A GROUP LIVING UNIT FOR DRUG ADDICTS:

An assessment of the Narcotic Drug Addiction Research and Treatment Units at Oakalla Prison Farm, 1956 - 1960

by

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ABSTRACT

Drug addiction has a special significance for the citizens of Vancouver, for in this city alone there is roughly one third of the nations drug addicts. This social disease is both widespread and threatening in that the number afflicted has increased steadily since the years of World War II. The thesis begins with a preliminary review of how drug addiction spread to Canada and to what extent it now exists. The effect of various drugs and the withdrawal process are described. An attempt is made to show the costs of addiction, and difficulties in policing the traffic in narcotics. There is some assessment of legislation governing the use of narcotic drugs. The central focus of the thesis is an evaluation of the group living units for treatment and rehabilitation of selected drug addicts within Oakalla Prison, known as the "Panabode units."

Methods used in evaluating the Panabode programs were many and varied. One of the most helpful was frequent visits to Oakalla and actual participation in all phases of program. Data also came from reports and texts of various authorities in the field, particularly from the findings of the Senate Committee on Traffic in Narcotic Drugs in Canada, 1955, and those of the "Stevenson" Report, Drug Addiction in British Columbia, 1956. At Oakalla, discussions were held with the administration, with the staffs of both Panabode units, and with addicts themselves. Case files and all personal records were reviewed. Discussions were also held with various staff members from the Narcotic Addiction Foundation, (Vancouver,) with doctors, nurses and hospital personnel who are frequently in contact with some phase of addiction. Panabode programs are compared to other programs which exist in New York, and in Lexington, Kentucky.

It is indicated that methods of treating drug addiction could be improved (a) by providing additional and better qualified staff; (b) by giving more individual attention to treatment; (c) by improving and increasing facilities and for a more self contained program. The importance of careful discharge follow-up is stressed. It is argued that the community is not attacking the problem of drug addiction on a broad enough front. Present treatment and rehabilitation facilities represent only a dim, half hearted response to a social illness that is now of alarming magnitude. Finally, legislative changes are suggested as a means of bringing addicts out into the open where they can be treated as sick people and not as criminals.

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Chapter 1

ORIGINS AND SOCIAL EFFECTS OF DRUG ADDICTION

In 1952, a committee of the Greater Vancouver Community Chest and Council reviewed the problem of drug addiction in Vancouver. The widespread prevalence of narcotic addiction, and the damaging consequences that such addiction is believed to have for the well-being of the community, had by this time become of wide public concern in this city. The work of this original committee brought into being a formal research team of experts composed of a psychiatrist,[1] a psychologist, a social worker, and an internist. Through the University of British Columbia, Federal and Provincial funds were made available for the research project. As part of its responsibility in sponsoring this study, the University of British Columbia set up an advisory Committee to oversee and assist the research group. The study commenced in March 1954.

The setting for the study was Oakalla Prison Farm where a large group of addicts were concentrated. The project itself was a survey of the many aspects of drug addiction: social, physical, psychological, psychiatric and historical. Also sought were general plans for the prevention and treatment of drug addiction, control

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1 This person was George H. Stevenson M.A., F.A.P.A.A., F.R.S.C., Psychiatrist and director of the research group.

of illicit trafficking in drugs, and suggested topics for future study.

In June, 1956, after two years of extensive work and study, the research group completed its project. The report of this group is commonly known as "The Stevenson Report" and will be referred to as such hereafter in this thesis. From its findings, evidence was submitted to the Special Senate Committee at that time on the traffic of Narcotic Drugs in Canada.[1] The group also offered certain concrete proposals to the original committee from the Community Chest and Council regarding their proposed pilot centre for the treatment and rehabilitation of drug addicts. These proposals, in the form of a brief, were submitted to the Provincial Government which saw fit to vote funds for such a centre.

Many things came out of this lengthy research study. It received good press coverage and created much popular concern. To date however, the most significant results of this study has been the realization of two treatment and rehabilitation centres: the Narcotic Addiction Foundation of British Columbia, and the Research and Treatment units at Oakalla Prison Farm, known as the Panabode units.

The Narcotic Addiction Foundation became a treatment centre for selected patients in December 1958. Through Provincial funds a building was purchased at 835 West 10th Avenue in Vancouver, B.C. Its program was fathered by the knowledge that many addicts poignantly

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1 The special senate committee was appointed in 1955 " to enquire into and report upon the Traffic in Narcotic Drugs in Canada and problems related thereto."

desire to stay off narcotics permanently and can do so if their individual problems are treated with understanding and if sufficient rehabilitation resources exist for their re-orientation into society. The Foundation represents a three year pilot study which seeks to shape this broad concept into four objectives - medical treatment of selected patients, their rehabilitation, experimentation and research into new methods of treatment and rehabilitation and a program of public education in the prevention of addiction.

Dr. Robert Halliday, a psychiatrist, has been given charge of the Foundation and its program. His staff now consists of an administrative assistant, a senior and two regular social workers, a psychological therapist, two psychiatric nurses, a full time cook, a janitor-watchman, a secretary and a stenographer.

The Panabode units within Oakalla Prison Farm were constructed in 1956. These units, one for selected male addicts and one for selected female addicts, were the first narcotic research and treatment units in the province. They are self-contained units segregated from the larger male and female jail units. Although theirs is largely a separate administration, the Panabode units are within the Oakalla Prison and so are governed to a large extent by the policy and procedure pertaining to the prison generally. This is a significant factor affecting their treatment programs.

The subject matter which follows will deal briefly with the

background of drugs and drug addiction, as well as its present prevalence in Canada, particularly in British Columbia. There will be some discussion of the drug addict himself and his personality. Trafficking in narcotics will receive some attention and an attempt will be made to indicate some of the difficulties with which the police have to cope in their efforts to control the traffic in narcotics. There will be a brief discussion of the costs of addiction to both the addict himself and to the society in which he exists. This will include the types of crime in which he is usually involved. Finally, an attempt will be made to assess critically Canada's Opium and Narcotic Drug Act.

