IT WAS 20 YEARS AGO TODAY...
AN INTERVIEW WITH H. DAVID ARCHIBALD
This document was published by the Canadian Centre on Substance Abuse (CCSA) and was made possible in part through a financial contribution from Health Canada. The views expressed herein do not necessarily reflect the views of Health Canada.

Suggested citation: Canadian Centre on Substance Abuse (2008). It was 20 years ago today... an interview with H. David Archibald. Ottawa, ON: CCSA.

©2008 Canadian Centre on Substance Abuse (CCSA). All rights reserved.

For additional copies, contact
CCSA, 75 Albert St., Suite 300
Ottawa, ON K1P 5E7
Tel.: 613 235-4048  Email: info@ccsa.ca

This document can also be downloaded as a PDF at www.ccsa.ca

Ce document est également disponible en français sous le titre : Il y a 20 ans aujourd’hui… Entretien avec H. David Archibald

ISBN 1-897321-69-4

Cover sketch of H. David Archibald done circa 1958–62 by popular Toronto newspaper caricaturist, W.B. Mac. Courtesy of the Centre for Addiction and Mental Health (CAMH) Archives.
IT WAS 20 YEARS AGO TODAY...
AN INTERVIEW WITH H. DAVID ARCHIBALD

H. David Archibald, C.M., M.S.W., D.Sc., F.R.S.H., was a leading figure in the substance abuse and addictions field, both here and abroad, for more than 50 years. He built a distinguished reputation through his association with the Addiction Research Foundation of Ontario (originally the Alcoholism Research Foundation, which he founded in 1949, and now the Centre for Addiction and Mental Health), the World Health Organization, and the International Council on Alcoholism and Addictions. His inspired leadership helped to give Canada an influential voice in the addictions field across the globe.

In 1987, Dr. Archibald was asked by Jake Epp, Canada’s health minister at the time, to serve as a one-man task force with responsibility for developing a “national focus” for Canadian efforts to address substance abuse and addictions. The historic Archibald Task Force report led to the establishment of the Canadian Centre on Substance Abuse (CCSA) in August 1988, with Dr. Archibald as its founding chair. In November 1990, he accepted an invitation from the government of Bermuda to help develop its new drug strategy, returning to Canada after a year to continue serving as CCSA’s chair until 1992.

Dr. Archibald, a Member of the Order of Canada since 1988, was interviewed for CCSA’s 20th anniversary by veteran Toronto-based health journalist Anne MacLennan.

Q In 1950, in a one-man brief to Ontario’s then-minister of health outlining your vision for the new Alcoholism Research Foundation (RF), you gave very high priority to the need “to detach the problem [of alcoholism] from the political arena.” Almost 40 years later, you served as a one-man task force on the “national focus” in the now-broader addictions field for Canada’s then health minister, Jake Epp. After extensive cross-country consulta-

A Alcohol and other drug use and misuse are highly complex issues, with diverse and inter-related health, social, economic and legal ramifications. They are also highly political issues and spark emotional, often badly informed political debate; this frequently has the secondary effect of badly misinforming or misleading the broader public.

Lessons learned early around the Alcoholism RF, and given the volatility of the issues around other drugs later on, were even more deeply held by the mid-1980s and the establishment of CCSA. An objective in both cases was to inform governments. However, the need was to get as close to the facts as possible at any given time in any given area and base any actions or developments on those facts, whether in treatment, rehabilitation, education and information, or “best advice” on policy.

Finding and providing the facts as they are, and not how someone believes or wants them to be, needs to be done without bias and without pressures from politicians and governments.”
Q And this view held through development of CCSA?

A When CCSA was established, it was held by everyone involved, not just those of us who were working directly in the field, but also politicians, many bureaucrats, and all of the federal political parties as well (see “Things are looking up...”, page 12); all agreed this work had to be done at “arm’s length” from governments, although with emphasis on helping to ensure they too had the facts, regardless of what they might choose to do with them.

Q You also pinned down early on the idea of inter-disciplinary academic research being at the heart of the work.

A Yes, our priority for the Alcoholism RF and right through to the establishment of CCSA was, above all, to explore the problems, to separate fact from fiction and rhetoric, through scholarly study. The objective was to develop better insights and perspectives on the problems, and not just through a spread of simultaneous research projects, but, rather—and this is key—through diverse research activities brought into one definite context and relationship to each other. The idea was to develop and coordinate research in the field through, and with, university-based researchers, then channel the findings through a central organization to facilitate strong community leadership and education.

