invariably some term of probation, is related to the quality of the participants' transformation. In both DTCs there is a team approach involving Justice officials (judges, crown prosecutors, defence counsel, probation officials) and health/treatment professionals, similar referral and screening processes, close monitoring of the participants' drug use and social circumstances, regular pre-court team meetings to discuss participants' progress and whatever negative or positive sanctions may be appropriate to advance them towards graduation (what some DTC informants refer to as "scripting the court session"), required court attendance for

participants, and an emphasis in court on direct (though in actuality quite brief) interaction between the judge and the DTC participant.

The Vancouver DTC does differ from its Toronto predecessor in several respects. Unlike the latter where clients are referred to an on-going public health operation (CAMH), its treatment program has been contracted out to a private, for-profit company. The treatment program also appears to differ from DTC Toronto's in several respects (e.g., treatment schedule and credits, gendered programming, an emphasis on a psycho-biological approach, providing meals and some "drop-in" features), while otherwise similar in terms of featuring group therapy, individual counselling, and incorporation of behavioural/cognitive as well as reinforcement theory approaches. The Vancouver DTC differs too in that, from the outset, it has had a full-time project coordinator as well as the usual designated CJS role players and the case managers (initially two probation officers were seconded to this role). The positions of judge, federal prosecutor and defence counsel are roughly half-time (two days plus per week) while all other positions are full-time.

As of the late summer of 2003, the Vancouver DTC has a full-time treatment/service staff of three therapists, two case managers, an aboriginal liaison person, a secretary and a program coordinator; in addition there is a part-time medical doctor (whose main employment is to provide medical services to accused persons at the courthouse). One of the two case managers is now seconded from social services, a linkage which presumably enables the DTC program to better manage or coordinate participants' welfare income, housing and other needs. Two judges participate in the DTC though one judge handles most of the cases. A private defence counsel, formerly with the Legal Aid service recently disbanded by the provincial government, has the contract to provide legal counsel for DTC participants (a task estimated by the lawyer to take three days a week). With one exception - a probation officer who had been a case manager - there has been no turnover among the designated CJS personnel and just one change among the treatment staff.

The treatment requirements, which participants must agree to as a condition of entering the DTC, have changed from an explicit time frame (roughly a year) to an explicit number of treatment hours. Treatment now calls for 265 formal treatment hours, at least 17 of which must be individual counselling and 158 group counselling; the difference can be made up in a variety

of ways, such as by stays in "detox", in recovery homes, in residential treatment programs, and by attending special educational programs. According to treatment officials, it would be possible to complete the treatment program in seven or eight months if the participant attended daily; few do so. The treatment approach as noted emphasizes a "psycho-biological perspective" (e.g., healthy breakfast and lunch meals are provided), and a "guided imagery" style (soft, relaxing atmosphere) for effecting a favourable therapeutic milieu. While the individual counselling sessions with therapists and the group counselling sessions usually take up only seven hours maximum per week, DTC participants are "encouraged to come and stay more", enjoying meals and participating in other activities there. Drugs are of course strictly forbidden and the approximately 40% of the current active caseload who receive methadone, must get them and consume them elsewhere. A voucher system for personal items is used to reward attendance and other positive behaviour. This is congruent with the utilization of rewards and punishments applied at court, where DTC participants may be praised, excused from some court appearances, castigated or jailed for short periods of time, depending upon their behaviours.

Thus far, summer 2003, some 150 persons (95 men and 54 women) have been admitted into the DTC and 7 have "graduated with honours", 4 have "graduated", and 2 others have completed the programs. These distinctions refer to how well the participants have met the graduation criteria noted above and they have implications for subsequent sentencing (e.g., honour graduates receive sentences of minimal probation without conditions while those who have simply completed the treatment program but not met the graduation criteria may receive significant probation terms and other "conditions". As of late summer 2003, some 26 persons are continuing in the DTC on an out-patient basis, 8 are in recovery homes or in residential treatment programs (where abstinence is required and for which they earn credits in the DTC treatment plan) and perhaps as many as 15 are "unaccounted for" and subject to arrest warrants. Given the characteristics of the hard-core addicts and the Downtown Eastside milieu, it is not surprising that relapses and "unaccounted for" phases are commonplace. DTC officials expect such shortcomings and are not quick to expel persons from the program; as one treatment person observed, somewhat tongue in cheek, "we tell them, this is your sixth and last warning".

While the success rate may seem modest, the challenges of changing behaviours of hard-core addicts in the Downtown Eastside milieu have to be taken into account. Virtually all DTC

team members stressed how crucial more housing opportunity outside that area is for attaining more successful rehabilitation; the defence counsel, for example, commented: "what all my clients say is that the hardest part of quitting is having to remain in the open/coerced drug use milieu because they can't afford to live somewhere else". Both treatment and Justice officials in the DTC remain enthusiastic about the program, celebrate the successes that do occur, and appear to work well as a team, devoted to the DTC philosophy and respectful of one another's role and contribution. Some DTC members - perhaps all of them if asked - were eager to see the Vancouver DTC expand to an active clientele base of 75 persons (a figure projected for the DTC in its original proposal) on the grounds that the larger numbers would improve programming.

Respondents also drew attention to several important strategies that the DTC team has been developing to improve the program. First, the treatment program is increasingly gendered with women regularly meeting by themselves in focused groups and in other contexts - a response to the facts that only one of the fifteen "completes" was a woman and that, as in most other DTCs (including Toronto), women have dropped out more frequently than males. Second, there has been increasing emphasis on basic issues such as health, food and coping skills - a development anticipated to be enhanced by the recent secondment of a welfare worker to the team. Third, driven by the objective of achieving abstinence, there is continuing encouragement of DTC participants (backed by strong judicial urgings to "get clean" and by a credit-earning formula for residential stays) to enter recovery homes and/or enrol in residential treatment programs. Initially, there was an effort to have DTC entrants immediately directed to such facilities but virtually all the early DTC participants backed off and went missing so that demand was shelved. Treatment staff commented that: "yes they all start as outpatients and they can get cleaned as outpatients; that is not unusual". Nevertheless, strategies to encourage such stays in "detox" and/or residential care if not residential programs, are continually being considered; moreover, program officials reported that a number of participants do at some point enter such arrangements when they are "ready" and, for the most part, they do so with success. Treatment providers indicated that accessing such facilities has not been especially problematic. Fourth, perhaps driven by the modest success rate, there have been proposals developed to expand the "catchment range" by obtaining referrals among drug addicts who are on probation - some DTC officials considered that such a strategy would yield some DTC participants of more moderate

"risk". Fifth, DTC officials at the treatment/services complex have found that it is very beneficial in retaining participants - and retaining participants has been shown to be crucial for success in DTCs - to have someone who can relate readily to them in a friendly, non-official capacity, such that the participants find the environment positive and attractive; in large measure such is the key contribution of the aboriginal liaison person in the Vancouver DTC. Looking ahead, some Vancouver DTC officials also anticipate starting a GED educational program on site and extending the program's reach to other addictions, especially to alcoholics.

There are several implications for a Halifax DTC which more or less flow from examination of the experiences of the Vancouver DTC. These include (a) the significance of some gendered programming, (b) the importance of networking well on an ethnic-racial basis where there is a significant minority presence; in Halifax this might suggest hiring an Afro-Canadian to perform the role carried out by Vancouver aboriginal liaison person (c) the crucial role played by treatment-court liaison and case managers, (d) the value of having a competent full-time program coordinator, and (e) the greater likelihood of success where the participants have adequate basic housing and social support.

THE SAINT JOHN NEW BRUNSWICK MENTAL HEALTH COURT

The Saint John Mental Health Court (SJMHC) began in 2001 under the moral entrepreneurship of a provincial court judge and a crown prosecutor (now deceased). They brought together CJS and government-based treatment services personnel to implement the new initiative without any significant new funding, either federally or provincially. In the spring of 2003, after two years in operation, the active caseload numbered eleven client offenders. The SJMHC in structure and functioning operates very much like the Toronto and Vancouver DTCs. Several informants readily "placed" it in the therapeutic jurisprudence context, along with the DTCs, the only other MHC in Canada (i.e., in Toronto), and domestic violence courts. Indeed, one informant suggested that other, kindred types of courts might flourish in the future, including possibly one for persons with FAS/E (fetal alcohol disabilities) who are charged with crimes. Most informants were well aware of the DTC phenomenon though not of the details of the Canadian DTCs. They typically observed that "mental health problems and drug abuse are intertwined - the addiction and mental health issue - so often that it is difficult to know which is primary".

It was not especially surprising then that in the summer of 2003, under the leadership of the same judge, and with other overlapping CJS and treatment personnel, and again with no new significant funding, a Saint John Drug Treatment Court (SJDTC) was launched. The judge was quoted in the local newspaper as saying, "we've realized that the drug problem is a significant one and our experience with the other program (i.e., SJMHC) is that judicially motivated programs can work effectively to deal with problems". The first client for the SJDTC was a twenty-one year man charged with a property offence. The SJDTC reportedly will, under certain conditions, be accessible by accused persons charged with criminal code offenses, as well as those charged with CDSA offenses. It was expected that the number of clients would be modest - one team official, in a telephone interview, characterized the initiative as a pilot project of perhaps five persons - and the judge reported that "[the SJDTC] will evolve according to Saint John's needs". The announcement of the SJDTC was accompanied by local newspaper reports citing a low level of recidivism among those graduating from the Toronto DTC and a significant cost benefit (i.e., it was said that the Toronto's DTC reportedly cost \$8,000 per year per offender

participant compared to the \$50,000 it costs to incarcerate a non-violent drug offender in a provincial institution for one year).

The SJMHC responds to offenders who purportedly have mental health problems but have not been ruled "criminally insane". The eligibility criteria require that the person has been charged with a criminal (not a charge under the mental health act) offence, typically "modest" offenses where convictions would not produce sentences requiring "federal time" (i.e., two years or more incarceration); the person has to be considered criminally responsible but with mental health problems. Opting for the SJMHC is voluntary for the accused person and is to occur only subsequent to discussion with defence counsel. As in the track one models of the Vancouver and Toronto DTCs, and as in many restorative justice programs, the accused person has to take responsibility for the offence but does not enter a formal guilty plea. As the crown prosecutor put it, there has to be some acknowledgement of responsibility for the crime, some acknowledgement of their mental health problem and some appreciation of the linkage between the mental health problems and the offence. The SJMHC could be designated as an alternative, pre-conviction option. Upon completing the treatment program, the charges may be withdrawn or the individual given a conditional discharge or, in the case of more serious offending, given a term of probation. Incarceration is avoided. Interestingly, even as the "graduates" return to court for this sentencing, they are given the option of still electing to go to trial (none apparently have exercised this option). Those dropping out of, or expelled from, the program, - relatively few, no more than a handful, reportedly - have their cases returned to court for processing but can expect some sentencing benefit for their participation in the SJMHC. In the event of dropouts or expelled persons, the case would be heard by another judge and prosecuted by another crown save perhaps in situations where the offender pleaded guilty and there was to be no trial.

As in the Vancouver and Toronto DTCs, the SJMHC sits regularly (every two weeks, Friday afternoon) where active cases are reviewed in court. Immediately prior to this court session (i.e., a few hours before), the SJMHC team, with the judge as active leader eliciting reports, directing inquiries and advancing the consensus, meets to discuss each individual's progress and decide upon the responses, rewards and punishments, that may be appropriate. The SJMHC team consists minimally of the judge, prosecutor, one or both of two defence counsel, a probation officer, and one or all of the treatment team from Community Mental Health Services

(a psychiatrist, a psychologist and a nurse); others in attendance may include a representative from the Salvation Army, or the owner/manager of a private residence, where some of the clients may be in a "special care housing" situation featuring structured, controlled living arrangements. Most SJMHC clients are outpatients who come to the clinic for treatment but who are also visited in their homes by the nurse.

The ambience of the SJMHC was similar to that of the Vancouver and Toronto DTCs in terms of the friendly atmosphere (e.g., the judge always asks if the accused recognizes everyone in the courtroom, and if not, publicly identifies them), the exchanges between the judge and the offenders (e.g., praise, exhortation directed to the defendant), and the underlying emphasis on conventional decorum (e.g., stand when being addressed by the judge). It was different in that the court attended to one defendant at a time while the others remained outside the courtroom, and all parties - defence counsel, prosecutor, probation officer and treatment personnel - spoke to the case at hand (this latter difference might well reflect the fact that in the small SJMHC operation there is no formal court-treatment liaison role). The SJMHC does not have a formal graduation ceremony or graduation day. The style of the SJMHC reportedly has evolved as a result of many discussions among the key players as to what would be most conducive to the court's successful intervention; it was determined that maintaining decorum and formality were crucial symbols contributing to such success.

Cases are flagged by crown and judges, defence counsels and now even some of the accused, reportedly, ask for it. Treatment people, when notified, check to see if the accused person is on file (apparently they usually are), and, if not, do an assessment prior to the person being accepted into the SJMHC. The length of the program is discussed by the team and while not formalized, a rough time frame is communicated to the offender via the defence lawyer. While there was no great reservation, there was some concern expressed by a few informants about the "proportionality issue" - whether the offence warranted the length of the treatment schedule. Treatment providers reported that the SJMHC participants received essentially the same kind of treatment as given their other clients or those not opting for the SJMHC. The psychiatrist considered that the amount of his time spent with the different types of clients depended largely on their needs. Still, he and other treatment providers allowed that there is more elaborate holism in this MHC and that participants stay in the treatment longer, benefit

more, and have more follow-up after the specific MHC treatment plan is over. The treatment plan may include curfews, house arrest, urine tests, required attendance at meetings and so forth. Non-compliance can result in (and reportedly has in a few instances) short stays in jail but the SJMHC team expects relapses and difficulties so the emphasis is on tolerance and harm reduction. Both the probation officer and the treatment nurse visit the clients at their homes or their special care facility.

As noted, the SJMHC received no significant new funding; accordingly, all the key role players, while designated for this court, continue to carry out their regular responsibilities. The probation officer, for example, has a caseload of seventy active files additional to his SJMHC secondment; from the probation officer's perspective, there is much more time and energy devoted to these cases - the files are demanding and there are more calls from and about the clients - though admittedly if the offender had gone through the mainstream court process, the probation officer would probably have to deal with the person in any event. The judge and prosecutor both have quite busy schedules, and the defence counsel include one person seconded from Family Services where he is employed full-time, supplemented by a part-time duty counsel paid on an hourly basis for her activities in the SJMHC. The same basic pattern of commitment exists on the treatment side. The community health nurse's workload has increased while the psychiatrist estimated that SJMHC participants now make up a small but significant part of his caseload, though these offenders, if granted probation or if jailed and provincial inmates, would possibly be in his caseload in any event. In the SJMHC there are no special coordinators, court liaison staff or special administrative support staff. Despite the extra burden, and notwithstanding a general wish to secure funding for the initiative, the SJMHC personnel were all quite positive about the initiative. There has been some concern from probation officers that without new resources, satisfactory service standards may be problematic. Consistent with that view, some treatment providers reported that the SJMHC appears to work best for those who have mental health problems but are not deeply into drug use or criminal activities.

Virtually all informants - CJS and Treatment personnel - considered that the chief features of the SJMHC that both differentiated it from conventional criminal court and accounted for its success, were the holistic approach (attending to a wide range of clients' needs and problems), and the collaboration of the SJMHC team. One CJS role player commented that "the

treatment may not be new stuff but the collaboration certainly is". All agree that there is more discussion and problem-solving as well as immediacy of response to the participants' behaviours. In the SJMHC there can be repeaters (reportedly there have been a few) though "the bar is set higher the next time". As in the DTCs, the coercive power of the court is tied closely to the treatment plan. All informants acknowledged the coercion but also noted that participants have a choice and do not have to exercise the option. The coercion is chiefly represented here by the avoidance of a record (or adding to it) and possibly avoiding short stays in jails (the offenses have been modest). The treatment providers reported themselves comfortable with court format and procedures.

Thus far, some 50 persons/offenders have participated in the SJMHC. The program is regarded by SJMHC personnel as being very successful. Although no official records or evaluation reports were available to this writer, reportedly the large majority of participants are either still active in the program or have completed it satisfactorily. One of the biggest problems has been having the participants take their prescribed medication. Treatment providers indicate that their initial scepticism has been conquered. Defence counsel report that most eligible offenders opt for it and most complete the program. Apparently returning a case to court is quite uncommon.

Several issues were raised by the SJMHC officials. Some were concerned that too many offenders with serious mental health problems are slipping through the system (i.e., that the penetration rate is too low). Another concern was that too many such offenders do not receive adequate, continuous defence counsel (the clients typically have few resources and legal aid is scarce). There was some concern too about what might be called net-widening or catchment whereby charges are resorted to in order to solve behavioural problems or where there may be unintentional misinformation conveyed to the offender (e.g., that they would be jailed if they did not opt for the SJMHC). This issue dovetails with the concern about proportionality - of treatment time vis-à-vis the modest offence - raised by defence counsel. As noted, the issue of team collaboration and information divulging among the role players, defence counsel and prosecutor, treatment providers and CJS officials, appears to have been resolved. A defence counsel commented: "dealing for your client's benefit is what we do and remember it's voluntary" while a treatment professional observed that while there is coercion and threat of

punishment "improving the health of clients is also important so you have to make tough decisions in this consensus milieu; the good and the bad co-exist and coercion has some benefit; besides it's an adult deal to make and voluntary".

In sum, then, the SJMHC, is a modest operation. No evaluation was available and very little documentation, protocol forms or brochures. It has depended on the commitment of a small handful of CJS and treatment personnel. Still, it seems successful and the team members all seem very positive about the concept. The recent DTC foray involves overlapping but not identical personnel, similar structures and processes, and is open to a wide range of criminal offenses.

THE OTTAWA DRUG TREATMENT COURT PLAN

An Ottawa DTC has been in the works for roughly three years. The initiative or moral entrepreneurship was provided by a provincial court judge who thought that the conventional court's processing and subsequent sentencing of drug users was ineffective and inefficient, and who was impressed with the Toronto DTC. Under his leadership a steering committee was established, some initial examination of salient data undertaken and a proposal developed for submission to the National Crime Prevention Centre of the Department of Justice. The funding being sought is largely for treatment and coordination activities, all of which would be provided by a contracted private, for-profit company. The Ottawa steering committee is very confident that their DTC will be up and running in the fall of 2003.