Considerable attention will be given to the foregoing aspects of drug addiction. However, the primary focus of this thesis will be a description and evaluation of the Panabode units at Oakalla Prison Farm. The location and description of Panabode properties and facilities will be outlined. Some attempt will be made to state clearly the philosophy, goals and purposes of the units. An effort will be made to analyze the administrative structure of Oakalla as it relates to the Panabode units and their personnel. General classification will be discussed as it exists within Oakalla and this will be followed by an examination of the criteria employed in the selection of suitable candidates for the Panabode treatment programs. Both treatment programs will be analyzed and evaluated. The importance of careful discharge follow-up will then be discussed and finally, there will be an expression of personal views and recommendations regarding the entire treatment program for both males and females.

In offering these views and recommendations, it is hoped they

might contribute in some way to improve the treatment of drug addiction at the Panabode units. It is further hoped that this thesis might make a positive contribution to anyone interested in the search for more effective means and methods of treating drug addiction.

THE EARLY OPIUM PROBLEM IN ASIA

In the eighteenth and nineteenth centuries, India produced great quantities of high grade opium. Many Indians used this drug for its pleasurable effects as well as for its medical values. In the absence of trained physicians, opium was a household remedy for all kinds of pains and aches, for the relief of dysentry, as a supposed prophylactic against malaria, and to ease the discomforts of infants and the aged. Opium was rarely smoked in India but was usually taken in beverages or in a solid form. Only a fraction of the opium produced in India was consumed there, the largest portion being sold to China.

China had grown opium in small but increasing amounts for many years. Nevertheless, Chinese preferred to smoke the better quality Indian opium, a habit which they had learned with the introduction of tobacco and the pipe from Formosa, where opium smoking probably originated. The Chinese too used opium as a household remedy.

During much of eighteenth and nineteenth centuries, a large portion of India was under the control of Great Britain and her East Indian

Company. Production of opium was controlled by the British and profits from its sale (chiefly to China) helped greatly to finance the Indian economy and to provide profits for the East Indian Company share holders. China, though it lacked a strong central government, was an independent country and, despite great poverty, was self contained and sought little trade with other countries.[1,2]

It is not known whether Indian leaders objected to the use of opium by her people, but official China protested vigorously to its use by Chinese citizens. Protests were based ostensibly on its harmful effects on Chinese users, but the Chinese Government feared the heavy economic drain as they sold only limited quantities of tea and silk in exchange for opium and always had a large negative trade balance. Because opium was also produced in limited quantity in China, it was thought by many English traders that the official Chinese protest against opium use was an indirect means of avoiding imported opium in favour of home-grown opium. English traders naturally wanted to keep their Chinese market. They were aware that opium was easily produced in India and of a higher quality than Chinese opium. They also refused to believe that China's opposition to opium was based on its allegedly deleterious effects on the people who used it, but felt that China's continued protests were largely because of economic

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1 Fairbanks, J.K. "TRADE AND DIPLOMACY ON THE CHINA COAST" Harvard University Press, 1953, Vol I

2 The Stevenson Report, 1956

reasons. The Opium Wars[1] between China and England resulted.

The wars between these two Countries ended in 1858 with the Treaty of Tientsin. China had to pay huge indemnities, was forced to open additional ports to European Countries and had to agree to admit opium as a legal article of trade. With this development, the use of opium became more prevalent in China. It was estimated that in some provinces and cities, as much as 90 per cent of the people became opium smokers.

Within England, protests began against the forceful imposition of opium on a large but virtually helpless nation for the sake of profits. It was not until 1891, however, that an anti-opium group in the House of Commons succeeded in passing a resolution to the effect that the system by which Indian opium revenue was raised was morally indefensible.[2]

A Royal Commission was established to report on the opium situation in India. Investigations were carried out in 1893 and 1894 and a majority report was printed in 1895.

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1 Before the outbreak of the Opium Wars, England had long wanted China to open up her foreign trade restrictions and was gradually bringing many pressures to bear on China. In protest, China banned all importation of opium in 1839 and destroyed a large quantity of British owned opium stored at Canton. This resulted in the Opium Wars which began in 1840 and ended in 1858 with the treaty of Tientsin.

2 The Stevenson Report, 1956

Accepted at face value, the report indicated that opium use in India was by no means a national calamity. However, many people regarded the Commission report as a piece of "whitewashing", and felt that emphasis had been placed on evidence which suited preconceived opinions with a parallel disregard for evidence by missionaries and others who felt that opium use had its unfavourable aspects.

The use of opium had already spread in Asia and in 1903 a United States Senate Committee was established to look into the problem in the Philippines. It seemed by this time that only Japan had no drug addiction problem. This was probably because it had been a self contained nation for many centuries, having little contact with other nations. Although opium was widely used in India, China and far Eastern countries in the nineteenth century, it would seem, from the observations made by various authors, that only a small proportion of the population suffered serious ill-effects from its use. Davenport in "China from Within" gave the opinion that opium is much less damaging than is the use of alcohol. May in "Survey of Smoking Opium Conditions in the Far East" stated that in his opinion, opium was no more abused than was the drinking of liquor and was indulged in for the same reasons. Merril in "Japan and the Opium Menace" was of the opinion that the effects of opium were generally more serious than those resulting from the use of alcohol. He also felt that the use of opium led to more poverty and physical debility on the part of opium users. Despite the various differences of opinion as to the harmful effects of opium, the effects of its use generally on societies where it was used openly and legally did not seem morbidly different from

the use of alcohol in our own country.

Wide differences of opinion existed among both white people and orientals as to the actual harmful effects of the use of opium. Emotional biases might have played a large part in this difference of opinion. Missionaries, for example, considered opium smoking a terrible vice, whereas business men, white or oriental, often regarded it as business men here regard whiskey in social intercourse. Many regarded the effects of alcohol as worse than those due to the use of opium.

THE EARLY USE OF OPIUM ON NORTH AMERICA'S WEST COAST

Chinese first entered British Columbia from the United States when gold was discovered on the Fraser River in 1856. The Canadian Pacific Railway then brought many others from China for construction of the railroad line through British Columbia in the 1860's. By the early 1880's there were more than 10,000 Chinese in British Colimbia in a total population of 60,000. There were only 20,000 white persons, the remainder being native Indians.