Q Education was also prominent on your agenda.

A From early on, we emphasized planning education programs, especially for parents, because so much of the information they were receiving through the lay media was based far more on emotion and fear than on fact. Also, because home and families were where children learn; they still are. Primarily, however, we sought to base all planning on research findings, whether in education, treatment and rehabilitation, or community development.

Q Given that the field changed dramatically, from covering alcohol problems alone in the 1950s to including other drug concerns in the 1960s, and then grew national and international through the 1980s, could you discuss the context in which initially the Alcoholism RF emerged? I imagine at least some of the challenges over the next many years, up to and including CCSA, were similar.

A The initial battles were around alcohol issues. That was 1947, just after the war, World War II. Debate was extremely polarized and politicized. On the one hand were very strong temperance forces; they saw it as strictly a moral issue and wanted alcohol use banned by government. On the other hand were those who wanted the government to move drinking out of the so-called “booze joints” and into the light of day. This latter side saw the widespread and illegal drinking patterns that had grown up in large cities—and the related health and social problems—as direct results of the hidden nature of alcohol use. I think some were also influenced by having been overseas during the war and learning to enjoy a drink in an English pub. In any event, people had strong opinions, but they were based on personal feelings and experiences. No one had much in the way of facts.

The thing exploded when the government legalized cocktail lounges and other “licensed” premises. The rationale was to bring drinking into the open and out of “motor cars and bedrooms,” as Ontario’s then-attorney general put it. This would allow for developing a better understanding of what the problems were and how best to deal with them and, at the same time, respond to the growing number of people who wanted to enjoy a drink in a more palatable social setting.

The premier who brought in cocktail lounges lost the next election, but the demand for action continued. So the Alcoholism RF came into a highly-charged “wet vs. dry”
environment, with demand high for constructive action.

**Q** What exactly did “constructive action” mean?

**A** Universally, it meant treatment. Again, that presaged many of the questions—and demands—later around drugs. An obvious first response was to start setting up treatment centres, but the counter-questions were equally obvious: Who needs the special treatment? And, how do you treat those who need it without specialized knowledge to do so? The first question we set out to address was: What are the effects of alcohol on the individual?

**Q** What, or where, were the models you examined to help get started and whose influences you could still see with the establishment of CCSA?

**A** Probably the single greatest influence at the outset—but with those lessons applied over time and finally to CCSA—was the outstanding work being done in the 1940s by Dr. Elvin Morton Jellinek, a scientist at the School for Alcohol Studies at Yale University.

I was teaching social work at the University of Toronto (Editor’s note: Dr. Archibald had been a pilot during the war), but had written a paper on Alcoholics Anonymous and had been invited to work through the 12 Steps with members. After that, I was fortunate to receive a scholarship to study with Dr. Jellinek at Yale. It was the first academic and systematic experience I had in this field.

About that time, the Ontario premier of the day (Leslie Frost) and Major John Foote, a war hero and Victoria Cross winner, who was also an MPP and extremely interested in the area, asked me to think about moving ahead with a foundation. So I spent two more weeks with Dr. Jellinek, who was by then at Texas Christian University, discussing the field in general and, in particular, what would be the best approaches to developing and managing it. The experience helped to set the course; in fact, he helped set the course for all of us interested at that time in the small, specialized field.

**Q** In terms of the next 50 years in Canada, what, if anything, did Dr. Jellinek pass on to you?

**A** Dr. Jellinek was profoundly influential in many lasting ways. However, a very outstanding personal characteristic and ability he had was his singular talent for bringing opposing sides together; he was loved by people with sharply conflicting opinions.

Coupled with the need to work without political bias, we saw this quality as criti-
cial. With the Alcoholism RF, the sides were “wet” and “dry,” and we needed to work with both; with CCSA, an important area of contention was between those favouring strict law enforcement versus, and very much separate from, those favouring demand reduction. Of course, much later, demand reduction came to be called harm reduction, i.e., the knowledge born of study and experience that getting rid of drugs and drug dealers, for example, does not alone solve drug problems, and that health and social issues must be balanced with enforcement efforts. At the time, the term harm reduction was not part of my vocabulary.