Like the Vancouver DTC, the Ottawa group has benefited from the proposals and protocols developed by the Toronto DTC. There is similar reference to two tracks, to waivers, eligibility and graduation criteria, similar processes of referral, assessment, team collaboration among CJS officials and treatment providers, and pre-court and court sessions. There are some sharp differences. First, the much smaller scale of the hard drug problem in Ottawa, compared with Toronto and Vancouver, and the desire to give the Ottawa program a different, special twist, have led the group to emphasize an offender-based eligibility (i.e., all offenses, but the more violent crime and most objectionable trafficking, committed by someone who has an addiction to hard drugs can lead to the DTC and CDSA offenses are not prerequisites). Secondly, reportedly at the suggestion of a police committee member, the Ottawa initiative aims to include youths; the program has an objective of having 25% of the participants being youth. In both these respects the Ottawa group claims to be set apart from Vancouver and Toronto. Also, while the evaluation of the Toronto project was conducted under the auspices of Justice, here, perhaps because a staff person with the Solicitor General (Corrections branch) was seconded to the group for the past year to develop the actual project proposal, the evaluation component, built into the project proposal, is to be carried out by the same Corrections unit.

The Ottawa DTC steering committee, after discussions with both governmental and private treatment providers has opted, like Vancouver, for the private organization, and apparently for similar reasons (e.g., costs, agreement on procedures); but, unlike Vancouver, here

the private treatment providers, in addition to carrying out verification, additional testing and actual treatment, also will coordinate all case management and liaison activity with CJS and with social services. Apparently, there will be no separate or distinct program coordinator. It can be noted that no treatment people were involved in the earlier deliberations of the Ottawa DTC since "there might have been a conflict of interest since the treatment contract was to be bid upon".

There was much collaboration, according to the judge, at the operational level among himself and federal and provincial crowns, and subsequently with various, other CJS role players (e.g., police, defence counsel, probation); but virtually no top level authorization apparently was sought or took place. The latter is somewhat surprising in light of the experiences of DTCs in Toronto and Vancouver in not being able to span the federal-provincial prosecutorial divide. The prosecutors (a federal and a provincial crown) will be the DTC's gate-keepers, with referrals coming from judges, defence counsel, police, and court workers. Eligible offenders will have to submit an application. As noted, the scale of the hard drug-crime problem is much less than in Toronto or Vancouver but it is comparable to Halifax, as is the major type of CJS-salient, hard drug addiction (i.e., crack cocaine and, much less, then prescription-based opiates). The Ottawa plan is to get up to a caseload of 40 within a one year period. Informants indicated they while they were confident they could reach that caseload even faster if they wanted, their desire is to have committed participants to this voluntary program, so eligibility criteria will be cautiously operationalized. The informants indicated that the Ottawa DTC will be basically an out-patient program with a preference for an initial 30 to 60 day residential placement if feasible. The treatment schedule has been developed and it is expected that the average adult participant will require about one year in order to pass through the phases and graduate; for youths, an average of fifteen months is anticipated. As in the other Canadian DTCs, a successful graduate is defined as one who is free from hard drugs use and shows some sign of social reintegration via work or school or family relations.

The Ottawa DTC committee members expect that the vast majority of their "clients" will be "track 2", that is persons who would have a high probability of being remanded and facing some jail time if sentenced in conventional court. Track 2 participants will have to plead guilty and then will be placed on bail (interim judicial release order) pending sentencing. As in the

other DTCs, at sentencing incarceration will be very unlikely for anyone going through the DTC program. The DTC team members considered that the coercive power of the court was needed to complement the "carrot" of bail and probation and treatment. They acknowledged that the DTC would be quite invasive, closely monitoring participants, touching all aspects of their lives, and, on average per participant, lasting over a long period of time. For some offenders, this might be seen as more harsh justice than they would otherwise receive, as several informants noted; but one interviewee expressed the common view in his remarks "it might be more severe [than regular court processing] but it's voluntary and treatment by itself just does not work". Several informants commented that they saw no profound difference in involving alcoholics either but that that is not part of their proposed program.

THE CANADIAN EXPERIENCE TO DATE

The Toronto and Vancouver DTCs at this point in time represent the DTC presence in Canada. They share many features, including similar offender/participant profile, similar eligibility rules (e.g., only CDSA offences for "track two" eligibility), similar protocols with participants, parallels in DTC structure and functioning (e.g., designated CJS and Treatment role players, team approach, similar sanctions, pre-court "scripting" sessions) and treatment format (e.g., outpatient emphasis, substance of treatment). They differ in several respects, especially in terms of the treatment provider (non-profit, governmental versus private sector), some aspects of the treatment strategy (e.g., in Vancouver there is apparently more emphasis on a psycho-biological approach which emphasizes, among other things, physical care and sound diet) and the involvement of police and community organizations (it is more formal and extensive in Toronto). Both DTCs, at this writing, are carrying about the same number of active, "in good standing", participants (roughly 35), a smaller number than initially anticipated for this stage in their development. In both programs there have been almost no "track one" participants, that is, less serious offenders (e.g., women facing prostitution charges) who could readily secure bail and who could have had their charges withdrawn in the event they completed the DTC program. In other words, both programs have been dealing with what has been labelled in the DTC literature as "some of the toughest clients". Overall, and among all those accepted into the program, the success rate appears to be roughly 15%. Both programs report significant success among participants who are retained in the program for more than thirty days. Both programs feature highly motivated CJS and treatment personnel who typically have remained enthusiastic about the DTC initiative. Indeed, the CJS role players in each DTC expressed a strong wish to have less restrictive eligibility criteria and a more expansive program.

Apart from Toronto and Vancouver, there is a DTC recently launched in Saint John (with one participant at this writing) and others being advanced in other large Canadian cities, Ottawa being the most likely to begin operations soon. As noted elsewhere, the Ottawa and Saint John DTC models differ from that of Toronto and Vancouver most significantly, but not only, in having a broad base of eligibility, being open to addicts with serious criminal records and charged with serious criminal code infractions. Some key Toronto and Vancouver DTC officials,

in addition to seeking a broader-based eligibility, have indicated a wish to expand their programs into other addictions (e.g., Vancouver and alcohol addiction) or social groupings (e.g., Toronto and youth). The number of Canadian DTCs, along the continuum from drawing board to launching to maturing, is growing. This development is congruent with the Government of Canada's policy of encouraging the DTC approach and will provide competition for the significant funding that it has made available. In early summer 2003, the major federal initiative to expand DTCs in Canada was announced, involving collaboration between Health and Justice with program management being carried out by NCPC (Justice). As of October, 2003 apart from Vancouver and Toronto, NCPC had received eight "expressions of interests" from centres throughout Canada.

PART TWO: THE SCALE OF THE PROBLEM IN THE HALIFAX AREA

INTRODUCTION

It has been reported that there are some 12,000 injection drug users in each of Montreal, Toronto and Vancouver. In Vancouver an estimate from the federal prosecutors' office is that there could be as many as 50 arrests made each week primarily for possession of and trafficking in hard drugs. With numbers such as these, it would appear that there would be a large pool of eligible DTC participants. Indeed Toronto, Vancouver, and on paper Ottawa, have all determined that for the nonce there would be a maximum set for DTC active participants (i.e., usually no more than 50 up to two years into the project). Still, as of June 1, 2003 there were only some 35 participants active in the Vancouver DTC, all but 8 as outpatients. Toronto's DTC as of September 2003 had an active, in good standing and all outpatient-serviced, clientele of similar size. The Ottawa steering committee group examined the scale of that area's drug crime problem and concluded that while it is significant and a DTC quite merited, a DTC would not be viable if eligibility was as specified in the Vancouver and Toronto instances; accordingly, as noted, it has advanced an offender-based and more youth-oriented eligibility in order to effect a larger pool of eligibles. Of course, a smaller program might well be viable too. Here the Saint John MTC could be a reference point since it has an active pool of less than 20 participants.

FEDERAL PROSECUTIONS

Federal prosecutors in the Atlantic Canada regional office in Halifax typically handle drug prosecutions for the metropolitan Halifax area. Occasionally they may deal with cases from elsewhere in Atlantic Canada that would be defined as "major cases". The several Federal prosecutors interviewed indicated that while drug charges of all types have been increasing in recent years, the number of persons charged with possession of or trafficking in hard drugs (i.e., schedule 1 and 2 CDSA) remains quite modest. Given the modest numbers and given the fact that not all those charged (especially among the largest category, namely the traffickers) would be assessed as addicted nor would opt for entering a drug treatment court program, the general

view was that a Halifax DTC should be offender-based where eligibility was not limited to persons charged with CDSA offenses. An average estimate was that a DTC, using Vancouver and Toronto criteria and benchmarks, would probably result in a DTC client population of perhaps, at most, a dozen persons after one year. These prosecutors indicated that most persons charged with possession of or trafficking in hard drugs were males and repeat offenders. They indicated that there was significant ethnic variation, especially among the traffickers, by geographical area in metropolitan Halifax; Caucasians dominated in the Spryfield area whilst Blacks dominated the Halifax peninsula and the major groupings were diverse in ethnicity in Dartmouth.

CCJS statistics for drug offenses in Canada support the assessments of the Federal prosecutors. The CCJS reports for 2001 and 2002 indicate a significant increase in "soft drug" offenses, particular cannabis possession, across the country; indeed for most of Canada the increase in drug charges is virtually totally accounted for by the increase in charges for soft drug possession. However, in Nova Scotia, as the prosecutors noted, there has also been a small but significant increase in crack/cocaine charges. The drug files data from the Halifax office of the Federal Department of Justice Prosecutions shed interesting light on these patterns. These data were examined for the fiscal years 2000-2001, 2001-2002 and 2002-2003. First, some context is needed to appreciate the data represented in Table 1. The data provide a profile of drug charges drawn from the new files associated with the various CDSA offenses in each year. On average, each file generated roughly 1.25 charges. Some files may also have referred to multiple accused persons but it was not possible with the data at hand to determine the frequency of this occurrence; in any event it would presumably be the case that the number of persons charged would be less than the number of charges. Repeater offenders may also be included; moreover, as noted, a very small number of files may deal with drug charges laid in Nova Scotian jurisdictions outside metropolitan Halifax. In sum, then, the rate per month of distinct persons charged in any fiscal year in metropolitan Halifax would be less than the rate of charges per month depicted in the enclosed table.

The data indicate that in each year most CDSA charges (between 75% and 80%) involved possession of and trafficking in marihuana and cannabis resin. These latter, especially at the minor level, have increased significantly but there has also been a small but growing problem

with respect to cocaine and other hard drugs. On a per month basis, minor cannabis charges have increased from 24 to roughly 42 per month over the three year period while more major cannabis-related charges have ranged from 12 to 20 per month by fiscal year. Charges related to "hard drugs" (cocaine/crack primarily) have increased, the rate almost doubling (i.e., from 7.5 to 12.5 per month) over the three year period. It is difficult to identify a trend in the latter because the figures depend heavily upon enforcement practices and the year 2002 witnessed two large drug busts by police in metropolitan Halifax. While drug offenses have clearly increased, it is also difficult to identify the size of the eligible DTC pool (assuming for the nonce Vancouver and Toronto eligibility criteria and benchmarks) from these data for many reasons (e.g., the uncertain user/trafficker overlap, hard core users could have been charged with marijuana possession, the data are for charges not individuals etc) but an estimate would be at most an average of a handful per month. Additional data from the Federal Prosecution Service indicate that, in 2002-2003 for instance, 75% of all hard drug charges were for trafficking or possession for purposes of trafficking. Since most CJS interviewees reported that traffickers frequently are not themselves addicted users of hard drugs (see below), the data above would suggest that the "handful at most per month" characterization is if anything a high estimate. Using the Vancouver and Toronto eligibility criteria, and considering their experience in having accused persons opt for the DTC, a Halifax DTC might be hard-pressed to reach an active clientele of a dozen.

HALIFAX REGIONAL POLICE SERVICE

Reports of the HRPS Drug Squad elaborate on the above federal prosecution statistics. The Drug Squad's "2001 Yearly Drug Report" indicates that 83% of the charges laid were for possession and trafficking in cannabis and that arrests in these instances accounted for 99% of the street value of drugs seized (i.e., 99% of \$3,690,000.). Apart from cannabis-related charges, there were approximately 54 charges laid related to cocaine (90% for crack) and another 20 charges pertaining to other drugs (morphine, methadone, diazepam, psilocybin, dilaudid and ecstasy). Discounting for multiple charges per person (whether as a result of multiple or single incidents), the initial eligibility pool for a metropolitan Halifax DTC, following the Vancouver and Toronto protocols, would then be maximally a handful a month - a figure consistent with that derived from prosecutorial data. And, of course, not all these persons would be addicts nor

likely to opt for a DTC option so the pool would shrink to one or two persons per month following the above protocols. It can be noted that the police charge data are solely from HRPS and that RCMP arrests in the metropolitan area are not included. It appears from the interviews that the latter would deal more with higher level producers and traffickers, typically not eligible to enter DTC programs.

Adult males accounted for about 80% of the cannabis-related charges, adults female and youths each contributing 10%. The large majority of persons arrested for cocaine and other hard drug offenses also were adult males, accounting for 75% of all persons charged. Females were charged in 8 instances and male youths in 10 instances. Among the youth, the majority were charged with trafficking, indicating perhaps more about the distribution structure of drug dealing than about addiction. Both yearly and monthly reports of the HRPS Drug Squad for 2001 and 2002 indicate that the majority of the adult males charged in the "hard drug" cases were young adults in their twenties.

The 2002 annual report provides similar patterns though several major "busts" in that year increased the proportion of persons charged with cocaine-related offenses. In 2002, roughly 66% of the persons charged were for cannabis-related offenses (down from 80% in 2001) and these arrests yielded 85% of the total value of \$1,225,011. in drugs seized (down from 90%). Because of the "busts", the number of persons charged for cocaine jumped from 54 to 192 though the number charged for "other drug" offenses remained at 20, and, as in 2001, most of these latter person charges were for psilocybin (i.e., magic mushrooms). As in 2001, adult males accounted for the lion's share of persons charged, roughly 80% for both cannabis and cocaine related drug offenses. As in 2001, crack cocaine accounted for over 90% of all cocaine charges. Less than 10% of the 192 persons charged for cocaine offenses were for simple possession while the remaining 90% split evenly between possession for the purposes of trafficking and trafficking.

Monthly Drug Squad reports for 2002 add some interesting details and variation to the above profile (see Table 2). The median total drug charges laid per month are 28 and charges for hard drugs usually range between 10% and 25% (the median is 20) of the monthly totals. Cannabis charges are usually (i.e., 80%) laid against adult males. There is little evidence of hard drug use, apart from crack cocaine, evidenced in the police reports. However, there is

considerable overlap in persons charged for cannabis-related and hard drug offenses, underscoring the interview and APTS reports of multi-drug use. It would appear that the multiple usage is particularly common among hard drug users. The reports also indicate that young male adults in their twenties make up the majority of accused persons and suggest that where the accused is significantly older they are more likely to be traffickers but not users. The reports highlight the pattern of policing the crime, namely the periodic sweeps/busts following a period (i.e., several months) of undercover activity (based on undercover purchases by officers, often with the collaboration of an insider facing court processing). The result of this style of policing the hard drug problem is that there is the pattern of a few arrests per month and one or two big months for arrests. In 2002 there was a particularly major Drug Squad "operation", dubbed "Mid-Way", which targeted mid-level drug dealers in several different parts of metropolitan Halifax. This endeavour ran from May to August and resulted in about 130 charges and 81 persons arrested; in addition, the total crack and cocaine powder seized had a street value of approximately \$150,000. Virtually all the charges resulting from Mid-Way were for trafficking under sections 5(1) and 5(2) of the CDSA. Clearly, the scale of arrests for trafficking points to a pattern of use far beyond what is reflected in the arrests for possession. There were other HRPS drug "operations" in 2002 (e.g., "Confident Harvest" in August and September focused more on cannabis and a different area of Halifax) and indeed interview data indicate that such operations are routine to the HRPS Drug Squad.

The HRPS reports dovetail quite well with the prosecutorial data and indicate the following drug crime situation; basically the hard drug problem, as reflected in drug charges and prosecutions, is a crack problem where the accused are overwhelmingly young adult males. There appears to be a significant percentage - interview data suggest as much as 50% - of those charged with trafficking who may not be users (e.g., youths and adults in later middle age). If eligibility for a DTC program is contingent on a drug offence and being addicted, it seems clear that there would be a small pool to draw from, certainly no more than a few a month. References and interview data suggest that the accused persons in hard drug offenses have a significant criminal record prior to their arrest, and perhaps, where addicted, prior to their addiction; that situation represents an important consideration for determining the prospects for a successful

DTC since, in both Canada and the United States, longstanding criminal record is associated with failure to graduate from the DTC program.

SECONDARY DATA SETS

Three other data sets were examined in order to appreciate how drug addiction might intersect other criminal activity. These were Community Corrections, Custody Admissions, and Court Appearances, all for Nova Scotia; they were made available through the collaboration of the Policy and Planning, Department of Justice. The Custody Admission files were obtained for the three years, 1999, 2000 and 2001, and deal only with adult offenders. Thus far, analyses of these files have been largely limited to overall frequencies which have indicated that (1) males accounted for 94% of the 5113 admissions to provincial correctional facilities during the three year period; (2) Caucasians constituted 83% of admissions where ethnicity/race was known while Blacks and Natives accounted for 9% and 7% respectively; (3) Halifax County residents accounted for roughly 35% of all admissions where information on residence was available, and (4) fully 70% of those admitted had had a previous term of incarceration.

Table 4 draws upon custody admissions data to compare the profiles of offenders with drug convictions and those with other convictions for this three year period. There were 273 persons (the data may include repeat offenders so the number of distinct persons might be less) in the former category, all of whom were apparently convicted of trafficking. The custody admissions identified with drug convictions have declined significantly in Nova Scotia since 1999, roughly by 40%. The other grouping, persons with non-drug convictions, totalled 4757 over the three year period. Table 4 indicates that in both groupings there has been much repeat incarceration; 60% of those with drug convictions and 70% of those with other offence convictions had experienced previous incarceration. As might be expected, those convicted of drug offences were three times as likely to have federal custody status (i.e., 37% to 12%). Given Nova Scotia's ethnic/racial make-up - some 95% Caucasian - it is not surprising that this latter grouping accounted for over 80% of admissions across the offence categories. It can be noted however that Blacks were more often found among the drug grouping than the non-drug alternative (i.e., 14% to 8%) and at a higher proportion than in the Nova Scotian population as a whole where they constitute some 2%. Native adults were also more likely to be incarcerated

than their 1.5% proportion of the Nova Scotian population would suggest but, unlike Blacks, their over-representation was greatest in the non-drug convictions category (i.e., 6%).