Opium came with the Chinese to both the United States and British Columbia. In the United States, it was a separate item of import from 1840 and not even subject to import tax until 1842. In Canada, opium was admitted without customs duty until 1897. In both countries, legal recognition was given to opium for smoking and import taxes contributed

handsomely to the economy of both countries. Opium importation did not end in the United States until 1909. Canada's Opium Act of 1908 officially ended legal admission to Canada of opium for smoking. However, smuggling of opium into Canada then developed on a large scale.

Opium continued to enter Canada as freely as ever, perhaps even more so, as there was no duty to pay. Police left anti-smuggling duties to Customs officials and were unable to prosecute opium smokers as such because the smoking of opium was not an offence under the 1908 Act. Because of this situation a Royal Commission was set up in 1910 "to investigate alleged Chinese frauds and opium smuggling on the Pacific Coast." In 1911, on the recommendations of this Commission, the Opium Act was ammended to make the smoking of opium a punishable offence.

Even at this point, evidence produced by commissions and various investigating committees did not reveal that opium was obviously harmful to many of the people who used it, or that the smoking of it by Chinese or white people caused appreciable harm to society generally. Certainly, some Chinese and white people became intoxicated from the smoking of opium, but this intoxication was a much milder and less dangerous type than that produced by alcohol.

THE ADVENT AND USE OF OTHER DRUGS OF ADDICTION IN BRITISH COLUMBIA

The use of cocaine began soon after opium smoking became prohibited.

For years, the drug problem as it existed in Vancouver consisted of the use of these two drugs. Over the years the pattern changed, however. By the beginning of World War II, use of codeine and benzedrine began to appear on the scene. As the war continued, an acute shortage of narcotic drugs developed, resulting in a tremendous increase in the use of barbiturates such as nembutal, seconal and luminal. Barbiturates are not listed under the Opium and Narcotic Drug Act but are governed by the Food and Drugs Act.

Towards the end of World War II police in Vancouver became aware that addicts were using in increasing quantities the drug known as heroin. Today, almost without exception, this is the drug which is creating the ever-increasing number of narcotic addicts in British Columbia. This drug is the opium derivative with the strongest habit-forming characteristics and is the most insidious of the illicit narcotics.

THE EFFECT OF VARIOUS DRUGS ON USERS

The opiates[1] hold a special attractiveness for drug addicts. This group includes morphine, heroin and codeine and their popularity lies primarily in the satisfaction they provide in the need for peace and calm. All opiates soothe the nerves, reduce awareness of pain and discomfort

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1 See Glossary

and tend to wipe out mental conflict and the uncomfortable pathological strivings that result.[1]

Tensions produced by the strivings are relieved and under the drug's influence the neurotic or psychopathic patient feels free, easy and contented, in contrast to his usual anxious state. Prolonged use produces mental and physical lethargy and loss of ambition. The only pleasure later received from the drug is the pleasure in relief from withdrawal symptoms. Frequently, the first dose of opium produces more pleasure than any subsequent indulgence.[2] Users appear to become hyper-suggestible while addicted. Those addicted are often comparatively free from signs of deterioration for years. When the addict's supply of opiates is stopped, he becomes ill with pain, suffers from cramps, vomiting, diarrhea, sleeplessness and possible death.

Heroin, taken both hypodermically and by snuffing, has the greatest addiction ability of all opiates.[3] Its effect in producing deterioration in personality with disregard for social and moral values is unsurpassed. Most authorities consider it the most difficult of all addictions to cure. Codiene has a definite though low grade addiction liability. Both

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1 Maurer, "The Argot of the Underworld Narcotic Addict." Part 1, American Speech, April 1936, pp 116 - 117

2 Kolb, L. "Drug Addiction Among Women," United States Public Health Bulletin #211 1925, p4

3 Kolb, L. & Dumez, M. "Experimental Addiction of Animals to Narcotics," Public Health Report #1463 Washington, p 30

dilaudid and metopon have high physical dependence and habituation liabilities. Demerol and methadone are synthetic analgesics[1] which are not chemically related to morphine but are addicting. They possess considerable habituation liability and after prolonged administration their addicts develop physical dependence on them.

Cocaine is, strictly speaking, not a narcotic,[2] nor does it now constitute a major drug problem numerically even in the United States. It produces a marked stimulation, a sense of exhilaration, euphoria and self confidence, an increased flow of ideas and a pressure of speech and activity. During this period of stimulation and a sense of competency, there may be an actual increase in capacity for work. As the effect of the drug wears off, however, the addict feels weak, depressed, restless, morose and irritable. The moral deterioration of the cocaine addict is even greater than that of the morphine user and prospects of a permanent cure are even less favorable than in the case of the morphine addict. Withdrawal of the drug is not accompanied by the painful experiences and tendency to collapse occuring in the withdrawal of opium derivatives.[3]

Marihuana, though not used significantly in these parts, is of major concern to police drug details in United States. This drug is

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1 See Glossary

2 See Glossary

3 Noyes, A.P. Modern Clinical Psychiatry, 4th ed., W.B. Saunders Company; Philadelphia and London; 1953, pp 515 - 516

obtained from a species of hemp plant grown throughout the world in both temperate and tropical climates and its active principle is an oil. Users of marihuana usually smoke it in the form of cigarettes commonly known as "reefers". There would seem to be a good deal of misinformation regarding the effect of this drug on its addicts.[1] Unlike opium derivatives, marihuana does not create a biological dependence accompanied by withdrawal symptoms and its use can be discontinued without great difficulty. "It does not lead to any physical, mental or moral degredation even after prolonged use."[2]

Following marihuana inhalation, there soon exists a sense of euphoria, increased volubility and psychomotor activity followed by a feeling of calm and pleasurable relaxation. The subject might sleep for several hours and upon awakening no longer feel exhilarated. Most users take marihuana to produce sensations comparable to those produced by alcohol. It is a popular misconception that use of marihuana leads to criminal habits. This opinion has not been sustained by actual experience and it is further pointed out that "alcohol causes infinitely more murders, rapes and crimes of violence than do morphine, heroin cocaine, marihuana and all other drugs combined."[3]

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1 Kolb L. "Marijuana, " United States Public Health Service Bulletin (hereafter referred to as U.S.P.H.S.) Washington, D.C. reprint # B-2575

2 Noyes, A.P. op. cit. p 520

3 Noyes, A.P. op. cit. p 521

Recent years have seen a considerable increase not only in acute barbiturate intoxication but also in barbiturate addiction.[1] The former accounts for about 25 per cent of all deaths by acute poisoning admitted to general hospitals, and more deaths are caused by barbiturates, either accidently ingested or taken with suicidal intent, than by any other poison. True barbiturate addiction is frequent and the sudden withdrawal of the drug may be followed by abstinence symptoms such as convulsions and/or a psychotic reaction resembling the alcoholic delirium tremens.