In some respects, it might be seen as almost a “class” issue. It was the idea that people using drugs, which were largely illegal, were at the fringes of society and even criminal.

A significant measure we took (to achieve CCSA’s objectives with regard to research) was to set up a series of meetings with diverse scientists from across Canada with the mandate of identifying specific priorities for research in the field. So, even during the lead-up to the establishment of CCSA, we were working to interest more scientists in the field and to broaden out relevant research collaborations across the country.

Q But from the outset, you also considered scholarly research as key?

A That was fundamental from the beginning. We had no knowledge; all we had were opinions. And, of course, the premier and others agreed.

Q Research was not, however, a mandate for CCSA. How did you see CCSA’s role shaping up in this area?

A CCSA would provide a national context and support development of new research by assisting in dissemination and application of research findings as they evolved. At the same time, it would facilitate development of research-based expertise via training activities, and so on. In other words, CCSA would be a conduit for research developments that we hoped would continue to broaden out from there, rather than being itself directly engaged.

By the late 1980s, a significant research capacity already existed in Canada. We had some 50 or so scientists working together across diverse, related areas at the ARF in Ontario; they, in turn, were working with others in universities across the country and, indeed, the world. At the same time, however, the subject of drug addiction in those days was not at all an attractive one.

Dr. Archibald was Founder and Chief Executive Officer of the Alcoholism Research Foundation (later the Addiction Research Foundation) for 25 years starting in 1949. This world-class institution became the Centre for Addiction and Mental Health (CAMH) in 1998. Photo courtesy of the CAMH Archives.
Q: Given the evolution, or perhaps revolution, of the field from its initial focus on alcohol to encompassing other drugs, what was the social context or climate from which CCSA emerged?

**A:** By then, many battles had been fought, of course. This seems a small point now, but it shows some of the strongly held beliefs and opinions people had, and the surprising disagreements that could arise seemingly from out of nowhere, although we were usually not surprised. When we decided to add “drug addiction” to the mandate of the Alcoholism RF and become the Addiction Research Foundation in the 1960s, which was actually a pioneering move in North America, there was quite an outcry, especially from the United States. People in the alcoholism field especially were loath to see “alcohol” and other “drugs” in the same sentence, let alone examined under the rubric of “addictions.” They were often pretty vociferous, and that continued for many years; I fielded some pretty heated telephone conversations.

In some ways, it goes back to what I was saying about “class war.” By the 1980s, using alcohol was now socially acceptable. Although overuse or misuse was not entirely condoned, drinking alcohol was still seen by many as absolutely removed socially, in fact removed in every respect, from use of other drugs, which were illegal and used, by and large, by young people. The idea of conflating, for example, golf club members addicted to alcohol with people addicted to heroin, whether they were young or old, was almost too much to bear for many people.

Later, when tobacco use began to be integrated into “addiction” studies, there was also surprising resistance to that and to the idea of cigarettes and so on being seen as addictive. Of course that too has changed tremendously.

Q: Was there not also a long period of what was called “reefer madness,” that is, very high concern around marijuana?

**A:** There was something close to hysteria in some quarters around marijuana use. Many young people, and others, were even amused by that; so much of it was, at best, fear-mongering. However, many others, including many parents, who were often badly served by frightening media reports—which emanated largely from the US—were terrified for their children. Politicians, of course, especially in the US, got elected on that fear.

Yet, school studies here in Canada, and there were similar US studies, were indicating the vast majority of young people of high school age here were not involved in any real sense at all with drug use; they knew it existed, saw it, read about it, and so on, but they did not use drugs. I remember people not directly involved in the field being very surprised when they actually understood the percentages. In fact, alcohol was and remained, and still is, I believe, their drug of choice; in fact, it may still also be the drug of choice for all ages.

However, the small percentage of people actually involved got blown way out of proportion by politicians and the lay media, and hence by the public. One effect of that, always, apart from being misleading, is firstly to remove the support and focus from the real needs. In this case, the real need was to try and help young people already in trouble, and their families. Also, and this is as important and critical, we needed to try to understand and be able to help, through early education programs, those young people, and their families, who might be at risk. The question then becomes who is more and who is less likely to be at risk? However, these things get lost in the rhetoric, which, in turn, can get translated pretty quickly into calls for more law enforcement. This often has political appeal, but it rarely responds to the problems as they are known to be.
Q I understand you once almost got arrested, and a specialized laboratory at the ARF almost got closed down, for having illicit drugs on the premises?