The two groupings of custody admission cases were quite similar in their gender make-up (i.e., 93-94% males) and in their education levels (i.e., 3 to 4% had some post-secondary education). But the drug grouping was older (44% to 50% aged thirty or younger), more likely to have resided in metro Halifax (i.e., 59% to 40%) and had received longer custodial sentences - only 14% received a sentence of 90 days or less while, among the non-drug convicted persons, 59% had such sentences. It can be noted that approximately 50% of the offenders convicted of drug trafficking received custody sentences of more than one year.

Community Corrections files (all adults) were accessed for a similar three year period. It was possible to separate the file into two subgroupings - those receiving conditional sentences and those receiving sentences of probation - and, for each subgroup, to examine patterns of referral to Drug Dependency (which provides treatment for drug and alcohol addiction / abuse) by gender, ethnic/racial origin, age, and most serious offence. Considering first those offenders receiving a conditional sentence order (conditional sentences were basically recorded as either "conditional plus probation" or "conditional supervision"), the data indicate that males were more likely to have a court-ordered referral (i.e., 45% to 36% among females), and that, overall, 44% of the offenders received such a referral as part of their sentence. There was some modest difference by ethnicity/race with Caucasians (45%) and Natives (41%) more likely than Blacks (35%) to be ordered to Drug Dependency. There was no difference at all in the mean age of those who did and those who did not get referred; in both cases the average age was 33.

Table 3A provides information on offence patterns averaged over the three year period. In the conditional sentence subgrouping, those convicted of drug trafficking contributed the most cases to the referred total, namely 17%; theft, major and minor assaults, and break and enter offenses each contributed between 10% to 13% of the referred cases. Interestingly, if one examines the data to determine for each offence the proportion of instances where the offender was referred to Drug Dependency, it turns out that ten offence categories had a minimum referral rate of 45%; these ten were robbery (75%), impaired driving (65%), PO mischief (60%), drug possession (60%), weapon possession (60%), minor assault (55%), other criminal code (55%), drug trafficking (50%), break and enter (50%) and theft (45%). Comparing referrals where drug

offenses were highlighted (i.e., the most serious offence) with those where other offenses were the designated most serious offence, there is no statistically significant difference in referrals to Drug Dependency though the referrals were indeed greater in the case of drug offences (i.e., 50% to 43%). Clearly, while referrals to Drug Dependency often were for alcohol treatment, these data strongly suggest that drug addiction may be a very significant factor in other criminal activity.

Turning to the grouping where offenders received probation sentences (see Table 3B), 40% of the offenders were ordered to Drug Dependency, with males significantly more likely to have been so than females (43% to 29%). Differences by ethnicity/race were also more evident than in the group receiving conditional sentences. In the probation grouping, Natives most frequently (53%) received referrals, followed by Caucasians (41%) and lastly Blacks (31%). Here, too, age mattered as offenders receiving referrals were older by an average of two years than those who did not (i.e., 34 to 32). The top five offenses, in terms of contributing to the total number of probation sentences with referral orders, were minor assault (accounting for 26% of all such referrals), impaired driving (17%) and theft, administration of justice offenses and break and enter, all with 7% to 8%. There were ten offence categories where referral orders were rendered in at least 30% of the cases, namely impaired driving (80%), drug possession (65%), drug trafficking (60%), cc traffic (55%), robbery (50%), major assault (50%), break and enter (45%), minor assault (40%), weapons (40%) and theft (30%). Comparing those with highlighted drug offenses to those where other offenses were "the most serious offence", the former were much more likely to be ordered into treatment for substance abuse (i.e., 60% to 40%) but perhaps the fact that 40% of the latter were also referred is the most important finding when considering the possibility of a drug treatment court and the eligible offences that could undergird it.

The third secondary data set analyzed dealt with court appearances information recorded in the Nova Scotian "Justice Oriented Information System" (JOIS). Again data over the three year period from 1999 to 2001 inclusive were accessed. Again the preparation and initial write-up by Policy and Planning, Nova Scotia Department of Justice (Smith, 2003) were essential for this report. The data represent all persons charged with at least one drug offence (whether possession or trafficking) and appearing in court in any or all of 1999, 2000 and 2001. In other words, persons were selected from the JOIS system if they were charged with a drug offence and

appeared in court within that calendar year period; also included were any other charges involving the same person where he/she appeared on those additional charges in the reporting year.

Analyses of these court appearance data can shed much light on the interconnection of drug and other charges. Since the data are provided in JOIS with charges as the basic units, some operational strategies have to be developed in order to identify distinct persons and distinct cases. The data can inform as to how many cases a person was involved with (a case is defined as all charges brought against a person where that person appeared for the first time on the same date and in the same court in relation to those charges, charges which may be related to the same or different incidents). At this stage in the analysis each year is treated as distinct and therefore persons are not distinct over the entire data set (i.e., person X recorded in 1999 may also be found in the 2000 and 2001 records).

Table 5 indicates that for the whole of Nova Scotia there were approximately 1000 distinct persons (the range was from 961 to 1,133) in each year appearing in court on drug charges. For every person there were 1.5 cases and roughly three charges involving that person in the specific calendar year. Given the multiple cases per person, given the fact that cases may themselves each refer to multiple incidents, and given the fact that each calendar year is exclusive, clearly there is strong indication that persons charged with drug offenses were often repeat offenders. It is also evident from the table that, in each calendar year, the selected persons appeared as frequently on non-drug charges as on drug charges. Some of these non-drug charges might be attributed to the drug charge, especially with respect to trafficking (e.g., police do a drug raid, charge a person for trafficking, find restricted weapons, stolen property etc). Perhaps other charges additional to possession charges might reflect drug addiction and secondary crime. It could be possible in future analyses to sort out this consideration by for example factoring out the trafficking offenses and associated charges.

From the perspective of locating the interconnections of hard drug offenses and other non-drug charges, the court data are problematic since only the general drug category, CDSA, is recorded and not the specific drugs involved. Accordingly, to extract estimates of the volume of persons and cases involved in hard drugs in these data, one would have to apply a weight factor derived from UCR data for the years in question. UCR data break out drug offenses by substance

type and provide the number of persons by gender charged with these types of offenses. Applying this estimation logic yields a weight factor between .14 and .32 for the six categories (i.e., three years by gender) for non-cannabis drug offenses. Weight factors are higher for females since females consistently have higher proportions of non-cannabis involvement (otherwise put, they are less likely to be charged with cannabis offenses). In any event, the conclusion of such estimation procedures is that court data indicate there were perhaps as many as 150 hard drug offenders in each of 2000 and 2001 in Nova Scotia and in the metropolitan Halifax area the estimated number would be consistent with that drawn directly from police and prosecutorial files (i.e., an average of five or six per month).

Overall, while analyses are still on-going, these secondary data sets clearly point to the interconnectedness of drug abuse and other criminal activity. Custody Admissions data highlight the patterns that those whose most serious offence was a drug crime shared many features with other offenders (e.g., previous incarceration, male gender, modest education) but differed in terms of having received longer sentences, being more likely to reside in metro Halifax and being older. Community Corrections data indicated that a high percentage of those receiving conditional sentences or probation supervision also received court-ordered referrals to Drug Dependency. In the case of conditional sentences, a number of criminal code offences generated higher rates than did convictions for drug trafficking. In the case of probation, the offenses of theft, minor assault and impaired driving generated over 50% of such court orders. High percentages of those convicted of crimes, such as robbery and break and enter, were ordered to treatment and, for many offences, persons convicted of non-drug charges were as likely as those convicted of drug offenses to be referred to substance abuse treatment. Court data indicated that in each of the three years considered, persons appearing on drug charges had on average 1.5 cases and faced 3 charges, and were as frequently appearing on non-drug charges as drug charges. There was clear evidence of multiple repeat offending. The court data also yielded estimates of hard drug accused persons in metropolitan Halifax consistent with the numbers directly derived from police and prosecutorial files.

HOW BIG IS THE PROBLEM: TREATMENT DATA

Data from APTS, Department of Health, indicates that referrals from referrals to APTS from the CJS have been roughly 10% of the total number of clients in recent years prior to 2002/03. For example in 2001/02 there were some 90 federal referrals (i.e., Parole) and some 810 provincial ones (i.e., probation) combining to account for 11% of the APTS client load. According to information from APTS, Department of Health, January 2003, court-referred individuals participate in at least five sessions at CORE and can volunteer to participate in further treatment. No data were available on how many court-referred individuals exercised that option but the interviews with probation officers and treatment personnel suggested that it would be a low percentage. The CORE program, designated as only available in metropolitan Halifax (i.e., Capital Health), reportedly emphasized educational orientation in the mornings and treatment/discussion groups in the afternoons. An underlying principle of APTS response to addiction was said to be a “biopsychosocial” approach.

In this section reference will be made to ten tables derived from APTS client files and with the collaboration of the Capital District Health Authority. Tables 6 to 10 provide data specifically for the Capital District (metropolitan Halifax) for the years 1998/99 and 1999/00. Table 6 indicates that referrals from Parole and Corrections accounted for roughly 9% of the APTS adult clients in both years, with most of these coming from the provincial Corrections. Table 7 identifies the drug problems reported for the adult clients. Cocaine/crack was the third most frequent problem, after alcohol (a problem for almost 80% of the clients) and cannabis. It is clear from the frequencies adding up to more than 100%, that multi-substance abuse was common. Crack/cocaine use was reported by almost 30% of the clients and rx opiates by 12%. Table 9 indicates that in both years - 1998/99 and 1999/00 - males were twice as likely as females to be clients of APTS in the Capital District. Tables 9 and 10 provide limited data for adolescents. Corrections and, much less, Parole account for slightly more clients, proportionately, namely 11% on average, among APTS clients in the Capital District. The gender difference is evidence too among adolescent clients but modestly less so than among adult clients. No data were available here for specific adolescent substance abuse problem but other APTS data indicate that the numbers are few for "hard drugs" (see below). Overall, then, these

tables indicate that Corrections and Parole account for 10% of Capital District's APTS clients, is largely a cocaine/crack issue and involves mostly adult males.

Data from APTS referral files for the years 2000/01, 2001/02 and 2002/2003 are provided for both Capital District and Nova Scotia as a whole in the following tables. Table 11 is a graph histogram detailing the frequency of the different types of addiction among the clients throughout Nova Scotia. Not surprisingly, the addiction characterizing the majority of the APTS clients is alcohol while cocaine, "benzos" and rx opiates contribute roughly equally to the yearly totals, each accounting for between 850 and 1050 clients in each year. On the assumption that a client with multiple addictions would be counted in several categories, it can be seen that the maximum number of cocaine-addicted clients taken in by APTS would be 1000 or 10% of the 2000/01 total client base of approximately 10,000; if opiate counts were combined with cocaine the total would be maximally 1900 and roughly 20% of the 2000/01 total. The 2000/01 distributional patterns hold up over the 2001/02 and 2002/03 years. The total referrals increased in 2002/03 as impaired driving cases formerly referred to a private company were redirected to APTS; accordingly, the proportion of alcohol addictions rose and that of cocaine and/or rx opiates decreased slightly. The number of cases of cocaine and rx opiate addictions in these two years remained relatively stable, approximately 1000 and 1100, and 1000 and 900 in 2001/02 and 2002/03 respectively.

Table 12 depicts the same frequency distribution for the Capital Health region which is basically coterminous with metropolitan Halifax. The frequency distribution of adult addictions among the client base is similar to that of Nova Scotia as a whole - on a scale of roughly 30% - but there are a few differences, namely a modest increase in the representation of cocaine and rx opiate addictions. The cocaine addictions are higher in the Capital Health region, ranging from 13% to 15% over the three years while the combined cocaine/rx opiate addictions account for between 22% and 25% of the total adult cases.

Table 13 identifies the main sources for adult referrals to APTS throughout Nova Scotia over the three years. It is unclear whether persons may be counted more than once for multiple and/or different source referrals in any given year but assuming those possibilities, the tables may inflate the number of distinct adults represented. In any event it is clear that the major referral sources are Corrections (e.g., "Attend and Complete" court orders) and Motor Vehicle

orders (e.g., attend and complete as a condition of regaining a valid driver's licence). The Corrections referrals, along with Parole, most salient for estimating a DTC caseload, averaged '800 plus' referrals yearly over the three year period. The other referral sources identified - Parole, Child Protection and Legal Services - contributed in total some 250 referrals in each of the three years. Unfortunately, with the data available, it is not possible to break down the Corrections or the Parole referrals in terms of the primary addiction entailed but it is assumed that many would involve hard drug addiction.

Table 14 depicts the distribution of referrals to APTS by source over the three year period. It is clear, by comparison with table 13, that Motor Vehicle referrals (i.e., impaired driving) are much more numerous proportionately in the Capital Health region. Apart from that difference, it is interesting that the Capital region proportionately contributes fewer addiction referrals for alcohol and drug abuse than its 33% of the provincial population and concentration of young adults would lead one to expect. The substance abuse problem clearly is not concentrated in metropolitan Halifax from the perspective of APTS caseload. In the Capital region, referrals from Corrections have ranged from 150 to 110 and the combination of Corrections and Parole referrals never exceeded 175 in any of the three years. As noted above, it is not possible with the data available to determine how many of the Corrections and Parole referrals would involve clients addicted to "hard" drugs. Given the likelihood that some of these referrals were for gambling and alcohol addictions, and given the possibility of multiple referrals for clients, a reasonable estimate could be 100 persons with hard drug addictions referred to APTS in any given year by Corrections (provincial) and Parole (federal) authorities. That figure dovetails quite nicely with the estimates provided by probation and parole officials in their interviews.

It is interesting to look a little closer at the regional distribution of hard drug use. Table 15 provides the 2001/02 data for all provincial adult referrals by specific hard drug use and by selected regional units. Because there is extensive multiple drug usage the numbers do not represent exclusive categories of unique persons; moreover, the reference is to drug abuse not drug addiction. The table shows that the Central region (i.e., Capital Health, metro Halifax) accounts for 30% to 33% of the male users of cocaine/crack and heroin in Nova Scotia but that there is more concentration of female users of these drugs in the Central region (i.e., over 50%).

Abuse of prescription drugs is less concentrated for both males and females (i.e., fewer percentage-wise in Central); interestingly, the less populated East region (i.e., Cape Breton) had almost the same number of referrals in this regard.

CONCLUSION

Through accessing a variety of data sources it has been possible to characterize the possible clientele base for a DTC in Halifax. It seems clear from federal prosecutions data and reports of the Halifax Drug Squad that pertinent CDSA charges - the basis for entry into Toronto and Vancouver DTCs - would constitute a very limited pool of eligibles. The 'hard drug' charges averaged about 7 a month in recent years which translate into 5+ distinct individuals and this figure, discounted for non-addicted traffickers, becomes 2 or 3 offenders per month; based on DTC experience elsewhere, less than half these offenders in turn would opt for the DTC and only 10% to 15% of those who did opt for it would graduate.

Analyzing data from the secondary data sources, namely custody admissions, JOIS and community corrections (conditional sentences and probation), it is clear that there are many offenders who appear to have a hard drug addiction among those convicted of criminal code offenses; indeed, the figures suggest that the proportion of such addicted people might well be greater than among those charged with the salient CDSA offenses. These data sets also point up the strong linkage between drug addiction and crime (multiple repeat offending). The number of "hard drug addicted" persons either on probation or parole or in extant NSLA caseloads appears to be roughly 200 a year, not a huge number compared to Toronto or Vancouver but perhaps constituting an adequate pool for a modest DTC initiative in Halifax that remained entirely focused at least initially on hard drug addicted offenders (i.e., did not include those with other addictions such as alcohol or gambling). Given a host of factors impacting on whether many offenders would opt for the DTC, the funnelling from charges to court processing eligibles noted above, and the experience of Vancouver and Toronto, it would appear that over a period of several months a client base of perhaps a dozen persons could be developed.

Data from treatment sources, basically APTS client data, dovetails well with the estimates of Corrections and Parole interviewees, namely that there are about a hundred or so convicted hard drug addicts in metro Halifax under supervision and in the Capital District

treatment programming. The addiction problem is well distributed throughout Nova Scotia but the cocaine/crack addiction is more concentrated in the Capital District, especially for women. The APTS data and other sources (e.g., Directions 180) indicate quite clearly that there is much addiction to hard drugs which may never manifest itself in the criminal justice system; for example, an indication of this larger phenomenon is that in the Capital District, there are some 265 persons receiving regularly prescribed methadone, 132 from public organizations (Directions 180 and APTS) and 133 from private physicians.

Table 1

Federal Prosecution Service: CDSA Charge Inventory Profile by Fiscal Year*

CDSA Charge	Fiscal Year		
	00/01	01/02	02/03
Cannabis (Marihuana Hash)	428	707	743
A. Minor**	284 (24 per month)	472 (40 per month)	502 (42 per month)
B. Major	144 (12 per month)	235 (19 per month)	241 (20 per month)
Cocaine/Crack	88 (7 per month)	80 (7 per month)	136 (11 per month)
Other Hard Drugs (Schedule 1 or 2)***	3	6	12 (1 per month)

Other Drugs****	25 (2 per month)	37 (3 per month)	35 (3 per month)
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* These data were compiled by the Atlantic Regional Office, Department of Justice Canada and essentially refer to prosecution cases in the metropolitan Halifax region.

** Minor refers to marihuana charges involving less than 31 grams and hash charges of not more than 1 gram. Major refers to all other cannabis charges.

*** These include morphine, heroin, and codeine.

**** These include ritalin, psilocybin, LSD, and mescaline, schedule 3 substances.

Table 2

**Halifax Regional Police Monthly Drug Report Charges
An Eleven Month Snapshot, 2002**

Month	#s Charged					
	Marihuana Hash*	Cocaine	Other**	Total	% Hard Drugs	% Hard Drugs By Male Adult
January	37	5	6	48	23	92
February	28	4	0	32	12	75
March	37	2	1	40	8	33
April	21	3	0	24	12	66
May***	39	34	0	73	47	85
June	27	4	3	34	21	100

July***	52	101	4	157	66	75
August	30	3	1	34	10	75
September	24	3	3	30	10	83
October	23	6	2	31	26	75
November	21	4	1	26	20	100

* Youth and adult females accounted for approximately 22% of these charges. Adult females were charged in 41 instances and youth in 34 cases.