As with alcoholism and narcotic drug addiction, the important factor in barbiturate addiction would appear to be an underlying personality difficulty. Individuals with character disorders frequently begin the use of the drug in order to experience its intoxicating effect. Morphine addicts frequently use barbiturates when they are unable to secure morphine or when they wish to reinforce the effect of that narcotic. Alcoholics frequently begin the use of barbiturates to relieve the tension following a period of heavy drinking and continue their use, often inducing toxic effects.

Barbiturates depress brain oxidation so that the chronic barbiturate addict is confused, often drowsy and depressed, shows poor judgement and impaired intellectual functioning with a regression of habits. He is often emotionally unstable, morose, quarrelsome, and,

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[1] Noyes, A.P. op. cit. p 519

if irritated by monor incidents or fancied insults, may become assaultive. Some become hostile and develop mild paranoia. Extreme cases will often find a patient regressing to an infantile level where he has to be waited on, fed, and nursed. Unlike the situation with narcotic drug addictions, a large proportion of the cases of barbiturate addiction result from administration by physicians.[1]

With regard to drugs generally and their physiological effect on users, Dr. Michael J. Saliba, Jr., a California physician who has made an extensive study of the physiology of addiction, describes the sequence of events in this way:

> "The tiny particles, called Nissl's granules, composing the brain and spinal nerve tissue, normally receive and send out impulses from and to the ears, eyes, nose, tongue, skin, the digestive, respiratory and circulatory systems, the muscles and bones. When a narcotic - for example, heroin, the most vicious of them all - begins to cover up these particles, the individual feels a tremendous exhilaration. The nerve impulses which cause normal apprehensions are the first to be muted. Worries disappear; a pleasant, warm, almost mystical sensation sets in - temporarily. With continued use, the narcotic throws the whole sensory apparatus out of line. Pleasing perceptions are magnified, unpleasant ones diminished. An agreeable five minutes seems like an hour. Ordinary noises sound like music. Common sights appear beautiful. Plain odors and tastes, even bad ones, become delightful.
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> "To the potential addict the first three or four experiences of this kind do not seem dangerous. But without knowing it, he has already been 'hooked.' This is what happens by the time he takes his second or third dose: as the narcotic covers over more and more nerve-tissue particles, the body's defense mechanisms go to work to replace them. The amount of narcotic which muted the original number of Nissl's granules will not cover the new particles. The addict must take more drug to get the lift. His system keeps pace, manufacturing still more new tissue in brain and spine.

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1 Ibid. pp 519 - 520

"Soon the point of no return is reached - with several hundred times the normal number of nerve-tissue particles in the victim's brain and spinal cord. As long as the tissue remains covered by the narcotic, he is happy. When it is not, several hundred times the normal number of nerve impulses reach the heart, the lungs, the digestive and other systems. Under the terrible bombardment he feels as though his head were about to explode, his bones ache, his muscles jump uncontrollably. Intense vomiting and diarrhea begin. The slightest sound is deafening, the mildest light blinding, the faintest odor or taste nauseating. Ants seem to be crawling under his skin.

"The agony of an addict who stops or even cuts down his narcotic intake is indescribable. It takes great courage to face this torture. Ironically, the body itself is ready to be amazingly co-operative. Within five days to two weeks after the narcotic is stopped, the system will have eliminated the surplus Nissl's granules and be back to nearly normal. But the great majority of addicts do not have the mental strength to resist and take the punishment of the first days of withdrawal." [1]

SYMPTOMS, DURATION AND METHODS OF WITHDRAWAL

Because in British Columbia we are concerned primarily with opiates, and heroin in particular, discussion of withdrawal here will deal essentially with persons addicted to these drugs. As other drugs have been discussed we have attempted to review briefly their abstinence symptoms. When opiates are abruptly withdrawn from an addict a definite train of symptoms known as abstinence or withdrawal symptoms appears. If within twelve to fourteen hours after the administration of heroin the dose is not repeated, these withdrawal signs and symptoms are yawning,

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1 Sondern, F.J., "This Problem of Narcotic Addiction - Lets Face it Sensibly," Reader's Digest, Published by Reader's Digest Association (Canada) Montreal, P.Q. Vol 75, #449, Sept 1959, pp32 - 33

lacrimation, rhinorrhea, sneezing and perspiration. In their moderate form these symptoms become more marked and tremor, anorexia, dilated pupils and gooseflesh are added. About thirty-six hours after the last dose or "fix" marked withdrawal symptoms appear in the form of uncontrollable twitching of muscles, development of cramps in the legs, abdomen and back and a rise in body temperature. The addict becomes intensely restless, suffers from insomnia, while pulse and blood pressure rise. In their severe form withdrawal symptoms include vomiting, diarrhea and loss of weight. Acute signs and symptoms reach their height about fourty-eight hours after the last dose of heroin and remain at this height for seventy-two hours. During the next five to ten days symptoms gradually subside.

As withdrawal symptoms develop the patient becomes restless, pessimistic, surly, fault-finding and irritable, and exhibits an unpleasant, increased motor activity. He experiences marked subjective feeling of weakness and considerable prostration usually occurs. He may curse, cry, be impulsively destructive and make suicidal gestures. To a large extent, the intensity of withdrawal symptoms depends on the amount of the drug the patient has been taking. To some degree the extent of the symptoms can be controlled by the patient himself. A patient who appears comfortable during the period of withdrawal should be suspected of access to illicit drugs.[1]

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1 Noyes, A.P. Modern Clinical Psychiatry, 4th ed., W.B. Saunders Company; Philadelphia and London; 1953 pp 515 - 516

Withdrawal treatment is the first phase of the over-all treatment for the addict. Perhaps it is the easiest and the least important part of the treatment program, but it has to be carried out before the longer and more difficult part can begin. It was the feeling of the Research Group on Drug Addiction in British Columbia that withdrawal treatment can be carried out properly only in a secure environment. The person should not have to be sentenced to jail in order to secure withdrawal treatment for his addiction. Nevertheless, the secure environment would prevent access to narcotics and probable discontinuance of treatment because of distress. There is a need for skilled and competent nursing services to safeguard against suicide.