A That was around street drug analysis. We had set up a small unit where young people who were buying street drugs anyway could, without prejudice, have samples of their drug purchases analyzed for possible contaminants by our experts. This kept us all—professionals and users alike—informed about what was on the streets, and it alerted young users to products that were cut with dangerous contaminants or were unusually potent, and so on. We published the findings in regular bulletins that were widely distributed to young people. All of this was with a view to reducing health risks, which has come to be known as harm reduction. Well, at that time, a policeman in charge of a particular section of law enforcement at the local level—I don’t recall which section now—disapproved and saw what we were doing as breaking the law. He came along to close this unit down for having illegal drugs on the premises. Fortunately, and this speaks to having a strong board, the Chief of Police was on the board of directors and was strongly supportive of the objectives of the program, so the episode ended fairly quickly, but it got a lot of attention. That was in the early ‘70s.

Q What was the state of drug policy in the lead-up to CCSA? I know, for example, that the US had insisted for many years that if it could stop drugs at the US border, it would have no drug problems.

A The US, in particular, always saw illicit drugs as an “off-shore” problem. It was always about another country, or countries. The idea of law enforcement as the “solution” had popular and political support and prominence in the US and well beyond there, largely because of US pressure. This approach assumes that if you stop production abroad, there will be no demand at home. Thus, at one time, there was a rather widespread belief that if you burned all of the opium crops in Thailand, for example, there would be no heroin, and no heroin problem, in the US.

This had been their view for many years, and they had had tremendous influence promulgating it around the world, partly through use of the United Nations (UN) Commission on Narcotic Drugs as a podium; it was quite pervasive. In fact, when the US and others did start to open up to the need to look for a more balanced approach—that is between supply and demand reduction programs—there was almost a “tailback” effect. In response to aggressive US pressure, some countries—and they were often very poor so it could mean fiscal problems at home—had hardened up their law enforcement efforts—sometimes to a very harsh degree. Then, just as they had adopted new enforcement methods, often with aid from the US, the US was starting, very minimally at first and by no means universally, to review its position. It made for some interesting meetings.

Q Had other drugs by then entirely replaced alcohol as the focus?

A No, alcohol research, and developments on that front, continued. In fact, we began to see programming that had been developed here starting to come back to Canada and being seen as US-made. That continued with drugs, I might add. But yes, on the drug front, there was a frantic quality to it, and a lot of hyperbole that was reminiscent of the early days with alcohol. In other words, there was more heat than light.

Q In this context, in the run-up to CCSA, was the apparently affable relationship between Brian Mulroney and Ronald Reagan, the then-prime minister of Canada and president of the United States respectively, and the fact the US had just declared another War on Drugs, significant at all?

“On the drug front, there was a frantic quality to it, and a lot of hyperbole that was reminiscent of the early days with alcohol. In other words, there was more heat than light.”

“At one time, there was a rather widespread belief that if you burned all of the opium crops in Thailand, for example, there would be no heroin, and no heroin problem, in the US.”
A Mr. Mulroney supported the idea of a national strategy and centre, but I doubt that relationship helped in any meaningful way although by then, or soon, Mrs. Reagan had launched her own anti-drug offensive, her “Just Say No” (to illicit drugs) campaign, and she was very active in terms of attending meetings in the US and even abroad. No doubt this had the support of the president. And Mrs. Mulroney was one of many spouses of heads of state who took on the cause, in a public way and for perhaps a year or so. All of them attended at least one international forum together, and occasionally they spoke about it in their own countries. Beyond that time, it appeared only Mrs. Reagan remained involved.

A Yes, here and abroad and across a range of venues—whether at governmental or non-governmental levels or through international research and education projects, etc.—we were really working above our weight internationally.

Canada, along with a handful of European countries—Sweden, Holland, Britain, among others—realized the supply reduction model had been relatively unsuccessful. Clearly, if the balloon of supply was pinched in one place, it would pop up on another side with another drug. It also turned out that many drugs could be grown or manufactured chemically right here at home, and some drugs being used, of course, were prescription drugs. How to respond to that? Why the demand? What are the health effects? How to try and ensure an addict, for example a heroin addict or a glue sniffer, can minimize the health-harm to him or herself and, as a fall-out from that, to his or her family and the society at large? These are among the demand reduction/harm reduction questions. And there were strategies that had been found to work.