** Other drug charges were for psilocybin (magic mushrooms), ecstasy, and LSD, respectively, 10, 5, and 4 cases. There were two other charges.

*** These two months yielded high numbers since they covered a period of several HRP special operations (e.g. mid-way) targeting both street and 'middle levels' drug traffickers.

Table 3A

Drug Dependency Referrals By Offence, Conditional Sentences Admissions, Nova Scotia, Community Corrections, 1999-2001

Top Five Offences Generating Referrals*

Drug Trafficking	17%
Theft	13%
Minor Assault	12%
Major Assault	10%
Break and Enter	10%

Top Ten Offences With High Percentage of Referrals

Robbery	75%
Impaired Driving	65%
Drug Possession	60%
Weapons	60%
PD Mischief	60%
Minor Assault	55%
Other CC	55%
Drug Trafficking	50%
Break and Enter	50%
Theft	45%

% Drug offences where referral: 50%

% Non-drug offences where referral: 43%

* All percentages rounded off. The Ns for the three years were 645, 682, and 603.

Table 3B

Drug Dependency Referrals By Offence, Probation Admissions, Nova Scotia, Community Corrections, 1999-2001

Top Five Offences Generating Referrals*

Minor Assault	26%
Impaired Driving	17%
Theft	8%
Administration of Justice	8%
Break and Enter	7%

Top Ten Offences With High Percentage of Referrals

Impaired Driving	80%
Drug Possession	65%
Drug Trafficking	60%
CC Traffic	55%
Robbery	50%
Major Assault	50%
Break and Enter	45%
Minor Assault	40%
Weapons	40%
Theft	30%

% Drug offences where referral: 60%

% Non-drug offences where referral: 40%

* All percentages rounded off. The Ns for the three years were 3370, 3146, and 3034.

Table 4

Selected Profile Features, Drug and Non-Drug Convictions, Custody Admissions, Nova Scotia, 1999-2001

Feature	Drug Convictions (N=273)*	Other Convictions (N=4757)
Previous Incarceration	60% Yes	70% Yes
Status		
Provincial	63%	88%
Federal	37%	12%
Status		
Remand	27%	38%

Provincial	53%	54%
Federal	19%	3%
Other**	1%	5%
Ethnicity		
Caucasian	81%	82%
Black	14%	8%
Native	3%	6%
Other	2%	2%
Gender		
Male	93%	94%
Administrative Area		
Halifax	59%	40%
Sentence		
Equal/Less Than 90 Days	14%	59%
Age***		
30 or Under	44%	50%
Education		
Less Than Senior High	34%	36%
Some Post-Secondary	4%	3%

* The numbers for drug conviction cases over the three years breaks down into 128 (1999), 70 (2000), and 75 (2001).

** 'Other' here refers to federal transfers and parole violations.

*** There were no youths in this sample.

Table 5

Drug Charges and Other Charges Laid in the Same Year Against Persons with Drug Charges, JOIS, 1999-2001, Nova Scotia

Year	Persons*	Cases**	Trafficking Charges	Possession Charges	Non-Drug Charges	Total Charges
1999	1133	1809	1004	934	1899	3837
2000	961	1419	624	845	1473	2942
2001	1023	1541	1092	833	1612	3537
Total*	3117	4769	2720	2612	4984	10316

*A person may be involved in more than one case and may be charged in more than one year.

**A case is defined as all charges brought against a person where that person appeared for the first time on the same date and in the same court in relation to those charges.

*** The ratio of persons to cases is 1:1.5, that is, for every person charged there are 1.5 cases involving that (average) person. The ratio of cases to total charges is greater than 1:2.

INSERT TABLES 6 - 10

Table 11

Drug Use Frequency (Addiction Services – Nova Scotia Adults)

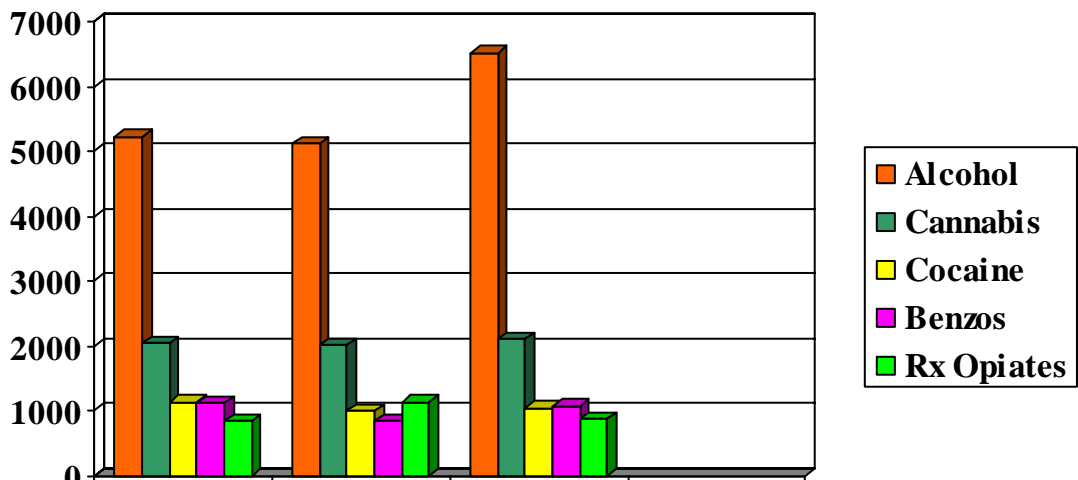


Table 12

Drug Use Frequency (Addiction Services – Capita Health Adults)

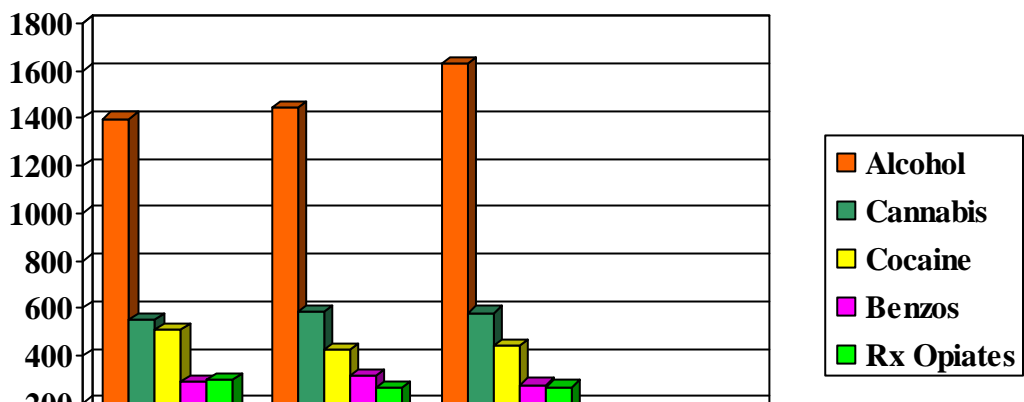


Table 13

Sources of Referral (Addiction Services – Nova Scotia Adults)

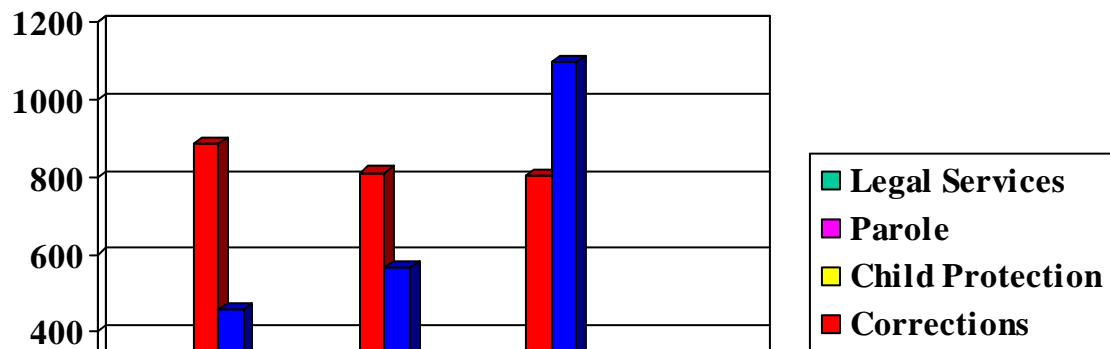


Table 14

Sources of Referral (Addition Services, Capital Health Adults)

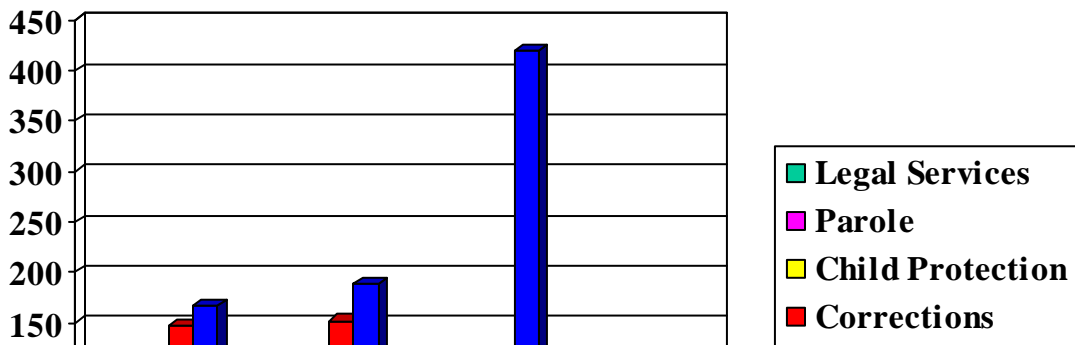


Table 15

Adult Clients, APTS, By Drug Problem, Gender, and Selection Regions, 2001-2002

Drug	Region
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	All	Central*	East**
Cocaine/Crack	711 M 280F	259M 163F	153M 40F
Heroin	117M 27F	34M 15F	25M 5F
Prescription Opiates	563M 272F	175M 91F	175M 72F

Source: Drug Dependency Services, Capital District Health Authority

* Central refers to the Capital Health region, roughly also metropolitan Halifax.

** East refers to the area encompassing the Strait and Cape Breton Island.

PART THREE: AN EXAMINATION OF STAKEHOLDER VIEWPOINTS IN HALIFAX

THE FEASIBILITY OF A HALIFAX DTC: STAKEHOLDER VIEWPOINTS

INTRODUCTION

Seventy-six persons were interviewed over a twelve month period, virtually all one-on-one, sometimes on multiple occasions, to get their views on the nature and extent of the connection between addiction to hard drugs and crime and the desirability and feasibility of a DTC initiative in the metropolitan Halifax area. Since most stakeholders had little familiarity with the DTC approach, the researchers basically described the Toronto and Vancouver DTCs but noted, as well, that there was much variation in the USA concerning all aspects of the DTC implementation and much variation too in the success of this approach. Most of the respondents were CJS role players but a small sample was secured of treatment providers and of either community-based or agency-based local stakeholders dealing with the addiction-crime linkages directly or indirectly.

VIEWS OF THE CJS SAMPLE

A modest but quite representative sample of 59 CJS role players was utilized in this project. Six provincial court judges, seventeen crown prosecutors, eleven defence counsel, seventeen probation officers, six police officers/officials, and two administrators (one court administrator and one senior Justice official) were interviewed. Virtually everyone was quite interested in the DTC movement and indeed in the larger issues of therapeutic jurisprudence, the problem-solving court, and the linkage between treatment providers and CJS processing of cases. Most persons had heard of the DTC concept and of rumours concerning its implementation in metropolitan Halifax but few interviewees had any substantive knowledge of DTCs so there were many questions raised about DTC processes and outcomes. The format for the interviews,

accordingly, generally entailed the researcher initiating the interview by providing a brief overview of the growth of the DTCs and the experience to date in Canada as regards eligibility criteria, process matters, treatment practices, scale and known outcomes. The CJS role players were then asked their views on the desirability and feasibility of establishing a DTC in metro Halifax. There was a common core of questions, including the extent of the hard drug - crime problem, the adequacy of current means to deal with it, the interviewee's experience in dealing with such offenders, the value of a DTC in this area, and special concerns or issues entailed should a DTC be initiated here (e.g., eligibility, protocols, required resources, equity). In addition, certain CJS role players were asked questions most salient from the vantage point of their own role. For example, probation officers were especially asked about their caseload characteristics (e.g., the proportion of hard drug addicts, the social characteristics of the probationers), their current collaboration with Drug Dependency (APTS), the support systems that exist for their clients, and case management issues. Judges, defence counsel and crown prosecutors were especially asked about federal/provincial prosecutorial collaboration, eligibility issues and whether they identified any problematic implications for their role in a DTC.

JUDGES

The six judges interviewed covered the spectrum of provincial court judges by rank, gender and years of service on the bench. The judges all were quite aware of the strong link between drug addiction and crime (e.g., prostitution, property crime). Their views differed substantially concerning the desirability of a DTC, ranging from principled objection (i.e., "the presumption of guilt in these kinds of courts bothers me since courts are about more than merely sentencing") to hedged support (especially skepticism about dealing with "chronic offenders" long part of a criminal milieu) to enthusiasm ("oh yes, for most addicts, crime is a consequence of addiction and their robberies for example are pathetic, clumsy, with little chance of avoiding identification, and driven by their addictive urges"). Perhaps the consensus position was advanced by one judge in his remarks that "it's worth a try; we should support people who have the motivation to change". That underlying motivation was acknowledged by the judge who was

perhaps most resistant to the DTC concept, when he tempered his critique by adding "But I can appreciate the motivation behind the DTC idea".

All the judges wondered about the volume of cases that would be directed to a local DTC but agreed that, if eligibility was offender-based (i.e., with some exceptions, open to offenders committing crimes related to their addiction) and not limited to those addicts charges with CDSA offenses, there would be sufficient numbers for a DTC to work with. Several judges specifically noted that a small program or project would be fine. In general, the judges considered that it would be preferable and appropriate for eligibility to be offender-based; as one judge commented: "I read several papers on the Vancouver and Toronto drug courts and was quite disappointed that eligibility was limited to drug charges". Judges also agreed that there should be no problem in obtaining the collaboration of federal and provincial prosecutors in achieving such an arrangement; those acknowledging a stickiness in the prosecutorial divide on jurisdiction believed any obstacles could be surmounted (indeed, several judges held that the current federal/provincial prosecutorial divide made little sense anyways).

The judges generally did not consider the current treatment practices for convicted hard drug addicts to be very effective and the few who mentioned the effectiveness of sanctioning for breaches considered it to be problematic in achieving its deterrent objectives. Typically, the judges held that "the treatment side needed shoring up", that "there is not enough structure there". It was commonly contended that the relations between "treatment people" and the CJS people in responding to convicted addicts were "cool at best", featuring little positive feedback, and left much to be desired. The DTC was seen as a way of enhancing the efficacy of that linkage. Several judges emphasized that the DTC can be effective because coercion is linked to treatment. For example, one judge commented, "A number of addicts just need a bit of a push. Some coercion can be useful, putting people under the gun, after a month or so you start to see benefits, so there's no way around it; it's coercive but very beneficial for some people". Judges were not explicitly asked about the value of residential versus outpatient treatment programs, or the viability of the latter, but one judge commented on this issue; drawing upon rich experience with the mentally ill, the judge felt that outpatient treatment could be effective, especially if strategically supplemented by short-term residential programs. The judges did not think that a DTC would yield much subsequent dollar savings for the CJS but they also did not believe that it

would be a great cost. They opined that no great resources would be needed to initiate a DTC locally - "there would be no great strain on resources". Only one of the five judges specifically asked, indicated that he/she would be interested in being the designated judge for a local DTC but all the other judges identified this same person as a prospect for the position.

PROSECUTORS

Seventeen prosecutors were interviewed about the DTC and its feasibility in Halifax, fourteen provincial and three federal crowns. At the provincial level, the sample represented well the range of prosecutors in terms of experience, rank and philosophy of prosecution. Virtually all the prosecutors had much experience with - and had thought much about - the strong drug addict-crime nexus in general and in the Halifax context. They appreciated that much crime could be attributed to offenders' seeking the wherewithal to support their addiction, and they acknowledged that the current response to that situation was inadequate with the result that court processing for such offenders resembled, to their frustration, "a revolving door". All the federal prosecutors were well-informed about the DTC model but very few of their provincial counterparts were, not surprising of course because in Canada only federal prosecutors have been involved thus far in the DTCs. The well-informed prosecutors were quite supportive of the DTC approach in general and potentially in the Halifax context.

Federal prosecutors of course regularly prosecuted the CDSA offenses but most provincial crowns indicated that, in a high proportion of their files, there were clear signs of substance abuse and possible addiction. Alcohol addiction of course was seen to be the most common but estimates of the correlation of offenses with hard drug abuse, if not addiction, ranged from 5% to as high as 50% percent of their files ("every second offender I prosecute seems to have a drug problem"). All prosecutors acknowledged extensive repeat criminal offending, apart from CDSA violations, on the part of hard drug users; as one respondent noted, "a lot of addicts are involved in criminal activities such as shoplifting and robbery to fuel their drug habit and there is a lot of recidivism". And all prosecutors agreed that, given the small number of annual salient CDSA charges, other usual criteria for DTC eligibility, and the likely opting out of many eligible accuseds, a viable Halifax DTC would have to have a different

format than those in Toronto and Vancouver, at least to be offender-based (i.e., hard drug addicts committing any offence, with specified exceptions, could be eligible).

For most federal and provincial prosecutors the issue of eligibility transcended the question of securing an adequate number of DTC participants; they considered that including addicts charged with criminal code offenses was "not artificial" and if not done, in the words of one federal prosecutor, "it would be a disservice to the community and to the offender addict too". A provincial prosecutor commented, "if only federally prosecuted charges defined eligibility, only a small percentage of the problem would be attacked, maybe less than 10%". Perhaps, too, some argued, in the long-run at least, for reasons of equity and problem-solving regarding addiction-based crime, consideration should be given to having a broader eligibility base from the point of view of different addictions and regions in Nova Scotia. Respondents often specifically called for a "made in Nova Scotia" DTC initiative suited to Nova Scotian patterns of crime and addiction. Several respondents, however, while advocating broad eligibility for a local DTC, were not inclined to be expansive on the matter of type of addiction, contending that the legal issues are different and frequently so, too, are the associated criminal code offenses (e.g., drug addiction and theft versus alcohol addiction and assault).