Most of the foregoing refers to the "cold turkey" method of withdrawal in which the addict is completely and suddenly cut off from his supply of drugs. This is the quickest form of withdrawal but is probably the most difficult for the addict himself. Another method of withdrawal is the "gradual reduction" method. This is a more humane form of withdrawal and the one having the longest tradition. This form of withdrawal is often used by addicts themselves. Down through the years, many drugs have been used as adjunct or replacement drugs in therapy. Methadone and Nalline are two which have been more efficient in latter years. Researchers almost universally condemn the "ambulatory" method of withdrawal. With this method drugs are administered in decreasing amounts but the addict remains ambulatory and comes to a clinic or centre for his decreasing doses. This method is considered expensive

and cumbersome and is rendered additionally unsatisfactory because when the addict experiences any distress he almost invariably secures additional supplies from illicit sources for self administration, and his physician has therefore no real control over treatment.[1]

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1 The Stevenson Report, 1956

Chapter II

PREVALENCE, CLASSIFICATION AND LEGAL ASPECTS

Drug addiction is prevalent now in all parts of Canada but the problems of this social disease are most apparent in the Province of British Columbia and particularly in the city of Vancouver where more than one third of the country's drug addicts are believed to exist. For this reason there is perhaps more attention given to Vancouver and the Province of British Columbia in this Chapter.

DRUG ADDICTION, CLASSIFICATION OF ADDICTS, THE ADDICT AS A PERSON

The Expert Committee of the World Health Organization[1] on

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1 The World Health Organization is a body within the United Nations Organization dedicated to the improvement of health standards and practices throughout the world. The first Assembly of the United Nations created the Commission on Narcotic Drugs. This body is engaged in a great humanitarian effort to suppress the abuse of dangerous drugs and thereby reduce human misery. The Narcotic Commission acts by making use, on the one hand, of the effective means made available by several Narcotic Conventions and, on the other hand, of public opinion.

Three international bodies are engaged in this work. The trade in narcotics is watched over by the Permanent Central Opium Board which meets semi-annually in Geneva. Another international organ, the Supervisory Body, meets semi-annually to review the estimates of all governments for medical needs. The Committee on Drug Addiction of the World Health Organization sits annually to review the field of newly discovered drugs to determine which shall be placed under international control.

The concerted international program in the field of narcotic drugs is directed towards the following objectives: a) Improving the national and international legislation and administrative machinery in the field of narcotics; b) Regulating national and international trade in Narcotics; c) Co-ordinating the efforts for treatment and eradication of drug addiction.

drugs liable to produce addiction defines drug addiction as "a state of periodic or chronic intoxication, detrimental to the individual and society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

1. An overpowering desire, or need (compulsion) to continue taking the drug and to obtain it by any means;
2. A tendency to increase the dose;
3. A psychic (psychological) and sometimes a physical dependence on the effect of the drug."

The Canadian Association for Adult Education[1] states "Drug addiction exists when a person's behaviour and way of life are determined by his dependence on and the availability of narcotic drugs which are harmful to him and hence to society."[2]

Generally speaking, there are three types of addicts. First, there are those called medical addicts. They have become addicted as a result of medical condition in which drugs have been legitimately administered for the relief of pain. Second, there are a number of persons known as professional addicts. They are medical practitioners, nurses, dentists and vetinarians, who, having access to them, have become addicted to drugs. The third group, and the one of most public concern, consists of those who obtain their supply from the illicit market; they are known as criminal addicts.

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1 The Canadian Association for Adult Education is a private National organization founded in 1935. Its purpose is to make information and education available to anyone who seeks it. The Association is financed by Provincial Governments as well as numerous private and public agencies.

2 Citizens' Forum "Should Drug Addicts Go To Jail," Canadian Association for Adult Education, 113 St. George St., Toronto Ontario, Oct. 1959

Himmelsback and Small[1,2] have pointed out that addiction to opium and similar drugs embraces three related but distinct phenomena: 1) tolerance, 2) physical dependence, and 3) habituation. Tolerance means the diminishing effect of the same dose of the drug when it is administered repeatedly over a period of time. As a result it is necessary to increase the dose to secure an effect equivalent to that of the original dose. Physical dependence means an altered physiological state produced by the repeated administration of a drug over a long period of time with the result that the continued use of the drug is necessary in order to prevent the appearance of a characteristic group of symptoms known as an abstinence syndrome. Habituation means an emotional or psychologic dependence on the drug because of the relief of tension and emotional discomfort which it affords - the need for its euphoria-producing effect.

The largest group of addicts is composed of individuals with personality disorders who became addicted to drugs through contact and association with persons already addicted. Members of this group are usually emotionally immature, hostile, aggressive persons who take drugs in order to secure relief from inner tension. They have few healthy resources or interests and are motivated by immature drives for immediate goals. The addict-to-be finds in the drug a release from tension felt as

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1. Small, L.F. & Himmelsback, C.K., "Studies on Drug Addiction" Supplement 138 to the Public Health Reports, U.S.P.H.S., Washington, 1938

2. Noyes, A.P., Modern Clinical Psychiatry, 4th ed., W.B. Saunders Company; Philadelphia and London; 1953, pp 513 - 514

a restless need for pleasurable or exotic sensations, the satisfaction of a longing for artificial elation or peace. Conscious discomfort is eliminated, repressed drives may be released and responsibility is evaded.[1]

In addition to the foregoing psychiatric views of Noyes, there is considerable evidence that the addict-to-be has usually to be socialized into the addict culture before addiction can begin. In other words, addiction is by and large group induced through association with other addicts. Also worth mentioning is the fact that drug addiction is often just one of a number of significant symbols declaring and confirming membership of a criminal sub-culture.

A second group consists of frankly neurotic persons with anxiety, obsessive, compulsive or psychophysiologic symptoms which are relieved by drugs.