When England, for example, legalized formal prescription of heroin to registered addicts, quite a large number of Canadian heroin addicts moved there, and I understood that most, perhaps all, lived out their lives quite successfully there under that plan."

Q Meanwhile, and by the mid-’80s as you’ve said, the ARF in Ontario was well established, and every province and territory in Canada had a commission or agency. Moreover, Canadians were working well together and had an excellent reputation internationally as well.

A There was excellent work being done here. The ARF had an outstanding reputation, but all of the other provincial and territorial commissions were also doing good work; Alberta particularly was building a reputation. Canada as a whole had an international reputation for the integrity and quality of its work, particularly the ARF’s research thrust and the work of the interdisciplinary research groups. But also, our ongoing emphasis on knowledge-based information and education, and inroads we had made in understanding and improving treatment, were aspects of the work here that were very highly regarded around the world. In fact, in 1978, the ARF had been named by the World Health Organization as its first Centre of Excellence in the world in this field.

Q So, by the mid-’80s, Canada had a significant reputation for research and work on the demand reduction side?

A The objective was national leadership to support and further the work already underway here as well as the significant impact our work was having abroad. One
need was to continue bringing together the various groups involved in the law enforcement/demand reduction debate, i.e., removing the barriers that tended to exist traditionally but that inhibit communication and understanding among the key players on both sides.

We had done a lot of work on this. In fact, regular meetings of the UN Commission on Narcotic Drugs were very productive for the Canadians; at those meetings, very senior Canadian federal and other officials from both the health and enforcement sides met and had the time and support to debate and discuss these questions together, not just with each other but also with their international counterparts. These shared discussions among demand and supply reduction representatives about the “whys” of drug use, and the effects, were extremely fruitful.

Q In what way did your own work abroad, for example in Thailand, influence your interest in the need for a national centre and strategy? For example, I know you frequently worked in the hills in the north of that country where farmers were producing the opium that sometimes wound its way to the streets of Canada in the form of heroin.

A Maybe, above all, Thailand underlined once again and finally to me the critical need for collaborative, international work; all of us on the globe, all of our societies, are very inter-connected. As for Thailand specifically, I was on the side of the farmers in the opium-producing hills. They were farmers first and last, opium was their crop, and they sold it to people in mule trains passing alongside their fields. That was it; they were poor, and this was the way they eked out a living. At least as important was the fact opium was their only medicine. It served them for all of their ailments from infancy through adulthood and finally through the trials of old age.

Q You were working with the WHO for much of that time. Did you see any progress made?

A Yes, progress was made. Often it was very simple, but very constructive for the people there. One simple thing we helped to establish was the understanding among villagers that keeping the water clean upstream would reduce some of the illnesses that people were getting from dirty downstream water. We were able to make some progress on that with a small but important educational approach. Also, working together with people from Chulalongkorn University in Bangkok, we were able to develop and get up and running village healthcare worker programs. These saw young local people trained in some very basic public health skills who regularly moved around the hill villages teaching basic prevention and treating minor ailments, usually without benefit of opium. Follow-up studies at Chulalongkorn later showed direct and very positive outcomes from those small and inexpensive programs.

Q Was this not during the same years that the US was wanting simply to burn all the opium crops in Thailand?

A Yes. I remember having tea with the prime minister and a United Nations representative one day, and someone from the US came in to press that case. He had little knowledge of Thailand or its people and misinterpreted as a “yes” the small nod the prime minister gave him; the prime minister knew it was more complicated than that.

Q So, Canada had made inroads at home and abroad…

A …which made the idea of a Canadian strategy and centre a natural evolution; a national focus would both reflect Canada’s leadership in the field and provide a national forum for linking disparate views and voices and expertise.
In Thailand, Dr. Archibald worked with, among others, the Hill Tribes of the north, part of the notorious ‘golden triangle’. At right, Dr. Archibald joins a World Health Organization official and Thai police in examining 10 kilos of pure heroin seized from the man and woman with their backs to the camera. A crop worth $300 to a village farmer could sell for $15 million on Canadian streets.

Q A seemingly inevitable question is why? Ontario’s ARF had been recognized by the WHO and had clearly been playing a significant role here and abroad. Had no thought ever been given to naming it the national body?