The prosecutors typically contended that the federal - provincial prosecutorial divide, which has considerably restricted eligibility in Vancouver and Toronto DTCs, to the chagrin of DTC advocates there, could be readily surmounted here. There were some interesting variations in responses concerning this position as well as how to structure a broad eligibility. Several provincial prosecutors noted that there were precedents for collaboration; one observed "we collaborate now and where there are both federal and provincial charges, the feds usually get the prosecution". A senior provincial crown cited that existing flexibility between provincial and federal prosecutions and saw no problem in a DTC where eligibility would be offender-based, adding that there should be designated crowns from each level to a DTC, such that addicted persons facing only eligible, major criminal code charges might be prosecuted in the DTC by the provincial crown while federal prosecutors would handle all other cases. This same type of arrangement was advanced by another senior PPS official who held that currently, where there is overlap of jurisdiction in charges, the level with the most minor case may cede the prosecution to the other level; he added, "where there is no drug charge, the province could delegate to federal

prosecution the criminal code charge of an addict if it is minor, say prostitution charges, and, if it is major, say robbery, then the designated provincial crown moves with it". Not all provincial prosecutors were so sanguine about the jurisdictional issue. Another senior administrator in the PPS, who agreed that if there is to be a Halifax DTC, it should be offender - based ("that's logical and fits the numbers"), contended, "transfer of cases, if required, would be a big step and definitely need ministerial approval and working out a protocol ... transferring cases outside jurisdiction may exist now but it is only dictated by resource allocation factors, not a fully new protocol".

All interviewed federal prosecutors agreed that, for a viable, indeed a truly fair and effective Halifax DTC, eligible offenses should include criminal code infractions. They considered that arrangements between the jurisdictional levels could be worked out for securing such non-drug cases once eligible offenses are identified; still, one federal prosecutor, while acknowledging an on-going regular collaboration across the jurisdictional divide as suggested above, reported that such transfers are few, and mused, "yes, collaboration, but there's got to be a drug charge there somewhere if we are going to handle it [prosecute the case]".

In assessing the value of initiating a local DTC, the prosecutors focused much more on comparative effectiveness in terms of CJS responses, than on differences in the treatment services. They were generally critical of the current CJS approach for dealing with addicted offenders, citing the high levels of recidivism and using the "revolving door" metaphor. Typically, they were not impressed with the deterrent value of conditional sentencing, described by many as "a major focus nowadays" in the CJS response to addicted offenders committing serious crimes; indeed, a few prosecutors considered that "the convicted are now laughing at the system". It was commonly held that in the current system there is little monitoring of court-directed orders such as "attend and complete", and ineffective enforcement of breaches of treatment orders. At both prosecutorial levels the respondents had difficulty recalling any cases of successful prosecution of such breaches. A senior provincial crown said that she thought she had prosecuted on a breach in the past but acknowledged such prosecutions would be very difficult since "there are waiting lists and sometimes other signs of voluntary commitment that the treatment people want, and when they don't get them, the person is expelled". One provincial

crown after declaiming the lack of monitoring and the inattention to breaches commented, "a big improvement would be if the court could keep in touch with the treatment".

The DTC was seen as a more effective CJS response for a variety of reasons, largely, as noted, enforcement or CJS reasons, namely the close monitoring and urine testing of participants, the regular court review of progress and the immediate consequences for violations of the undertakings (i.e., breaches). Revoking bail was seen by many prosecutors as the "hammer" or "stick" keeping the participant in treatment. One federal prosecutor held that the main difference about the DTC is sustaining the addicted offender's motivation by wielding the stick - "it's the DTC and the rules or it's jail". A senior provincial prosecutions advisor (very knowledgeable about the Toronto DTC) commented that "judges can always call a chamber meeting, raise the issue "can we do something here, treatment-wise?" and delay sentencing pending the offender taking treatment, and if all went well, then suspending the sentence. The DTC works better since bail can be revoked if warranted. It's a lot easier to revoke bail (an interim judicial release) than to charge for breach of probation".

Most prosecutors acknowledged knowing little about treatment services or the Corrections (probation) - APTS (treatment) linkage though there was a widespread view that the best programs were allegedly found in federal prisons. Commonly, prosecutors simply shrugged and basically contended that treatment is available but the crucial issue may be whether the person is ready to fight the addiction; for example, one provincial prosecutor noted that "treatment programs are available but you can't force a person ... most addicts [addicted offenders] are players ... you can lead a horse to water blah blah"; another provincial prosecutor agreed that any treatment program only works if a person is motivated to change, adding that, in his experience, there appears to a point in life when addicts are ready to quit, "a maturing out" for drug addicts and for criminal behaviour generally ... a big drop-off in the mid to late thirties". Generally, without getting specific about the treatment provided, the majority of prosecutors considered that with a DTC there would be both a better strategy (effective coercion) and context (reviews and consequences) for treatment as well as more intensive and sustained treatment. Virtually none of the prosecutors referred spontaneously to the potential DTC implications for a holistic approach to the addicted offender that would also include social welfare considerations as well as treatment and CJS undertakings.

Concerning the costs and benefits of a DTC, almost all prosecutors did not think profound effects (whether costs or savings) would be entailed on the CJS side by establishing a modest-sized DTC in Halifax. They thought that personnel and administration costs could be largely absorbed within the present system. One senior crown with much administrative experience and also much familiarity with the Toronto DTC commented, "There would need to be some indulgence in scheduling for court time and maybe some extra time for judges but is it extra costs if they are normally handling these cases?" A veteran provincial crown contended that 'there would be no problem getting a courtroom; the ones at Water Street are frequently empty' [regular criminal court without jury for both CDSA and criminal code offenses is held at the Spring Garden court house]. A federal prosecutor acknowledged that a DTC would likely involve more court time and space but was quite skeptical that the costs would be great and proposed several cost-saving options such as holding the DTC in the evening. The prosecutors did contend that having designated crowns and defence or duty counsel - something they all considered quite essential to the team model of the DTC - would require probably up to 50% secondments. And while they may have discounted new resource requirements on the CJS side, virtually all prosecutors held that there would probably be a need to shore up resources on the treatment side and to consider having some coordinative roles (e.g., project coordinator, court-treatment liaison).

If the sample downplayed the costs of mounting a DTC in Halifax, they also discounted the benefits it would produce for the CJS directly, while allowing that eligible individual offenders might be well served and that a successful DTC could reduce some of their frustration at repeatedly prosecuting the same small percentage of addicted offenders. Most provincial crowns did not think that diverting cases with criminal code violations to a DTC would do much to reduce the PPS workload, presumably because even with broadened eligibility they still expected that the number of participants would be modest, and also because of past experience with other movements such as restorative justice which in their view did not appreciably change the stress and workload of provincial prosecutions.

As noted, all prosecutors held that eligibility to a Halifax DTC should be offender-based, for many reasons, especially for generating the numbers for program viability and for ethical and problem-solving imperatives. Federal prosecutors, while contending that there is a high

proportion of addicts among those charged with trafficking (as one argued, "why take such risks if they are not addicts"), realized that CDSA eligibility would yield few participants. One federal prosecutor observed that, at the time of interview, there were only 25 active cases dealing with possession and trafficking of hard drugs in federal Halifax files (active designates a case between the charge and sentencing phases); he added that even with an offender-based eligibility, he'd be surprised if there were more than a dozen participants in a Halifax DTC. Typically, too, the provincial prosecutors expected that the number of addicted criminal code offenders who would be eligible and would opt for a DTC would be well under 5% of their caseload. Almost all prosecutors envisaged a modest-sized DTC. They also usually identified the pool of likely participants as primarily male, crack-addicted, older addicts, and having a long record and much previous exposure to treatment - all characteristics associated with success in DTCs. Several respondents also commented on the resilient social networks they observed among the addicted offenders (e.g., supporters being present at bail hearings). There was some uncertainty concerning the significance of the motivation to get bail and avoid custody as a reason for opting in since a number of prosecutors suggested sentences tend to be much less harsh than in the USA and conditional sentences to be quite frequent in Nova Scotia.

Overall, there was much support among the prosecutors (certainly all the federal prosecutors) though not the unequivocal and pervasively enthusiastic support for a DTC program found among defence counsels. A few provincial prosecutors were quite enthused; one such person observed "I am in favour of dealing with crimes rooted in illness outside the criminal justice system or in a different way"; another expressed hope that the "beneficial" program could be extended to youth. Most provincial respondents, at least did think that a DTC initiative could work and preferred it to the status quo or other initiatives; one young prosecutor said, "the DTC concept I could initially see working, more so than others proposed such as domestic violence court or aboriginal courts". One of her senior colleague allowed that "it should be tried" while another probably captured the most common sentiments with his view that a Halifax DTC is "probably a good idea if it gets to the roots of the problem which has so many spin-offs". Certainly a number of prosecutors expressed their frustration at having to deal with the same pitiful offender again and again and see the person directed to the same unsuccessful treatment program. And about half the prosecutors expressed a willingness to be the designated DTC

prosecutor for their level of jurisdiction and most did not think it would be a challenge to find among their colleagues, others willing to do so.

As a group the prosecutors, basically the provincial prosecutors, were much more likely to have advanced caveats and alternatives when discussing the feasibility of a Halifax DTC. Several prosecutors stressed the importance of having the public on side and considered that much effective marketing would have to take place if the DTC were to take roots; one suggested that the public was "already at its limits of tolerance" while another senior crown argued that while a Halifax DTC would probably have to be offender-based, certain crimes would have to be excluded because they would be unacceptable to the public and to the victims. A few provincial prosecutors also raised the caveat of the provincial government being "caught out on the limb" when federal DTC project funds were exhausted and thus having to make federal priorities, its priorities. Others warned that, given the pattern of sentencing, the DTC option might be selected only by chronic serious offenders who could thereby forego custody, making a tough challenge for the DTC approach. Other caveats included concern for equity in processing offenders (should addicted criminals receive all this attention and resources?).

A number of alternatives were raised. A handful of provincial crowns indicated that their preference would be for something else, such as a domestic violence court, but they acknowledged that the DTC concept was the current "in-thing" and being federally funded, so they accepted its priority under the circumstances. as the best way to get at some serious CJS problems. A frequent alternative suggested was the possibility of targeting the same problems as the DTC does, through conditional sentencing, beefed up by urine tests and resources permitting close supervision, regular court reviews and access to more intensive treatment. Other alternatives suggested included having a DTC-type program based on handling addict files differently but not having a separate DCT court.

In sum, there was significant overall support for initiating a Halifax DTC among both levels of prosecution. For many reasons, there was strong consensus that eligibility should be offender-based (with some offenses excepted), not limited to those with CDSA charges. Almost all prosecutors considered that the jurisdictional divide between federal and provincial prosecutions could and should be surmounted through new protocols. It was anticipated that a Halifax DTC would have modest numbers and have modest costs and benefits but nevertheless

have potential for effectively rehabilitating a small number of multiple repeat offenders and perhaps, in the long-run, impacting on a larger number of offenders with diverse addictions. The current CJS response to the addicted criminal and the current relationship between Justice and Treatment were seen to have serious shortcomings. The DTC concept was seen to bring considerable advantages in new mechanisms or tools, strategy and context that could significantly enhance the possibilities for successful treatment and rehabilitation. The provincial prosecutors in particular advanced a number of caveats and suggested some alternatives to a DTC initiative but the bottom-line for most was that the DTC would be a worthwhile program for metro Halifax.

CORRECTIONS

The seventeen interviewees from Corrections ran the gamut of the provincial department's hierarchy and specializations, and also included two Corrections Canada employees (an official especially responsible for coordinating rehabilitative programming for released prisoners addicted to hard drugs, and a front-line, contract employee). It was acknowledged by provincial authorities that there was little programming available for addicted inmates in provincial custody. As one official commented; "the average stay in jail is thirty days so not much programming is done". This reality was conveyed during a recent hearing (Mail Star, July, 2003) to determine whether a young offender would serve federal or provincial "time". The manager of programs at the provincial Burnside Central Nova Correctional Centre commented: "Don't send youth here since there are security problems for youth and extensive drug activity going on. Most people are here for remand, transfer and for probation or parole violation while others (fewer than 50) are serving, on average, sentences of less than three months. There are no substance abuse programs whatever other than a community volunteered AA program". At this same hearing, the case manager coordinator at the federal Springhill institution, in making the argument that young offenders have been successfully housed there, noted, "we have excellent programs for overcoming drug abuse".

The local Corrections Canada official was quite proud of the programs for overcoming substance abuse provided under Corrections Canada auspices in federal prison (i.e., OSAPP) and upon release (CHOICES). CHOICES entails ten half-day counseling sessions and then a string of

weekly maintenance sessions. Published evaluations reports have shown that both OSAPP and CHOICES have been effective in reducing recidivism, presumably also in reducing if not eliminating addiction. Reviewing the caseload of the fifteen parole officers in metro Halifax, the official estimated that there were roughly fifty parolees in the area who could be described as addicted to hard drugs. He felt that a local DTC would be a good initiative and could "fill the vacuum existing at the provincial level". The official raised several issues for a local DTC, namely the need to sort out the addicted from the fakers ("there are a lot of fakers") and the value of a residential program as in a half-way house model. Interestingly, the field-level employee noted that in the several months that she had been involved in a half-way house arrangement, seven of the twelve released inmates had been returned to Springhill for parole violations relating to drugs (usually determined by urine tests), adding that there was much resentment by the released offenders concerning the "intrusiveness" of the housing rules. This employee also noted that most of the centre's occupants had strong social ties (partners, children) and seemed sincere about wanting to overcome their addiction.

Among provincial correctional officials there was much support for a local DTC initiative but also much uncertainty about the role that the department and the probation officers would play in such a DTC, and much skepticism about the effectiveness of any DTC implementation. Several informants suggested that since DTCs are pre-sentence they might relieve the workload for probation which is post-sentence; this viewpoint diminished when they were informed about the significant role of probation services in many DTCs. The probation officers usually identified themselves and other co-workers as leaning more to either a law enforcement or a harm reduction philosophy. There was a good mix of viewpoints in the sample. The former were (i.e., law enforcement oriented) were more inclined to see the DTC movement as part of a larger approach which has reduced accountability and resulted in minimal consequences for breaches, and cuddling in place of effective treatment. The latter (i.e., harm reduction oriented) were more enthusiastic about the DTC concept and less alienated from the treatment providers; as one of them commented, "you have to step up and at least try something, have a pilot project".

Despite the differences in approach, there was a very widespread view that the present response to the drug-related crime problem was simply not working. Provincially, court-ordered educational and counseling orientation / treatment is referred to Drug Dependency or APTS, a

unit of the Department of Health. In the metro Halifax area, this has meant that those addicted offenders have to attend facilities in Dartmouth, not a convenient, accessible locale for many of those referred, according to probation officers. It was widely held that the current court-ordered treatment for drug-addicted offenders was ineffective, and that the 'attend and complete' court-order was minimally adhered to ("just a signed attendance sheet"). Further, it was held that the cooperation of the provincial treatment providers with probation services was largely nominal and ritualistic and that little information was exchanged partly because of different philosophical outlooks and work norms, and partly because of alleged fear of retaliation on the part of treatment providers were they to disclose information to CJS officials; accordingly, it was argued that few offenders overcame their addiction via these referrals.

One probation officer expressed a common theme with her comment that "Even though we refer [the offender] to Drug Dependency it's hard to talk with them because of Health "laws". At the upper end [of the bureaucracies] they may think there is cooperation but at the front-line there is no information exchange with Health. I can't even check whether the person I referred, attended sessions". Even veteran probation supervisors echoed these comments; one noted, "we can provide information to them but it is extremely difficult to receive information from them". Other probation officers contended that neither Corrections nor Treatment has sufficient resources enabling the field-level, front-line people to be persistent enough to make the regular contact which could effect a better collaborative relationship. For example, one probation supervisor observed that there is only full time clinical therapist for the whole of Bedford, Sackville, Fall River etc and they only do individual counseling at a secretary-less office. Moreover, most probation officers indicated that breaches were usually not taken seriously enough by the courts, the lack of consequences thereby handicapping effective case management; indeed, several probation interviewees indicated that when breaches do come up in court, "nine times out of ten, it's the probation officer who is on trial not the offender". Not surprisingly then, even those probation officers more attuned to a strict law enforcement approach often considered that a DTC project would be worth a try.

Certainly most interviewees appreciated the usual DTC practices of close supervision, urine testing, issuing bench warrants, having immediate consequences for a DTC participant's violating his/her DTC conditions (e.g., missing counseling or court appearances) or committing

new offenses, as well as the much closer collaboration a DTC effects between treatment providers and CJS role players. Several probation officers emphasized how in their own case management, court-ordered urine testing has become an effective tool; as one said, "we use it as a prod, as a way of reaching them about their drug use and related criminal activity; it's something they can't deny [if testing positively] so we can present the options to them". As noted, however, there was significant skepticism, especially among those with a law enforcement orientation, that these and other usual DTC features would be well implemented.

Caseloads were examined through interviews with both regional office managers and many probation officers throughout metro Halifax (including all those supervising conditional sentences) in order to estimate the number of hard-drug-addicted offenders currently on probation. Virtually all probation officers stressed that at least half, if not more, of those convicted of trafficking were not themselves addicts but rather, in the words of one probation officer, "in it for the money, the cars, the clothes, the gold chains etc". Indeed, some probation officers noted that "attend and complete" treatment orders issued by the court were often meaningless since the offender had merely used the addiction claim to secure a more lenient sentence. It was widely held that a DTC that limited eligibility to those charged or convicted of CDSA offenses, which are largely trafficking, would have a very small caseload and would hardly be worth the effort. There was wide consensus that a DTC should be offender-based not offence-based. By consensus, not file by file examination, it was concluded that there would be roughly between fifty and sixty-five clients addicted to hard drugs among the Bedford/Sackville, Dartmouth and Halifax offices. It would appear that about half of this estimated number would be serving conditional sentences (CS) in the community. Interestingly, one probation officer specializing in handling such CS cases observed that "these are the CS people who are the most problematic for me and who perhaps should be in a DTC".