A third group consists of persons who in the course of physical illness received drugs over an extended period of time and after the termination of the ailment continued their use. Probably, however, all persons who acquire addiction in this manner have some fundamental emotional problem which caused them to continue the use of drugs beyond the period of medical need. Many addicts were intemporate in the use of alcohol before they became addicted to drugs. In practically all addicts their previous adjustment to life was marginal or unsatisfactory.[2]

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1 Noyes, A.P., op. cit. p 513

2 Ibid., p 513

ANALYSIS OF ADDICT POPULATIONS THROUGHOUT CANADA

Table 1[1] shows statistics compiled in 1955 from the card index records maintained in the Division of Narcotic Control of the Department of National Health and Welfare. The table reveals for that year a known addict group in Canada of 3,212. Of this number there were 333 professional addicts, 515 medical addicts and 2,364 criminal addicts.[2]

Police in the large addict centres of Canada and particularly in Vancouver indicate that the incidence of addiction has increased since compilation of the afore-mentioned figures so it can be said that present figures will exceed those mentioned.

The 1955 Senate inquiry indicated that of the 2,364 criminal addicts, Montreal was known to have some 200, Toronto about 400 and Vancouver about 1100. The balance are in prisons and in such other Canadian cities as Halifax, N.S., Hamilton,Ont., Moose Jaw, Sask., Calgary, Alta., to name a few.

Neither race, intelligence, occupation nor religion appear to have any bearing on the physical proneness to addiction. The only common denominators known are the physical and chemical effects in the body resulting from the use of drugs.

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1 See table on page 26

2 For an explanation of the different types of addicts please refer to page 22

Table I Total Addict Population By Province and By Types

(Canada, 1955)

Province	Criminal	Medical	Professional	Totals
British Columbia	1,101	46	38	1,185
Alberta	141	32	20	193
Saskatchewan	45	11	23	79
Manitoba	148	12	16	176
Ontario	655	188	127	970
New Brunswick	2	19	13	34
Quebec	260	171	77	508
Nova Scotia	12	31	16	59
Prince Edward Island .	-	4	2	6
Newfoundland	-	1	1	2
Other Areas	-	1	1	2
Totals	2,364	515	333	3,212

Source: Adapted from proceedings of the Special Senate Committee on the "Traffic in Narcotic Drugs in Canada, The Senate of Canada, 1955, p.475

Because of legal and moral sanctions, addicts do not willingly reveal their identity. Court and prison statistics are therefore the main sources of information on addiction. It must be remembered, however, that the unconvicted always constitute an undisclosed fraction of the total number of addicts. This makes it difficult to determine the true statistical situation and rate of increase. Concerned people find that they are dealing with the control of a phenomenon whose proportions are not known with accuracy.

BRITISH COLUMBIA'S TRAFFIC IN NARCOTIC DRUGS

Information from the Royal Canadian Mounted Police and from Vancouver City Police indicates that most of the heroin reaching the illicit market in British Columbia originates in Mexico. From here it is shipped to the Eastern United States and then to Eastern Canada to cities such as Hamilton, Montreal, and Toronto. It is believed that some comes from the Eastern Mediterranean, and also from the Peoples Republic of China via Hong Kong. Some enters Vancouver directly from the Orient by ship and, because of the large Vancouver market, it is thought that some now comes more directly from Mexico. The larger portion, however, is still believed to come to Vancouver from Eastern Canada. Heroin is purchased in Eastern Canada at prices ranging from $500 to $600 per ounce and sometimes as much as thirty ounces are purchased at a time. There are many means by which the heroin is then brought to Vancouver - planes, trains, automobiles and even by mail. Packages or containers

are usually camouflaged and brought in by some person unknown to the police. Incidentally, the baggage of travellers between points in Canada is not subject to inspection as is the case when entering or leaving other countries. Nevertheless, traffickers go to great lengths to disguise and camouflage their shipments of drugs. This would include such ingenious methods as sending through the mail in small parcels in a talcum powder tin, or hidden in other types of cosmetics. It may be brought in in rubber containers concealed in the gas tank of a car or hidden in the false bottom of a suitcase or other baggage . When it reaches Vancouver, heroin is turned over by the distributor to an associate whose job usually is to pack it in capsules and "plant" or hide it in various locations throughout the city, then giving these locations to the distributor. When the associate, known as the "plant" man, begins placing the heroin capsules, he will have with him a white powdery sugar of milk which resembles heroin. He mixes one ounce of this sugar of milk with one ounce of heroin, adulterating the drug to make up a two ounce mixture. A supply of number five clear gelatin capsules obtainable legally at any drug store, would be on hand into which he would cap up the mixture. One ounce of this mixture will make or fill four hundred capsules, more or less. Thus, from the original ounce of heroin, 800 capsules of adulterated heroin are obtained. The "plant" man's next procedure is to pack five of these capsules into a small ordinary rubber balloon, tying the end of each balloon with a slip knot. He then places ten or twenty of these balloons into a rubber condom, tying the end of the condom with a slip knot. Next, his procedure is to "plant" or conceal these bundles

around the city in different locations and at definite markers. The marker is usually a stop sign, fire hydrant, telephone pole, street sign post, the corner of a garage, or even a clothes line post. The street address of premises adjaecent to the marker is then written down, usually in code form, and turned over to the distributor.[1]

The stage is then set for the next step in the distribution procedure. The distributor first mentioned is now contacted by the "pedlars" or "pushers" for their supply to sell on the street. On the street in Vancouver this distributor usually charges $2.00 a capsule to the street pedlar or pusher. Thus, the original ounce of heroin purchased for $600, and made up into 800 capsules of adulterated heroin brings the distributor $1600, or a profit of $1000. Handling 30 ounces at one time would bring the distributor a profit of $30,000 and it is known to police that in some instances the heroin is adulterated to a greater degree by the distributor than indicated here.

The "plant" man who does the original capping up, will usually use a different location each time he does this work. Places most often used are auto courts or motels where there is an inside private toilet

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1 Mulligan, W.H. (Police Chief for the city of Vancouver, 1947 - 1956) Discussion of British Columbia's traffic in Narcotic Drugs has been adapted from Mr. Mulligan's brief to the Special Senate Committee on the Traffic in Narcotic Drugs in Canada, 1955, and is contained in the published detail of this Committee under the Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada, Queens Printers, Ottawa, 1955, pp 59 - 82

into which he can flush the drugs should he be surprised by the police.