A There had been many moves in that direction over many years, and even tentative federal-provincial agreements about it. At one time, it came extremely close; there was only one world-class outfit. However, formally making a provincial agency a national one would have given more prominence to the one province and its accomplishment than to other provinces and territories. This did not sit well with some politicians of the day. So, other than that, and those discussions went on for years, that was it; the ARF was not going to be the national centre.

Q Yet, health was and remains a provincial concern. What did people think a national centre could do that provincial agencies couldn’t?

A As I said in my Task Force report to the minister, a national organization would bring together professionals from across Canada to develop policy and strategies. My Task Force consultations indicated, for example, there were gaps in information exchange, in development and availability of prevention materials, in training, and in research, and it confirmed the absence of any effective coordinating mechanism for the disparate efforts under way here.

“Ultimately, there was consensus that what was needed and desirable was a long-term federal commitment, a genuine federal-provincial partnership that would maximize use of existing resources and expertise, and be accountable to the people of Canada.”

Ultimately, there was consensus that what was needed and desirable was a long-term federal commitment, a genuine federal-provincial partnership that would maximize use of existing resources and expertise, and be accountable to the people of Can-

CELEBRATING 20 YEARS • CÉLÉBREONS 20 ANS • CELEBRATING 20 YEARS • CÉLÉBREONS 20 ANS
ada. There was also consensus on the need for independent, balanced policy advice of both a national and international nature.

Q Given what you have said about the supply/demand reduction equation, it is interesting the lead minister was the health rather than justice minister.

A That took some maneuvering, but pressure was put on the prime minister and, ultimately, he appointed the health minister to oversee this. The objective was to shift the balance to include demand reduction; that it was Mr. Epp was very appropriate.

Q You noted in your report to Mr. Epp that development of a national strategy for Canada demonstrated the “importance and unique capacity for departments and agencies of the government to work towards common goals.” You also said the success of the process was a tribute to the Canadian government’s system and leadership.

Here are your words: “Canada is one of the few countries in which this process has occurred, and the opportunity to be a world leader in the alcohol and drug abuse field is real, assuming that the continued implementation of the strategy proceeds positively and with the anticipated results.”

A That was true.

Q Did you foresee the evolution in the 1990s away from any independent drug and alcohol agencies at the provincial or territorial level to incorporation of these services into the general health care delivery system?

A As a matter of fact, I used to promote that. It could not be only about law enforcement; moving it to health care was right.

Q But it was later subsumed into mental health, in Ontario at least.

A That was and is less appropriate.

Q Understanding how important you considered CCSA’s independence from political considerations, was it difficult to maintain that independence?

A It is always tremendously difficult to keep at arm’s length from politics. At the ARF, one of my major tasks was to keep it away from the bureaucrats. But I had a very strong board of directors. At CCSA, I concentrated on getting a strong, independent board of representatives from across the country.

Q What does “strong” mean to you in this content?

Dr. Archibald addresses the Healing Our Spirit Worldwide conference in July, 1992, in Edmonton, which was sponsored by CCSA and Health and Welfare Canada.
**A** I mean people who have achieved something in their own right and in their own areas, people who are leaders, people who can go directly to the prime minister or premier of the day and have a meeting.

**Q** In mid-January, 2007, the Globe and Mail ran a story with the headline: “Storm brews over drug strategy; Ottawa putting too much emphasis on law enforcement.” It referred to a report from the BC Centre for Excellence on HIV/AIDS, which was about to be published in the HIV/AIDS Policy and Law Review.

Do you have a sense of déjà vu?

**A** Sadly, yes. Yes.

**Q** However, you have not modified your position that politics and development of new and knowledge-based policy and education do not mix?

**A** Not at all. I am more convinced. Democracy as a form of government is not invulnerable. In the final analysis, it goes where its citizens, through their elected politicians, take it—or where, by default, they allow it to be taken by their politicians.


In December, 1992, Dr. Archibald became the first recipient of the CCSA Award of Distinction in a special presentation made by Her Excellency Gerda Hnatysyhn, wife of then-Governor General Ray Hnatysyhn.
“THINGS ARE LOOKING UP…”

The passing of Bill C-143, an Act to establish the Canadian Centre on Substance Abuse

With the aid of a “note to file” he wrote on August 31, 1988, David Archibald, CCSA’s founder and first chair, recalls the final weeks leading to passage of Bill C-143, the legislation that established CCSA as Canada’s national centre on substance abuse.