The probation officers noted the paucity of residential programs (other than detox and some special arrangements involving small non-profit operations which were well-appreciated by probation officers) for addicted offenders in the metro area. One probation officer, for example, claimed that "residential programs for adults are almost non-existent. There are few beds at Drug Dependency so it's hard for the addict to get away from it [the drug milieu]. Even detox beds are not always available. People may be saying, please help me get a bed. I want and

need help. But we are helpless". Some other probation officers were more optimistic at least about accessing detox-type facilities but suggested that the ease of doing so would depend on the past experience of the client (i.e., frequency of use) and their own networking with treatment people. They generally considered that outpatient programs could be effective under the right conditions (e.g., close supervision, urine testing, immediate consequences for violations of undertakings, a motivated client). At the same time several probation officers stressed the need for the strategic use of residential programs in order to free a person from a negative milieu and/or cope with the addiction.

Several probation officials echoed the comments of one who observed that "a DTC could offer tailor-made programs for offenders unlike probation services where it's one size fits all and where a recommendation to Drug Dependency [for a bed] finds there are no openings". About half the probation officers readily identified a couple of persons on their current caseload that the DTC would "fit perfectly".

It was generally advanced that probation officers would be most suited to the role of case managers in a DTC, largely because "they have the big picture" (i.e., a practical approach and experience that takes into account the offender's needs and specifics, and community resources as well as the CJS's concerns to reduce crime and protect the public). A few probation officers argued that Justice is ultimately responsible for the case so the case manager should come from the Justice, not Treatment, side. Using caseload norms for handling conditional sentences (i.e., forty files), it was estimated by most probation informants that one probation officer seconded to the DTC would be sufficient were the active participants to number about thirty. The probation officers did not think there would be a problem finding volunteers from the existing staff complement for the position of DTC case manager should that materialize; indeed, several persons indicated that they would consider volunteering in that eventuality.

Given the characteristics of successful DTC participants as identified in both the American and Canadian case studies cited earlier - males, older addicts, crack/cocaine users, persons not steeped in a criminal subculture, frequent exposure to treatment programs, some social support that could be mobilized, adequate housing - probation officers were asked about their clients who were drug-addicted. They reported that, on the negative side, many of these persons were deeply rooted in the criminal milieu (e.g., had lengthy criminal records and the

criminal subculture was dominant in their social milieu). On the other hand, the positive side, the drug addicted clients were mostly male, crack cocaine users (though many were multiple drug users, crack cocaine was deemed to be the principal addiction) and a number were older persons (i.e., mid-thirties and older) who reportedly did indeed sometimes appear to be tiring of the addiction. A number of probation officers also noted how surprised they were at the resiliency of the clients' supportive social networks (especially of course family ties); despite all the harm and hardship that the offender had left in his or her wake, there was positive social support that could be mobilized if the addicted offender began to turn around his/her life. Several informants considered that this was particularly true in the Afro-Canadian community where the community presumably never totally abandons the addicted criminal "because there is so much distrust of the criminal justice system that it would be like turning the person over to the wolves". Housing, too, was generally seen as not especially problematic though several probation officers noted that in some cases a change of residence was pivotal to a successful turn-around (e.g., moving out of a drug-infested rooming house). On the whole then, the social characteristics of the addicted clients, as described by probation officers, augured well for a successful DTC.

DEFENCE COUNSEL

Defence counsel, whether the seven Nova Scotia Legal Aid (NSLA) staffers or the four private counsel, were unanimous in their view that a local DTC would be a very positive initiative. A few asked rhetorically, "who wouldn't be" [in favour of the idea]. All considered that eligibility should be offender-based, not restricted to those charged with CDSA offenses. One private counsel commented that "it is important to protect society, not just the offender, and most addicts doing criminal code property offenses may do so for the purposes of getting drugs and they are as much in need as those facing drug charges per se"; indeed, it was commonly stated by the defence counsel that few of their clients charged with drug offenses appeared to have been addicts. Combining the estimates of all NSLA lawyers from their own case files, it would appear that there could be at least as many as 100 hard drug addicts on NSLA active lists, virtually all facing criminal code, not CDSA, charges. The defence counsel generally saw no major institutional or resource obstacles to the implementation of a DTC in metro Halifax. The private counsel view was summed up in the rhetorical remarks of one, namely "how much of an effort is

it to have a drug treatment court?" Among NSLA staff, there was a widespread view that the DTC should have a designated defence counsel and that the person should be a NSLA secondment. Contracting out the DTC 'duty counsel' role was not ruled out and analogous current positions were noted (e.g., contracted duty counsel for defendants in custody). At the same time, the positive sentiment for a DTC was reflected in comments that some NSLA staffers would like to take on the DTC defence/duty counsel role and that the NSLA staff would readily accommodate to the secondment of one of their colleagues to the DTC. Given the heavy caseload of the NSLA lawyers - several hundred files, court dates fixed till mid-2004 - such virtually unanimous comments from NSLA lawyers testify to a strong conviction.

The strong sentiment for a DTC, particularly among NSLA respondents (the private counsel neither defended many persons charged with drug offenses nor were a high proportion of their other clients addicted to hard drugs), appears to be deeply rooted in experience. Many noted that a significant proportion of their clients were addicted to hard drugs and a majority were addicted to one thing or another. Further, several cited specific examples of clients who had died (two cases were said to have been suicides) because of their substance abuse problems, but who had expressed deep desire to overcome their addiction and would have been possibly well-served by a DTC option. Others pointed to the driven, spontaneous and seemingly unpremeditated character of the criminal acts of their addicted clients. One lawyer, for example, cited the case of a woman who committed a handful of armed robberies in a one year period, all crude, "easily arrestable" actions, driven by her addiction. Perhaps such experience accounts for the strong negative reaction they expressed if a DTC was established based solely on CDSA convictions. One NSLA respondent noted her deep disappointment upon finding out that the current Canadian DTCs are so limited in their eligibility, while another commented that he could never be associated with a DTC limited in this way (i.e., eligibility limited to relevant CDSA charges) because, from the outset, he would be at odds ("a rebel") with it and clamouring for an offender-based approach. A NSLA lawyer argued that 90% of the prostitutes charged are addicted as well as high proportions of those committing robbery and fraud and then added "you can't exclude these people if the goal is to reduce human misery".

Virtually all defence respondents were adamant that the current CJS-Treatment approach to the addicted offenders was very wanting. Many of the NSLA lawyers indicated that they had

spent a lot of time over the years "trying to work out a treatment scenario for client-users". Most of these efforts were pre-conviction and pre-sentence but, whatever, they were usually unsuccessful. Indeed, several defence counsel acknowledged that the primary success - and sometimes the primary motivation or strategy - was perhaps in influencing the sentencing favorably for the client. Several respondents reported that their addict clients often characterized their treatment experience at APTS as "not enough counseling focus nor is the support there when needed". And the defence counsel generally agreed that the current system of jail and/or probation-supervised court orders to "attend and complete" treatment programs did not work. Jail was said to be no solution, especially provincial jail where there is no real treatment opportunity, For almost all respondents, the court-directed treatment referrals to APTS are usually unsuccessful and the court sanction for breaches of treatment orders is almost non-existent - "breaches are rarely charged or convicted".

The advantage of a DTC was said to be the team approach for CJS and Treatment personnel, close monitoring and focused multi-dimensional programming, and "the hook and the stick" (i.e., conditions, immediate consequences, revocation of bail, deferred sentencing) helping people who, after full discussion with defence counsel, voluntarily opted for the treatment path, keep on it. Generally the defence lawyers readily acknowledged the "invasiveness" of the DTC approach (all official DTC team partners sharing information about and focusing on the DTC participants intensely and for a long duration) but they considered that it was the best alternative for many offenders burdened with hard drug addiction. One NSLA respondent commented, "yes, the DTC is invasive and not ideal but it is needed". A few observed that while it might be preferable to have much more resources directed to voluntary treatment and community programming, that does not appear to be a realistic option; besides, some addicts were deemed to apparently need structure and coercion to remain in treatment; as one private defence lawyer observed, "sometimes if they are under thumb, recovery is greater". Of course, such agreement with the DTC model did not mean that the defence respondents were without suggestions on how to make it more protective of their clients' interests; one NSLA staffer, for example, mused about a DTC process whereby, in place of a guilty plea by the defendant kick starting the process, the crown, as in insanity cases, would first have to establish culpability.

In discussing, based on their case files, the characteristics of the offenders with a hard drug addiction, the defence counsel identified the Halifax area as having the type of addicted offenders who have been successful in other DTC initiatives (see section A above for discussion of the positive correlates of DTC graduation); most potential DTC participants were male, addicted to crack cocaine, had many past episodes of treatment, usually had adequate housing, and appeared to have retained a resilient social network (e.g., have some strong ties, family and friends show up in court). Most respondents also noted that this subgroup of clients often had a long criminal record and involvement in a criminal milieu prior to their addiction. This latter characteristic is negatively correlated with DTC successes but those respondents with whom this matter was discussed were undeterred concerning the value of and likely success of the DTC approach; as one senior NSLA lawyer commented, "that just means there is a challenge to respond to". As for whether their clients who might be potential DTC participants would select this option, the NSLA lawyers appeared to share the sentiments of one senior counsel who said, "not all [declared eligible] would opt for it and some counsel might well suggest the crown's case is not strong and recommend against it, but if the DTC worked, word of mouth might cause more to opt for it".

In terms of resources required, the defence counsel anticipated that there would be a need to "shore up the treatment side and perhaps some community organizations such as Adsum House. Marguerite House [etc]". Several held that based on certain experience (e.g., NCR court) an outpatient program, more accessible and less resource demanding, could possibly be effective. They also suggested that hiring a project coordinator would be a wise investment given the many different roles involved and the need to link up with a host of community services too. Notwithstanding their commitment noted above, respondents indicated that perhaps a 50% funded secondment from NSLA would be reasonable if not required. All interviewees who were asked agreed that there was great advantage in having a designated defence counsel for the DTC, similar to the situation in the Not Criminally Responsible (NCR) court program, both to enhance the quality of defence services and to contribute to the DTC's team approach. In discussion of requirements on the defence side, most respondents appeared to hold to a standard of one full-time defence counsel for fifty clients given the demands of the DTC (e.g., team sessions plus court plus frequent consultations with clients)..

In calling for an offender-based eligibility for a Halifax DTC, the defence counsel did not anticipate a major problem in overcoming the prosecutorial divide between federal and provincial jurisdictions. They suggested that there is significant collaboration and flexibility at present; indeed, one senior NSLA staffer observed that "they [federal and provincial prosecutors] seem casual enough in court, discussing and deciding who is going to take files". Several of the NSLA staffers also observed that the concept of a proactive court evidenced in the DTC has many precedents or analogies in, for example, the family court system (e.g., the team concept, court reviews of progress) and the NCR court (designated personnel, Treatment-CJS teaming, regular progress reviews, rewards and sanctions for behaviour).

DTC procedures and the dynamics of the DTC relationships could possibly pose some ethical and professional issues for defence counsel, since he/she would be part of a CJS-Treatment team sharing information, assessing, and reacting, sometimes punitively, to the convicted addict for whom he/she was acting as defence counsel. There would appear to be two crucial principles whose combined realization might well be necessary to resolve any anxiety on these scores, namely the principle of informed voluntary consent and the principle of reasonable consent. In discussing the ethical and professional concerns the defence counsel typically indicated that they would be able to collaborate fully in the DTC team approach (a) because the process would be initiated on a voluntary basis by the offender subsequent to being fully informed about options by the defence counsel; presumably this would include discussion of the case and likely sentence; the participants would plead guilty and waive certain rights in selecting the DTC option (e.g., right to a speedy sentencing) - this presumably would meet the principle of informed voluntary consent; and also (b) because the defence lawyers considered it to be in the addicted offender's best interests to follow this path given its presumed benefits for the addicted offender (e.g., the process is justified by the client's needs and lack of success in other treatment scenarios) - this presumably would meet the principle of reasonable consent. As one defence counsel commented, in such a context the defence counsel becomes "a booster" of the DTC approach, while representing the participant at bail hearings and at sentencing hearings within the DTC context. A senior private counsel noted that once the required preliminaries are over (i.e., the satisfying of the two principles, the plea, the waiver), working for the client becomes

more of a problem-solving, management issue and in many ways is not qualitatively different from what defence lawyers often do.

Overall, then, there is strong consensus among the defence lawyers, whether private or NSLA, that the DTC court would be a welcomed initiative, beneficial to the addicted offenders and for the CJS itself. In their view, the need and the numbers are there for a modest, offender-based DTC court. They perceive the DTC as bringing into place something in the Justice/Treatment nexus that is currently unavailable and the absence of which has meant inefficiency and ineffectiveness as conveyed in the metaphor of the revolving door. The defence lawyers see no profound institutional obstacles to the established of a DTC, noting the patterns of collaboration that already exist among federal and provincial prosecutors, and the precedents in other court milieus for virtually all of the DTC's processes. Further, the respondents perceived no significant threat to the integrity of their role as defence counsel in the team model characteristic of the DTC. Lastly, the defence lawyers anticipated that the DTC pilot project would require basically modest and largely accessible resources but some additional funding as well.

POLICE

Police views on the DTC issue were obtained from a small sample of six persons who, as a grouping, covered the spectrum of policing officials, police executive, drug squad member, community officer and court officer. All police officers were members of the Halifax Regional Police Service. Several of these officers were well informed about the other Canadian DTCs and all had considerable familiarity with the local criminal hard drug milieu. All the interviewees emphasized the strong linkage between drug addiction and criminal code offenses such as prostitution, theft and robbery. It was suggested too that at least half the traffickers were "in it for the money" and would probably not be assessed as addicts. The hard drug problem was identified as basically a crack/cocaine problem though multiple drug use was said to be extensive and many other illegally possessed and trafficked drugs were noted (opiate pills, LSD etc). Three chief areas of the metro drug scene were identified as the key commercial areas for hard drug trafficking (Spryfield, 'Uptown' Halifax and North Dartmouth). Estimates of the number of hard drug addicts known to the police varied significantly but the modal response was between 100 and 150. Police officers considered that prostitutes (especially the fifty or so street prostitutes)

were often addicts and blacks were over-represented even though making up, at the maximum, only 20% to 25% of the total hard drug addicts. It was generally held that many hard drug addicts may never come to the attention of the police.

Police interviewees were positive about a DTC in metro Halifax. Several thought it would "bring focus to the response to criminals who are addicts" and probably all would have agreed with the following remarks of a community officer, "There is a need for healing in society. We need whatever band-aids will help the wounds, even if they're just band-aids". Not surprisingly the police, on the whole, believed that the program should be offender-based (i.e., open to people with serious records charged with serious criminal code infractions) and felt that with a little will the prosecutorial divide that limits eligibility in Toronto and Vancouver DTCs could be bridged here in Nova Scotia. At the same time, there were some qualifications and hesitations raised by the police interviewees which yielded a view that starting modestly, even if just with CDSA charges, might be a good strategy. There was a concern that a DTC might be perceived as the CJS not taking crime and drug use seriously enough, that offenders would fake addiction as many traffickers allegedly do now to receive lighter sentences, and that the bulk of their police colleagues, perhaps more law enforcement oriented, would require some persuasion and exposure to the DTC approach in order to be more open to the initiative. Still, no one objected to a DTC project and as one enthusiastic police supporter of the DTC idea opined, "a DTC could be very positive even if the numbers were few".

Police interviewees were not impressed with the current treatment and CJS responses to the criminally involved hard drug addict. They referred to an ineffective treatment system, largely a consequence of the offenders' lack of motivation coupled with poor collaboration between treatment and probation role players, and, in the CJS, a revolving door where initial sentences and subsequent response to breaches were not effective deterrents. In general the police were unclear as to what their role might be in a DTC and did not envisage it being especially significant. In their view the resources would be required basically for treatment and for coordination.

OTHER JUSTICE OFFICIALS

Both the other senior Justice role players interviewed considered the possibility of a Halifax DTC to have some merit such as bringing focus to the response to addicted offenders. One respondent, who believed she knew enough about the substance of the current response to advance an assessment, contended that court-ordered treatment via APTS was "not very effective" and that the probation supervision - treatment services linkages were weak ones. Both officials were wary of initiating a DTC Halifax, particular one with a broad-based eligibility, extending beyond federal prosecutorial responsibilities, that could at some point significantly draw upon provincial CJS resources. Both officials readily placed the DTC concept in the context of the therapeutic jurisprudence movement and observed that, at present, there is no other therapeutic jurisprudence court specialization in Nova Scotia (e.g., no domestic violence or mental health or aboriginal "Gladue" or impaired driving court). Perhaps not surprisingly, both focused on factors of costs and administrative responsibility in considering a DTC initiative. They appreciated the potential access to federal funding for a DTC project but were concerned that ultimately, once the project period was finished, the costs of the DTC would fall on provincial shoulders where Justice funding is already squeezed and where other initiatives have been shelved partly for lack of resources (e.g., a domestic violence court). In such a scenario, the province might well be caught up in following federal rather than provincial priorities, trapped in an initiative that would not be its priority for new programs.

The senior court administrator noted that while it may be true that a DTC would deal with accused persons who would be court-processed anyway, in a separate court approach there could be new costs involved, both infrastructural (i.e., court facilities and court time, some modest support staff) and perhaps judicial costs. He pointed out that the provincial court facility is quite pressed nowadays as it is (i.e., "there is a real capacity problem right now") and added that the DTC model of frequent court appearances obviously means a lot of court activity (i.e., ten offenders appearing once a week for a year could be said to be equivalent to hundreds of cases). He wondered whether alternatives such as sentencing circles could accomplish as much in dealing with offenders addicted to hard drugs as a designated, specialized, set apart court model. The other official emphasized the additional costs that would be required for treatment services and for coordination and monitoring of DTC arrangements and activities. She argued that

perhaps the best strategy would be to contract out the treatment aspects of the DTC, contending that there are sufficient local private sector resources and that a federal-based program with contracted treatment services would be least likely to impact on provincial resources and priorities.

Both officials were not opposed to a DTC initiative but appeared quite unconvinced of its priority for the area and wary of potential long term obligations. They were more supportive of a DTC along the lines of Vancouver and Toronto where federal prosecutions (and federal funding presumably) has been central. They considered the federal - provincial prosecution divide in jurisdiction to be not that easily overcome but suggested that if the comparatively small scale of the problem in Halifax warrants more expansive eligibility criteria (i.e., crimes by hard drug addicts apart from CDSA infractions) then, if "the feds" were willing to handle such cases, the provincial authorities would probably "go along" and agree to such a new protocol.