When the street pedlar or pusher contacts the distributor he pays over the money and is then given the location of one of the "plants". He will go there immediately, search for and recover the hidden drugs. The street pedlar will often go to some safe place himself and still further dilute the heroin. As an illustration, if the street pedlar buys 50 capsules, he would dilute it, again using sugar of milk making 100 capsules from the 50 he purchased. This pedlar has paid the distributor $100 for his 50 capsules, and he now has 100 capsules of doubly adulterated heroin. This man then sells to the addict on the street at an average price of four dollars per capsule, realizing $400 or a profit of $300.

The method used by the street peddlar is to put ten or twenty capsules in a rubber container, place this small bundle in his mouth, and proceed to a beer parlour, cafe, or pool room, there to await the drug-seeking addicts. The street pedlar will sometimes use a man known as a "steerer", who walks around the vicinity where addicts congregate, telling of the pedlar's whereabouts to any known addicts that he meets. The street pedlar proceeding to a location such as those mentioned is very careful to find a seat facing the entrance, and he usually sits with his back against a wall. The drugs are in his mouth and he will swallow them immediately should he see a police officer entering the premises. When it is necessary for the pedlar to swallow the drugs, as it often is, these people are adept often at regurgitating them, and, being in a

watertight rubber container, the drugs are recovered undamaged.

When a street pedlar is contacted by an addict he is paid four dollars and the addict then receives his capsule. A pedlar may even take the drug out of his mouth seated where he is and pass it to the addict. Generally, however, he will go to a toilet and lock himself in one of the cubicles then extracting from his package the required number of capsules. By this precaution he protects himself from the police, for should the police endeavor to catch him at this point by breaking into the cubicle, the pedlar will immediately flush the drugs down the toilet and the police would be compelled to release him for lack of evidence.

Having his capsules from the street pedlar the addict immediately wraps them in silver paper, and places them in his mouth so that he can swallow them if checked by a police officer. Like the pedlar, he can recover the drugs intact after the officer leaves should he have had to swallow them. With the drugs the addict usually proceeds to his room which is probably located in one of the cheaper hotels or rooming houses. He will look around carefully to make sure no police officer is awaiting him. After checking his room, the addict will pick up his paraphernalia for using the drug. It is rarely kept in the room, but rather will be hidden in an adjaecent hallway, bathroom or toilet. Returning to his room, he locks and bolts the door, sometimes even barricading it with chairs or other furniture. The addict will often wait for a short period after this step has been taken in the event that he has been followed by

the police, who might break in the door in an effort to catch him with incriminating evidence in his possession. When satisfied that the coast is clear, the addict then prepares to take his injection of drugs. There are only five to ten minutes involved usually in preparing and cleaning up afterwards. Paraphernalia usually consist of an ordinary teaspoon, a hypodermic needle, obtainable at any drug store, a few drops of water and matches, and an eyedropper.[1]

In recent years drug pedlars have resorted frequently to another method of getting drugs to the addict on the street. This method is commonly known as the "mobile" method of distribution. Several pedlars may join forces operating together. An addict wanting to buy drugs phones a certain pre-arranged number and the pedlar takes the order, at the sametime instructing the addict to wait on a particular corner. This corner will usually be in a more isolated area where there is the least possibility of police detection. One or two men drive around in an automobile for the pedlar. They have drugs with them and phone in to the pedlar periodically to receive from him the location of waiting addicts. On receipt of a location, the men in the car drive there and pick up the addict almost without stopping the car. They drive the addict around while the transaction is taking place, then let him out quickly and drive on to another contact.[2] This type of pedlar usually sells at a "wholesale"

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1. Mulligan, W.H. op. cit. p 65

2. Loc. cit.

price, - five capsules in a balloon for fifteen dollars, or sometimes three capsules for ten dollars. This method is extremely difficult for the police as the pedlar keeps the windows up and car doors locked, and will calmly swallow the rubber balloon of capsules while police are trying to break the windows and get into the car to seize the drugs before they disappear in front of their eyes. Making it additionally difficult for officers to follow in the police car and surprise the peddlars is the fact that they keep a sharp lookout, becoming very suspicious if a car following them makes even two changes of direction to coincide with their own.

From the foregoing accounts of methods used in distributing drugs and of precautions taken by those engaged in their use and distribution, it will be obvious how difficult it is for the police to catch distributors and addicts with incriminating evidence.

COSTS OF ADDICTION

When a person first becomes addicted he can get along with only one "fix" a day using 1/8 grain, but in time he finds that he not only needs a larger dose of drugs but needs it more often, until he is using one capsule to a "fix" four times a day. This is what the average addict is estimated to use although it has been known for addicts to use as many as fifteen capsules a day or more. Such addiction would probably consist of four "fixes" a day, each of three capsules.

Supposing the addict were able to buy his drugs at the "wholesale" rate of three dollars per capsule, he would need at least twelve dollars per day for drugs. To obtain this amount, the criminal addict must steal or obtain by other illegal means at least thirty-six dollars worth of goods, as stolen goods bring only about 1/3 of their actual value when disposed of through a "fence" or receiver of stolen goods.

Vancouver has now in excess of twelve hundred criminal addicts. If the figure of one thousand is used for the purpose of illustration, the following would be the cost of such criminal addiction in Vancouver. At twelve dollars per day each, this would mean twelve thousand dollars per day cash to keep all supplied, or a total monthly average of three hundred and sixty thousand dollars. To supply these one thousand addicts with their daily dosage for one year would cost approximatly four and one half million dollars. There is only one way for the addicts to obtain this money and a conservative estimate of the equivalent cost in crime would be ten million dollars.[1]

With regard to this situation one can readily appreciate the difficult task confronting the police. Not only do they have to try and cope with the problem of distribution and sale of drugs, but they also have to cope with the crime committed by addicts in their efforts to

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1 Mulligan W.H. op. cit. p 66

obtain the money necessary to support their habits.

It could be mentioned too that the foregoing do not represent all the costs directly resulting from the use of drugs. Consideration must also be given to the not inconsequential costs of maintaining convicted addicts in institutions. Another sometimes forgotten expense is the cost to private and public agencies of maintaining the families of addicts who are serving sentences. These represent only the financial costs and do not reveal clearly the human costs of uprooted homes. The sentence of a marital partner to prison frequently strains the marital relationship beyond repair. Homes are often permanently broken and children caught up in such "nightmares" suffer immeasurably from resulting deprivation. The problem of addiction as it now exists in Canada, involves psychological, social, medical and legal aspects.