The edited chronology below highlights, sometimes between the lines, the political skills of the man dedicated throughout his career and above all to ensuring the separation of scholarly study and development of research-based knowledge from the shifting and often fickle pressures of politicians and governments.

His August note to file captures some of the tensions and upsets around the very political act of getting the Bill passed and CCSA established. Signing off on the note just hours before the government enacted the Bill, he ends on a positive note: “Things are looking up.”

June, 1988

“I met with Herb Gray, the Opposition (Liberal) Leader, and Ed Broadbent, leader of the New Democratic Party (NDP), to discuss the possibility of all-party support for this Bill when it was presented to Parliament. They assured me support would be forthcoming.” (Progressive Conservative Brian Mulroney was Prime Minister at the time.)

June 20

“Mr. Gray wrote to the Honourable Jake Epp, the health and lead minister on the Bill: ‘I am writing to urge that this proposal (Bill C-143) is given sympathetic consideration and would be grateful to receive your comments on the status of this proposal …’

“In his reply to Mr. Gray, Mr. Epp expresses support for the (Task Force) report prepared by myself and recommending the creation of a national centre on alcohol and drugs; he says he intends to introduce the Bill ‘very shortly.’ Mr. Epp goes on: ‘Naturally, I would hope that
all parties will be supportive of the Legislation, thus permitting me to move it through the House of Commons quickly.

“I also received a letter from Mr. Broadbent, thanking me for the meeting and the copy of my Task Force Report and indicating NDP support for the Legislation.”

---

**July 21**

The Bill received first reading.

---

**August 19**

The crucial second and third readings were scheduled. “No one thought there would be any problem in the Bill’s passage. However, two MPs (one Liberal, one NDP) rose to speak. Although they did not appear to be against the Bill, they spoke for too long, and time ran out, thus denying the critical second and third readings.

“We only learned this three days later, on Monday, August 22, at a meeting in Ottawa to discuss potential board members for our new national centre; the ‘celebration’ became a bit of a wake.

“Once again, I was requested to try to ensure all-party support for another reading. I called again on Mr. Gray, but I also … (reached out to a number and range of people with potential political influence). To all of them, I requested an expedited re-submission of the Bill, as well as assurances all of the (political) parties would support rapid passage.”

---

**August 26**

“…Mr. Gray called me to say the House Leaders had come to an agreement, and Bill C-143 would be reintroduced as the first item of business on September 13, the day after Parliament reassembled.”

This date was worrying, however. “I was concerned, and indicated this to Mr. Gray, that September 13 might be too late as there was a possibility the Prime Minister would call an election on that day and dismiss Parliament. Mr. Gray agreed that, if the Government were so disposed, he would support reintroduction of the Bill any time before that date.

“A half hour later, I had a call from ____, the MP who had talked too long and had seemed to be throwing up stumbling blocks on the initial reading. We had a pretty heated exchange, since this was the person who had really caused the delay and the now-real possibility we weren’t going to make it on time.

“In the end, the temperature of the exchange came down a bit, and it looked as if there would be no problems next time. I called Ottawa to provide a synopsis of this telephone
conversation and said that if a ‘window of opportunity’ to reintroduce the Bill opened before September 13, as far as I could tell, there would indeed be all-party support this time.”

---

**Tuesday, August 30**

“A possible ‘window’ opened, but it (the discussion) was going to be immediately after the (volatile) free trade debate, some time in the evening during the hour for private members’ bills. Then, a key MP said he wanted to speak to the Bill but was not inclined to be in the House at 10 in the evening and so was not inclined to support the idea of the Bill coming in after the free trade debate. This left only Wednesday (August 31) or Thursday as options.

“That night, one of my contacts called to advise me there ‘appeared to be a deal;’ the Legislation would be introduced and, it was hoped, passed by Parliament at 3 pm on Wednesday August 31.”

---

**Wednesday morning, August 31**

“____, (another contact) called advising me the Bill was to be passed and would enter the Senate possibly the next day (Thursday) or, at the latest, Wednesday of next week.

“So, it looks as if it will be passed either this Thursday or, at the very latest, September 13, when the House reconvenes.

“Things are looking up,” ends the note.

On August 31, 1988, “Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada,” enacted the Canadian Centre on Substance Abuse Act; the national centre was a reality.