CONCLUSION

Among the CJS role players interviewed in this project there was widespread support for implementing a DTC in metro Halifax. Almost everyone agreed, for practical and fairness reasons, that eligibility should be based on an offender's addiction to hard drugs, whether the offence charged be a CDSA or a criminal code infraction. There was a widespread, though not unanimous, agreement that the current ways of responding to the addicted criminal were inadequate from the point of view of dealing effectively with the offender and in reducing the harm of his/her actions for society at large. It was contended that there were serious shortfalls concerning the linkages between treatment programs and CJS prescriptions and actions, and that the sanctions for breaches were, for one reason or another, ineffectual. The strengths of a DTC approach were seen to be (a) getting more at the roots of the offenders' actions, and (b) effecting a team approach between Health and Justice prescriptions and actions, and (c) using coercion effectively to enhance rehabilitation. Other strengths were seen to be the immediate consequences, both positive and negative, for the addicts' behaviour, and the holistic focus that a DTC brings to bear on the addicts' attitudes, behaviours and social situations. The potential weaknesses of a DTC were seen as most likely at the implementation level (e.g., will there be consequences for violations?) but there were occasional concerns raised about expending scarce

resources on this particular grouping of offenders and some uncertainty about the motivation of the offenders opting for the DTC. In all role categories of the CJS sample, the central position was that the resource requirements for a DTC were not huge and, for a modest-sized DTC, perhaps could be largely directed to treatment and coordination. Similarly, in all role categories, there was a common view that some colleagues would be appropriate and eager to be seconded to the DTC. The characteristics of the local offenders driven by addiction to hard drugs, as identified by the CJS sample, were, with the exception of criminal record and roots in a criminal milieu, the features found in evaluations of DTCs to be associated with participants' success in the program (e.g., crack/cocaine addiction, older persons, males, past treatment experience, and resilient positive social networks). There was important variation within and between the CJS role categories but also a significant commonality that favoured a DTC being established in Halifax.

TREATMENT PERSPECTIVES

Six persons associated with APTS and/or the more encompassing Nova Scotia Department of Health were interviewed, two on several occasions. The respondents reported some satisfaction at the success of their anti-addiction, substance abuse programs and were proud of some of their innovations in treatment. The program CORE (see description above) was highlighted as was MATRIX, an adaptation for females with addiction problems. APTS' use of acupuncture to reduce craving and create a favorable milieu for counselling and group therapy was cited as an example of innovative treatment strategies. The respondents, especially those most engaged or familiar with CORE, noted that they attempt "to establish a positive atmosphere and do not force people but work with them". While committed to "change and abstinence", they expect, and accommodate to, much relapse - "the average number of times a client tried [treatment] before success is eleven". In their view, their programs are readily accessible and no one is turned away for space reasons. Any availability problem has been with reference to "beds" where there is indeed usually a significant waiting list. The treatment respondents noted, however, that outpatient services are in vogue for both practical, policy reasons (i.e., the general movement in Health to outpatient programming) and validated treatment theory (e.g., residential treatment like prison treatment takes place in an "artificial" milieu). It was noted, too, that there

are various detox centres in mainland Nova Scotia and several non-profit organizations manage residential facilities (e.g., Alcare receives an annual grant of \$180,000 from the Department of Health to operate twelve beds) which the bed-scarce APTS can link into, though all resources face strong demand.

There was some acknowledgement by respondents that the current treatment programming available for convicted addicted persons, referred to APTS by the court through probation services, was of limited value, even though some successes were noted... This assessment, in the case of what some respondents referred to as "high risk, involuntary clients", was related to two major themes, namely that the treatment program, for this grouping at least, has been more educational orientation than intensive counselling and other related treatment, and that the outpatient-based program is of modest duration and undertaken by these persons involuntarily (i.e., they are directed to participate by probation services usually on a court-order). These shortcomings of treatment programming for court-ordered offenders appear to be commonplace in Western societies, as was evidenced recently in presentations at the 2003 International Conference On The Prevention and Treatment of Dependencies, where a central theme was the absence of "real" treatment in the current Health-Justice nexus (especially with respect to conditional sentencing).. As noted above, the basic program provided by APTS, namely CORE, has only a limited number of sessions and while the court-referrals (probationers) can request, and would likely receive, further treatment, few apparently do. As well, the interviewed Treatment respondents typically shared the view of the probation services respondents that the Corrections-APTS linkages often have been problematic. It was noted that "no shows" are commonplace among the "Attend and Complete" probation referrals ("it's hard to get group therapy going under the circumstances"), and that, while required information about attendance, if not performance, is transmitted to Corrections, the probation officer supervisors often do not appreciate that treatment staff have responsibilities (professional and ethical duties) to their clients, and are not themselves clients of the CJS. Clearly, there seems not to be much of a team approach nor a shared philosophical outlook usually operative in the current Corrections-APTS response to the convicted addict.

While there was some variation among the treatment respondents (APTS therapists vis-à-vis Health officials) in these respects, these interviewees usually advanced a harm-reduction

model (i.e., more emphasis upon improving the quality of life than eliminating the addiction) in responding to addicts, and there was some sense that their approach conflicted with the dominant sentiments (law enforcement) and the dominant style (coercion) of the CJS officials. As noted, there was also professional preference for responding to voluntary requests for treatment. Several respondents indicated clearly that their priority would be to obtain more resources in order to enhance the conventional treatment provided to all clients, not giving priority to those only coming to their services under pressure. For most treatment respondents there was some wariness concerning the team approach between Justice and Treatment so strongly emphasized in the DTC's therapeutic jurisprudence model.

Clearly, the respondents had pondered the implications of the collaborative team model for the client-therapist relationship, the possible subordination of treatment to a punishment-oriented CJS, and the appropriateness of the DTC's use of certain sanctions (e.g., short-term incarceration of a few days) in "motivating" clients. Still, the treatment people, especially the APTS staffers interviewed, recognized that referrals would come from the CJS authorities one way or another, and the DTC model at least had some elements of voluntarism, as addicted offenders had to elect this alternative and waive certain rights. Some treatment providers agreed as well that strategic use of coercion may be required to achieve benefits for some clients. Respondents were all aware, too, that their Ontario equivalent, CAMH, was a major player in the Toronto DTC, collaborating in developing the project proposal and providing all the treatment services. It was noted also that APTS currently collaborates in programs where lack of credited treatment success has punitive consequences for the client (e.g., family violence and impaired driving treatment programs). As for the more free-wielding exchange of client information in the DTC milieu, several respondents articulated views similar to those of defence counsel cited earlier, namely that the professional and ethical issues for participation were not prohibitive for them because there was informed voluntary consent on the part of the client and that consent was reasonable, in their eyes, under the circumstances.

The Treatment respondents identified the possible benefits of the DTC approach as being four-fold. First, they contended that it was superior to the alternative of incarceration ("imprisonment doesn't cure"). Secondly, they presumed that the DTC would bring urine testing, close scrutiny and immediate consequences for failing to honour commitments, all of which

would affect the motivational factor for addicted high risk offenders facing jail otherwise. Thirdly, the team approach of the DTC would generate more effective collaboration between the Treatment and Justice staffs and bring greater focus to the needs and circumstances of the client; several respondents considered that greater agency collaboration could be a legacy of a DTC project. Fourthly, the DTC would undoubtedly mean a more intensive, longer-lasting treatment program for addict offenders which would certainly make successful rehabilitation more probable.

The respondents did not anticipate any particular differences in the substance of the treatment that would characterize the DTC but rather more of it and, by implication perhaps, more depth in counselling and therapy. Several respondents noted that while the treatment would be on an outpatient basis, residential programming would be used as a compliment for strategic reasons (e.g., if a participant required it to come to grips with his/her addiction, to bring together participants in special support sessions etc). The respondents were confident that beds would be available when needed on such a basis. A few respondents suggested that hiving off the DTC participants from other, voluntary clients might be an appropriate strategy in early phases of treatment. It was reported that Corrections' referrals in the past had brought different sentiments and a more manipulative behavioural style to the group sessions, thereby reducing the effectiveness of the group therapy ("they take over the sessions") and leading to a counselling practice of limiting the number of such clients (no more than two) per group. Having the DTC clients in their own group and perhaps assimilating them at a later stage in general group sessions was seen as a possibly effective treatment strategy both for them and for other clients.

All respondents considered that the eligibility for a DTC should be offender-based with certain specified restrictions. They saw no reason not to bridge the prosecutorial jurisdictional divide that characterizes the Vancouver and Toronto DTCs. Even with such eligibility, all respondents believed that "numbers" would be a problem, presuming the DTC were restricted to addicted offenders committing serious enough offenses to be facing possible jail sentences. They wondered how many would select the more invasive DTC option and how many would stick with it. Several respondents reported that their contacts in Toronto had indicated that "numbers were such a problem there that they had to lower the threshold for admittance" and that the drop-out rate there was very high in the first and second months after entry.

The treatment respondents considered that APTS would be "the logical body" to provide the treatment services in a Halifax DTC and the APTS staff indicated a willingness to take on the task. While acknowledging that there were other treatment providers, both private and non-profit, who might express an interest were a contract to be tendered, they felt that APTS was the appropriate agent for several reasons, namely their much greater capacity, experience and resources, the importance of having balance between Health/Treatment and CJS interests and perspectives (i.e., subordination to the CJS interests/views might be more likely when the treatment services are provided by less institutionalized, contracted organizations), and the advantages of treatment services being provided by a governmental body when and if the province has to assume all financial responsibilities, something most respondents considered almost inevitable in the long-run. Several respondents also observed that recent contracting out of some services for persons with substance abuse have been unsuccessful.

The Treatment respondents all contended that significant additional resources would be required for a DTC even if the number of participants would be modest (i.e., a current file load never beyond twenty-five). The treatment services they envisaged in a DTC, per client, called for, as in Vancouver and Toronto DTCs, a relatively large number of treatment hours per week for roughly a year, much more than in the regular programming being offered by APTS. The respondents also noted the need for some coordinating liaison role(s) for a smooth-running DTC, as well as the need for at least one case manager who would work closely with the clients, holistically integrating services and client needs; the case manager in their view should be rooted in treatment services not probation services in order to ensure that the therapeutic issues are fully considered. Treatment respondents also called for evaluation to be built into the project from the beginning.

Treatment respondents raised a number of additional issues concerning the possible DTC initiative. There was a general consensus that in the long-run other addictions, especially alcohol, might be considered eligible for the DTC, especially as the treatment program would be essentially the same. There was also concern about taking on long-term obligations following federal priorities; as one respondent said, "who pays when the project funds are gone". Finally, Health respondents in particular expressed some concern about having the DTC project serve just one region of the province should the project be successful. One respondent commented,

"there would be howls". APTS / Health data do indicate that the metropolitan Halifax region has only its proportionate share (based on population numbers and age structure) of provincial addictions, even hard drug addictions apart from crack/cocaine. At the same time, there is some irony in the concern since the major APTS anti-addiction program to which probationers are often referred, CORE, is apparently only available in the metro area.

Overall, the Treatment respondents appreciated the shortfalls of the existing CJS-APTS efforts in responding to the repeat and serious offenders who are addicted to hard drugs. Most, and especially the APTS staffers, welcomed the opportunity to work more effectively with these clients, and saw the DTC approach as possibly allowing that to happen.

SOME COMMUNITY STAKEHOLDERS' PERSPECTIVES

Only a small sample of eleven community stakeholders was interviewed. All provided, through the organizations they typically managed, some community-based or agency-based services to persons who often have "addiction issues" and frequently come into conflict with the CJS. The former organizations included Directions 180 ("low threshold" methadone clinic), Stepping Stone (helpers of and advocates for sex trade workers), Halifax Needle Exchange, North End Community Clinic, Dixon Community Centre and Adsum House (short term residential shelter for women and children). The latter, agencies affiliated on a national basis, included John Howard Society (assisting offenders), Coverdale (court services and counselling for women), Salvation Army (diverse services and programs for offenders), and St. Leonard's Society (residential facility for offenders on release orders). None of the respondents had any substantial knowledge of the drug treatment court concept and its implementation in the United States and Canada (though several did recall hearing of new drug programs in Toronto and particularly in Vancouver where there has been much publicity about safe site areas for injecting hard drugs); accordingly, as was the case with many CJS interviews, the interviewer often began the interview with a brief description of what a DTC entailed, basically referring to the Toronto-Vancouver approach. All respondents were quite interested in discussing the DTC concept and readily offered their views on the matter.

The respondents reported high levels of addiction among their clientele. Of course the Needle Exchange and Directions 180 programs dealt specifically with people with "addiction

issues"; the latter program provides methadone daily to some 50 clients. Stepping Stone respondents indicated that 80% of their reportedly "close to 200" clients (sex trade workers) had serious hard drug addiction problems. Coverdale indicated that about two-thirds of the 220 women, for whom they provided personal counselling over the past year, had addiction issues (primarily alcohol). Managers in two of the residential programs - Adsum and St. Leonard's - reported that between 30% and 50% of their clients had addictions (primarily alcohol) and that many were receiving treatment from Drug Dependency (i.e., APTS). The "hard drug" problem was basically identified as use of crack cocaine and dilaudid, though a few also mentioned other prescription, opiate-based drugs and some cited LSD. The community stakeholders depicted the hard drug user as having multiple addictions. Most considered alcohol addiction to be the biggest problem for their clients as a whole. The community stakeholders "closest to the ground" (e.g., Needle Exchange, Stepping Stone, Directions 180), did not see the hard drug problem as diminishing; indeed, several considered crack use to be increasing.

It was commonly noted that extensive criminal involvement (prostitution, fraud, minor robbery, shoplifting) was characteristic of the addicted clients (one community-based organization's manager commented, "75% of these clients are repeatedly involved with the CJS and the other 25% just haven't been caught yet"). Not surprisingly, all these respondents felt that DTC eligibility made no sense if it were not offender-based rather than limited to CDSA offenses. One community respondent, who also claimed to be an active sex trade worker, referred to the relentless pursuit of money for her addiction as follows: "the money [from prostitution] is good but I spend every dime on drugs, so it's not like we're rich". Another respondent, who thought a crucial benefit of the DTC concept was recognizing the distinction between the offence itself and the force (addiction) behind the offence, observed, "when I used to steal stuff, it wasn't because I was a thief; it was because I was an addict; I wanted a fix". A Coverdale manager whose staff regularly attend women in court commented, "drug charges are rare but addiction is a huge force behind a lot of criminal behaviour".

The respondents differed in terms of how well they viewed the current response to the crime and addiction linkage. All appeared to be well aware of CJS practices and current treatment programming as provided through CORE, MATRIX, CHOICES, AA, and NA. Those who believed that something more invasive and intensive, such as a DTC approach, was required

were especially respondents associated with the community-based organizations. They, and some of the other respondents, contended that the powerful nature of addiction necessitated coercion and structure. They especially decried the inconsistency of the courts ("some judges mandate treatment for addicts and some don't"), the lack of an holistic approach (especially inattention to housing and socio-economic needs) and the superficial response of CJS and Treatment prescriptions ("the roots of the problem are ignored"; "there's no follow-up"). One respondent commented that where treatment orders are included in sentences, there is "no coercion or intense involvement by the CJS ... there seems to be little follow-up on the part of probation and thus addicts often do not pursue the [ordered] treatment". There was a common view, among the whole sample, that the court's approach in sentencing is to leave the details or specifics of treatment up to the probation officer and nothing much happens. Most respondents also held that, while there are programs offered in federal prisons that have value for addicts dealing with their addiction, there is nothing available at provincial jails. Thus, the addicts are largely on their own and, given the hold of the addiction, continue in the same lifestyle.

Not all respondents discounted the current CJS-Treatment approaches to the addicted offender. And most in fact thought that the actual treatment programs themselves, community-based or otherwise, were good, and that the problem was more the context for treatment rather than the actual treatment provided. There was occasional criticism directed at the governmentally-based Drug Dependency (APTS) on the grounds that it has allegedly not responded well to "court-ordered people" and is "intolerant of relapse, tardiness and other failures to meet the requirements of the program". As for the CJS, one agency director observed that judges have increasingly considered non-jail/prison sentences such as house arrest [conditional sentencing] and added, "judges already have the power to mandate treatment; there's good treatment available; it's not perfect, the programs are stretched, but the power to treat addiction already exists in the current system". Respondents regularly cited beneficial anti-addiction and other programs (e.g., education, work skills) available in federal prisons. Clearly though, there was some divergence between those who thought improving the current institutional and community responses should be emphasized and those who thought that what the DTC has to offer is precisely what is needed to more effectively get at the problem, namely an holistic approach, "structure", and strategic coercion.

While there was no strong opposition expressed to the DTC model, and all respondents were in favour of alternatives to the incarceration of hard drug addicts who commit crimes, not all these stakeholders were enthusiastic supporters of the DTC concept. Generally those persons who were most intimate with the daily life of hard drug users, either because of previous personal addiction or close personal ties with addicts, were the most inclined to think that a DTC, envisaged as having a non-incarceration thrust, a team approach of CJS and Treatment, rigorous monitoring of treatment orders, and immediate consequences or sanctions for violations of DTC conditions, would be very beneficial in causing many persons to successfully come to grips with their addiction issues. As noted above, they highlighted several DTC dimensions as crucial, and not currently much evident in the CJS response, namely holistic focus (coming to grips with complexities of addiction as several respondents put it), structured activities and close monitoring, and behavioural consequences for violations of commitment.

For some respondents the holistic imperative meant the justice system acknowledging the roots of the addict's crime - "the bottom line is that it's a disease, the disease of addiction that needs to be treated, not the symptoms". The coercive element was considered necessary, even while opting-in was voluntary, and treatment had to be mandated, presumably because as one respondent commented; "you're never going to be totally willing on your own ...never entirely ready to get clean; [indeed] whether they like it or not [addicts should be forced into DTC]". It was believed that immediate and significant consequences had to be there for people who did not comply with the program they opted for; as one person commented, "There needs to be consequences for your actions; that's the whole point of the justice system". Still, the respondents making that point, typically from the community-based organizations, did not believe that the consequences had to be incarceration, and argued that relapses had to be allowed for; one respondent commented, "there has to be consequences [but] if an addict fails to show up, they need to look at why they're not showing up".

Respondents who were sceptical concerning the need for, and value of, a DTC, a separate court along the lines of DTCs in Vancouver and Toronto. made one or all of three arguments, namely having a different philosophical approach, low expected number of participants, and building upon existing capacity. Several persons arguing for the harm reduction approach considered that the DTC was still basically a crime model of the addicted offender and aimed at

total abstinence even if tolerating some relapse along the way. This argument was sometimes attached to a "people approach" to the addiction problem that would involve the addict in designing the response program rather than the presumably top-down coercive approach of the DTC. Another contention was that in all likelihood few would opt for the DTC path. One agency respondent believed that "it would be a struggle to find offenders who both face serious criminal punishment and who are willing to seek treatment"; another such respondent contended that "realistically, a lot of addicts are not interested in quitting": still another respondent, most familiar with female addicts, drew attention to the low number of women in regional federal and provincial custody (i.e., about fifty in total) and argued that "if the DTC was basically offered as an alternative to custody, women would be significantly absent from the process". For the sceptical respondents, a better alternative was deemed to be improving the current system, providing more resources to reduce the strain (e.g., lessen the length of waiting lists for beds) and building upon the good services and programs already available rather than initiating still another approach. Interestingly, none of the respondents from community-based organizations made these arguments. The likely number of participants was though always an issue. Respondents involved with Stepping Stone observed that it would be rare for offenders to receive jail time for prostitution charges alone, and if avoiding custody were a major motivation for DTC participants, clearly there would be few prostitutes in the program; however, many prostitutes, they noted, face custody on related charges (especially accumulated breaches but also theft and so on) and thus could be quite interested in the DTC option. Other respondents contended that in their experience there were, locally, many hard drug addicts embroiled in crime because of their addiction, who would welcome the approach of the DTC.

Several key issues and a number of suggestions were advanced by the community stakeholders (community and agency-based) were a DTC to be initiated in Halifax. The potential pool of participants was, as noted, somewhat controversial but most thought "the numbers were there" if the eligibility was offender-based. A related issue was whether the program might include offenders with alcohol addictions, clearly identified as the primary addiction by these respondents. Thirdly, there was some question concerning what role these organizations might have in a DTC approach and what implications there would be for their resources. All

respondents seemed willing to collaborate and this was especially the case for the community-based organizations.

A number of suggestions for a local DTC were made including, having those opting for the DTC involved in the program immediately upon approval of their admission ("positive motivation wanes rapidly after sentence"); restricting admission to non-violent offenders; providing training/orientation for all DTC personnel ("there needs to be big time training for lawyers, judges and corrections staff about addiction"); incorporating community-based treatment and support programming ("there is a strong network of social and community services in Halifax ... through careful planning and partnerships, the full range of treatment and rehabilitation can be provided in this city"); ensuring that the DTC is responsive to female clients as well as males; having post-DTC support and treatment follow-up ("addicts are vulnerable post-treatment"), and "selling" the DTC concept to the public.

Overall, then, the community stakeholders in this small sample saw merit in a DTC initiative while the level of their enthusiasm varied for a number of reasons, but perhaps most especially depending on how much importance they attached to having a highly structured, strategically coercive combination of enforcement and treatment to respond to the offender with an addiction to hard drugs. Respondents from community-based organizations appeared to be more supportive of the DTC approach than the agency-based respondents because they emphasized such a need. All respondents considered that a metro Halifax DTC would have to be, and should be, offender-based. All agreed, too, that there was a strong linkage between addiction to hard drugs and widespread criminality.

OVERALL CONCLUSION

There appear to be four major conclusions from the many interviews of CJS Officials, Treatment Staffers and Community Activists discussed above, namely

(a) The interviewees were generally quite favorably disposed to seeing a DTC in metro Halifax. Defence counsel were unanimous and enthusiastic in their assessments. There was more diversity among the other CJS role players (judges, prosecutors and probation/parole officers) in their philosophical approach to Justice matters and in their priorities for Justice initiatives but, aside from a very few respondents, the general response was that a DTC initiative would be "worth a try"; indeed for a good number, there was enthusiastic support for a DTC. Respondents on the treatment side were also generally positive and reported themselves ready to be involved. They appeared to envisage the DTC as an opportunity to bring more focus to, and engage in more intensive treatment of, their clientele of CJS-referred hard drug addicts. There was diversity in the views of community activists but most of these respondents considered the DTC concept interesting and likely to have a beneficial impact on hard drug addicts and by implication the drug-crime linkage; those most in support of a DTC appeared to be more closely involved with the day to day lives of "hard drug" addicts.

(b) The DTC was seen to be of potential value for effectively responding to hard drug addicts who commit crimes, because of several of its chief features, especially (1) bringing focus and an holistic approach to dealing with the addicted offender; (2) having a team approach between Justice and Treatment which makes more likely that the response will be appropriate and enforced; (3) close monitoring and effective supervision (case management) of the DTC participant; (4) having immediate consequences for behaviour, both positive and negative; (5) having dedicated or designated personnel in all roles whose knowledge of the addicts and addiction will increase with experience. It was generally considered that the DTC thrust was needed and justified by the evident difficulty of rehabilitating these offenders or deterring their criminal activity through

regular punishment, and by the clear, strong linkage between addiction to hard drugs and extensive criminal behaviour.

(c) Virtually everyone believed that eligibility for a DTC in Halifax should be offender-based with restrictions only for serious violent crimes and other offenses repugnant to the public (e.g., anything involving harm to children). This view was partly based on practical factors, essentially that there would be an insufficient pool of eligibles if a person had to be charged with a drug offense. But, more than that, most respondents believed that an offender-based model was the ethically-appropriate response and would best get at the problem of addicts and crimes. A large number of respondents across the groupings interviewed held that other addictions should be considered too, especially once the DTC initiative has proven itself and become institutionalized; clearly, alcohol addiction was seen as the number one addiction problem both from a purely "numbers" point of view and with respect to the addiction-crime linkage.

(d) There was widespread agreement that a fully implemented DTC in Halifax would at a minimum require a shoring up of treatment capacity since a key dimension of it is more intensive and long-term treatment. Whether CJS, Treatment or Community based, respondents identified this resource requirement. Of course how much resources would have to be marshalled would depend chiefly on the number of DTC participants. Respondents from the CJS and Treatment milieus generally considered that a project coordinator would also be necessary since the DTC program by its nature is holistic and multi-dimensional, drawing upon and connecting a wide range of professional and community personnel and services. There was much uncertainty as to the resource requirements for the different CJS functions. Certainly virtually everyone anticipated that there should be a designated judge, duty counsel, federal and provincial prosecutors, and probation officer but whether these positions could be filled through secondments and scheduling and translate into minimal new resource requirements was too complex to be assessed in the interviews; given existing workloads for these roles, and given the modest expectations concerning the number of DTC participants, no one suggested that the

positions were full-time slots. Community activists were concerned about the implications for their resources should they be significantly involved, but at this point the nature of their possible participation was quite unclear.

PART FOUR: POSSIBLE FUTURE DIRECTIONS FOR HALIFAX

FUTURE DIRECTIONS FOR HALIFAX: OPTIONS AND ISSUES

The literature on DTCs indicates that there are basic features that identify a DTC such as voluntarism (e.g., offenders must opt for the DTC), an extensive and intensive, phased treatment program, significant collaboration between treatment and CJS role players (e.g., a team approach), close supervision of DTC participants and regular monitoring of their compliance with DTC rules, timely utilization of rewards and punishments, an holistic approach to the participants' addiction and related problems, and a more personalized relationship between CJS officials and the addicted offender. At the same time, there is considerable variation in DTCs in terms of the scale of their operation (e.g., number of participants, frequency of court sessions), the targeted groupings (e.g., youth, adults, minorities, track one or track two offenders), eligibility criteria (e.g., type of offending highlighted), structural linkages (e.g., whether the treatment services are provided by regular governmental programs or contracted out to private or non-profit organizations, types of coordinating roles), treatment format (e.g., out-patient or residential emphasis), formalization of CJS distinctiveness (e.g., whether designated and exclusive CJS role players, and new, detailed protocols and waivers), and addiction focus (e.g., hard drugs or soft drugs, whether other addictions are eligible). In addition, as noted in the chapters above, there are many policy issues raised by the DTC approach, such as changing role expectations for treatment and CJS role players (especially perhaps for treatment professionals, defence counsel and judges), equity concerns (e.g., justification of the allocation of scarce resources to the targeted population), and the extrapolation possibilities for other regions and other addictions. Of course, a fundamental issue, and the one most stressed in the DTC literature, is whether the DTC approach is effective (i.e., significantly rehabilitates the drug addict offender) and efficient (i.e., is a good investment considering costs and benefits). While there are

many methodological caveats associated with the DTC project results to date, evaluation reports have generally found the DTC initiatives to be both effective and efficient, especially when comparisons are drawn between, on the one hand, "graduates" and those participants retained for at least thirty days in the DTC, and, on the other hand, early drop-outs, eligibles who did not opt for the DTC, and other convicted offenders with an addiction to hard drugs.

The evidence - statistical and qualitative - indicates that there is a significant "hard drug addiction - crime" pattern in Nova Scotia and in metropolitan Halifax. It seems, also on these grounds, that, with some exceptions, most notably perhaps at the federal corrections level, the current CJS-Treatment approach to this problem is neither effective nor efficient. There appears to be nothing about the metropolitan Halifax situation that would suggest that a DTC could not be implemented here and achieve the kind of success that DTC projects have had elsewhere under similar as well as different conditions. There are many precedents reported upon in the DTC literature. The characteristics of the addicted offenders, the type of hard drug addiction, the apparent resiliency of the offenders' social networks, housing conditions and social programming - all are congruent with the thresholds that the American and Canadian DTC experience indicate to be associated with success. There may be a few negative correlates of success that are applicable, such as the age distribution of the targeted population and the extent to which the eligible offenders have been thoroughly embedded in a criminal milieu. Additionally, on the plus side, as summarized in the last section, there tends to be general support for a DTC initiative in the metropolitan Halifax area among CJS officials, treatment professionals and community stakeholders.

There are three issues that merit especial scrutiny in the Halifax context, namely scale, treatment capacity and moral entrepreneurship. While acknowledging a significant hard drug and crime pattern, it is unclear what the scale of a Halifax DTC would be. That would depend on the eligibility criteria as well as on whether eligible offenders would opt for a program that is quite invasive and of significant duration. Alternatives, such as the increasingly common conditional sentences, might well be much preferred by most offenders, save those who want the structure and coercive support of a DTC. A DTC program based on solely CDSA offence eligibility would not appear to be an efficient initiative in metropolitan Halifax (see below). A DTC program, based on the offender's hard drug addiction (i.e., an offender-based, not offence-based eligibility)

appears be more appropriate here though it would still be uncertain how many offenders would opt for it (see below). As noted, DTCs in North America have varied much in term of scale so a Halifax DTC, whether having a handful of participants or as many as twenty-five, could be justified; of course, as a pilot project, a Halifax DTC could have implications, too, for subsequent expansion to other regions and to other addictions.

Treatment capacity is a salient consideration given the intensive and extensive character of the DTC treatment programs and the uncertainty as to the size of participant pool. As noted above, current treatment programming (e.g., CORE) and special facilities (e.g., beds) are limited in relation to CJS-directed drug treatment. Still, knowledgeable professionals believe that with some new funding for designated treatment providers (possibly funding up to two positions were the DTC active pool to be projected as fifteen or so clients) and other, modest service delivery costs, a DTC could readily be mounted. Given these additional resources, there appears to be widespread - and reasonable - confidence that an out-patient type of treatment program, complemented by some "detox" and residential programming on an "as required" basis, could be effected in the present context; this is the format followed in many other Canadian and American DTCs. It is unclear, but quite possible according to some informants, whether treatment could be provided outside the government-based APTS framework, by contracting private treatment services.

A common characteristic of successful DTCs appears to be their having strong "champions", or what sociologists refer to as moral entrepreneurs, in the CJS. Committed advocates, pushing the initiative along within and beyond the CJS, and often taking on responsibilities additional to their usual, impressive workloads, have been crucial to the DTCs' achievements. There does not appear to be a dominant voice for a DTC in the Halifax CJS context but, as reported above, there certainly are advocates at all levels of the CJS able and eager to mobilize and commit for such a project. To facilitate implementation and coordination among CJS personnel, treatment providers and community stakeholders and support agencies, a strong case can be made for having a full-time project coordinator, as in Toronto and Vancouver DTCs; the diffuse advocacy pattern in the Halifax area CJS would seemingly underline the value of such a position here.

Overall, then, it would appear that a Halifax area DTC, broad in eligibility criteria but still likely to be modest in scale, could be readily mounted with good prospects for successful achievement of the usual DTC objectives. Some new resources would be required to ensure those prospects, especially additional resources on the treatment side, and some resources for project coordination. On the CJS side, it is unclear whether significant new resources would be required, at least until the DTC participant pool increased beyond a handful; at present, a strong case could be advanced for some funding to relieve Nova Scotia Legal Aid or to contract the part-time services of private defence counsel. It would appear wise for a proposed DTC project, in its first phase, to focus on adult offenders addicted to hard drugs and committing diverse offenses. In the second phase, and in the long-run, issues of extrapolation to youth, to other regions and to other addictions (especially alcoholism) should be considered for equity reasons, if not for concerns of effectiveness and efficiency.

APPENDIX: A BRIEF NOTE ON THREE OPTIONS

OPTION ONE: VANCOUVER AND TORONTO ELIGIBILITY CRITERIA

As noted, in both the Toronto and Vancouver DTCs, eligibility, for all intents and purposes, is limited to those charged with possession or trafficking in hard drugs (CDSA offenses) and subject to federal prosecution. Federal Prosecution and HRPS data for the Halifax area show (a) an average number of seven persons charged and prosecuted per month, yielding perhaps an average of five distinct persons per month since a person may be charged several times in the course of a year (not to speak of recidivism over different years); (b) since at least 75% of the charges in the case of hard drugs are for trafficking and since at least 50% of the traffickers would not be likely to meet the addiction criteria, the five per month becomes perhaps a little more than two distinct persons a month; (c) since only about half of the eligibles could be expected to opt for the DTC (the experience in Toronto and Vancouver and elsewhere concerning "track 2" eligibles) and since some offenses may be ineligible, the net pool for a Halifax DTC might be as low as one candidate a month.

A program based on such small numbers could be viable as witness the Saint John experience discussed above and some American projects. However, given the few participants and the probable success rate of roughly 15% -20% for track 2 participants, a DTC would be problematic for efficient resource allocation and for the enthusiasm of its advocates; pressures to get successes would be great (would the tail be wagging the dog?). Additionally, such a DTC initiative would alienate potential treatment and CJS supporters who see little logic or fairness in having a program based on such limited eligibility criteria.

OPTION TWO: BROAD-BASED OR OFFENDER-BASED ELIGIBILITY

Of course there would probably be some restrictions on the offenses that could permit eligibility, but including addicted offenders charged with a wide variety of criminal code offenses, as well as those subject to federal prosecution, could yield a modest sized DTC for metropolitan Halifax. Multiple interviews at different points in the CJS have indicated a fair consensus that, at this point in time, there are some 200 plus persons who might qualify for a DTC - i.e., addicts committing crimes in large part driven by their addiction to hard drugs. Estimates from Probation, Parole and NSLA concerning the number of "hard drug" addicts among the overall agency caseload yield approximate numbers of 50 each for Probation and Parole and 100 for NSLA. This 200 figure dovetails well with the estimates of HRPS drug squad officers. It could possibly yield, after six months to a year, an on-going active DTC clientele of fifteen to twenty persons and, after a start-up period, a success rate perhaps of four or five graduates a year. Could there be more? There may well be many more people addicted to hard drugs as suggested by local sources (e.g., Directions 180 and Department of Health statistics) but, given that the DTC process begins with a criminal offense and that

it would probably attract only "track 2" accuseds (i.e., those with a high probability of being remanded and subsequently receiving a sentence of some incarceration), the estimates seem appropriate and, perhaps, even generous. Recall that Vancouver and Toronto DTCs with their much larger addict populations have an active current clientele of only roughly thirty-five persons (of course, on the other hand, eligibility is restricted in both cases, as noted above). The numbers would justify a DTC program and down the road perhaps one could consider alcohol and/or gambling addictions - addictions which appear to be susceptible to the similar treatment and therapeutic jurisprudence approaches.

OPTION THREE: USING THE CONDITIONAL SENTENCING FORMAT

As noted above, a number of prosecutors and probation officers have suggested that the objectives of a DTC might well be otherwise attained by putting more resources into - beefing up - conditional sentencing where the offender has an addiction to hard drugs. By such a strategy, there might be more supervision, more mandated treatment, more frequent testing for drug use, and so on. Data indicate that conditional sentencing has become quite common in cases involving drugs in Nova Scotia. There have been 2,852 conditional sentences rendered in Nova Scotia between September 1996 and September 2002; 16% of these went to offenders convicted for drug offences (there may have been other charges but in the JOIS data system, the drug charge was deemed to be the most serious offence), approximately eighty per year. A conditional sentence is a jail sentence which is subsequently set aside in lieu of an offender being required to meet certain conditions of house arrest. Those offenders receiving a conditional sentence must serve full-term, and a conditional sentence can be considered for any sentence less than two years with a few exceptions (e.g., crimes carrying a minimum sentence such as robbery with a firearm).

DTC proponents, while not discounting the possible value of a "beefed up" conditional sentencing program, emphasized that even with more resources it would not be based on the principles that account for the successes of the DTCs, such as the close teamwork between CJS personnel and treatment providers, the proactive and continuous role of the court, and the court-monitored multi-faceted and holistic approach to the addicted offenders' shortfalls and problems. Certainly the symbolic significance (i.e., status, power, authority) of the court and the judge - so often cited by DTC participants as crucial to their overcoming their addiction - would unlikely be as effectively conveyed by a probation officer. Others have contended that the structure and processes of the DTC facilitate much more the effective utilization of immediate rewards and punishments contingent on the offender's behaviour. Defence counsel have suggested that there would be little incentive for the offender to deal with his/her addiction in conditional sentencing and, like other informants, argued that the fact that the sentence is delayed in the DTC format provides a major incentive for the participants to meet the DTC conditions tied to the interim judicial release (i.e., post-conviction bail). These arguments in support of the DTC option appear to be quite persuasive. None of

the Canadian DTC projects cited above (Toronto, Vancouver, Ottawa and Saint John) considered that conditional sentencing could achieve their DTC objectives. It would clearly be interesting, however, as part of the evaluation of a Halifax DTC project, to use the extant conditional sentencing program as a comparison.