Although addicts are seldom involved in crimes of violence, they resort to most other types of crime to obtain money for drugs. A common form of addict crime is theft. It is usually of a shoplifting nature although some addicts are adept at prowling hotels and rooming houses where they steal money, clothing and valuables of sleeping or absent guests. Addicts also turn to burglary forgery, strong-arming of drunken citizens, holdups and prostitution. Prostitution is also of concern to public health officials because of the spread of venereal disease, tuberculosis and other communicable disease.

AN ASSESSMENT OF CANADA'S OPIUM AND NARCOTIC DRUG ACT

The Opium and Narcotic Drug Act was originally enacted in 1908 to end the legal sale of opium for smoking. Since that time it has been periodically ammended to restrict or prohibit the sale of other narcotic and less dangerous drugs and to regulate a system of licensing and control for the licit use of these drugs for scientific and medical purposes. It has stated penalties for violations of the Act in its various parts.

The enforcement of the Opium and Narcotic Drug Act is the responsibility of the Federal Government. The Royal Canadian Mounted Police seek to control the illegal importation and sale of narcotics. The Department of Health and Welfare through the Division of Narcotic Control, is responsible for the legal importation and distribution of drugs.[1]

Barbiturate Drugs and their use is governed by the Food and Drugs Act. While barbiturates can also cause addiction and greatly impair social functioning, this act will not be discussed here.

A great number of addicts feel that the prohibited use of opiates is an infringement of their rights as a minority in a democracy. They claim to have just as much right to use heroin legally as others have to use alcohol. They regard heroin as a substitute which gives them greater

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1 Kirkpatrick, A.M. "New Approach To Drug Problem Suggested", Reprinted from the Canadian Bar Journal, Vol. 2, No. 6, Nov. 1959

comfort than does alcohol. While this view might have some superficial plausibility, it must be remembered that the majority, through Parliament, must evaluate the rights of minorites as they relate to the general public welfare. In so doing, Government, not only in Canada but in most other countries of the world, has decided that heroin and certain other drugs should not be available for private use.

Curiously, the Opium and Narcotic Drug Act does not make it an offence to be a drug user (with the exception of the smoking of opium.) It only makes it an offence to be in possession of narcotic drugs.[1] The Act does not seem to be concerned as to why some people seek possession of narcotic drugs. The mandatory minimum sentence of six months for possession implies a period of "treatment" for the addict. However, it is worthy of note that in most Canadian prisons, there has been little or no attempt at or facilities for the treatment of addiction. It is also realized by most criminologists and penologists that a prison sentence should be a punishment of last resort.

The punitive features of the Opium and Narcotic Drug Act have become increasingly severe since 1908 when there were no laws prohibiting the use of opium for pleasure. It is not in the penalties alone however that the addict appears to be under a special disability. An example might be cited in the case of an individual found in possession of several capsules of heroin. He may be required to prove that he did not have these

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1 See Glossary re. "narcotic drugs"

for the purpose of trafficking. The onus is on him to prove his innocence of intent to traffic in narcotics. This is very much in contrast to the well recognized principle of British justice by which a person is deemed to be innocent until proved to the contrary beyond all reasonable doubt.[1]

A further hardship inflicted on individuals convicted under the Opium and Narcotic Drug Act has been their inability to be considered for parole. For most types of conviction a person undergoing sentence may be considered for a remission if he has served a specified portion of his sentence. However, the National Parole Board of the Department of Justice has usually chosen to exclude persons convicted under the Opium and Narcotic Drug Act from such consideration. Of late, however, there has been some relenting in this regard although the attitude towards such offenders does not appear much to have changed.

The present punitive appraach to drug addiction has not been an effective deterrent to the addict motivated by the need for drugs or, for that matter, to the non-addict dealer in pursuit of substantial profits. The illicit traffic has not been suppressed and neither has the spread of addiction been prevented. This is not to suggest that the law enforcement efforts to control addiction should not be continued in order to contain this social peril within the smallest scope.

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1 The Stevenson Report, 1956

That the addict himself is considered a criminal is a great pity for he really represents a profound medical problem. It does not follow however that crime and the use of drugs are mutually exclusive of one another; they go very much hand in hand under present legislation. Regardless of the criminal associations which may have led to the taking of the drug, or the prior delinquency which might have led to these associations, or of the subsequent criminality to maintain the habit, the addict is, in a very real sense, a sick person and in need of the help of the medical profession in co-operation with various adjunctive helping professions such as social work and psychology. The addict is in the grip of a disease which has a pathological effect on him beyond his power of control.

In view of this, it is also arguable that penalties for illegal possession of narcotics are unreasonably severe when the addict is found to be in possession of relatively small quantities of drugs for his own comfort and enjoyment. The purpose of this part of the Act is to eradicate the illegal traffic in narcotics. Where convictions are of a trafficking nature severe sentences are understandable. However, if there are special circumstances in connection with any given case which might warrant a different approach, it would seem desirable that the court should be allowed discretionary powers to suspend sentence or to impose a fine. At present magistrates have no authority to do either and must sentence the addict to at least the mandatory six month sentence. As aforementioned this sentence implies a period of "treatment" which cannot possibly be carried out to any extent in most Canadian prisons.

One further question is posed by many who wonder why "medical" addicts (when their need for narcotics for medical reasons no longer exists) and, "professional" addicts should be given favoured treatment as compared with that given to the so called "criminal" addicts. If addiction itself is the real enemy and illegal possession of narcotics the assigned reason for legal action, then both the "criminal" addict and the "professional" addict are in exactly the same category after the latter's right to have narcotics for professional purposes has been suspended. Although it is not suggested that addicted physicians be sentenced to prison, it is suggested that the law deal with both in the same manner.[1]

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1 The Stevenson Report 1956

CHAPTER III

THE PANABODE UNIT FOR MALE ADDICTS

In British Columbia, the first two treatment and rehabilitation units for narcotic drug addicts were established within Oakalla Prison Farm in 1956. It was felt by those involved in bringing the units into being that any name including or making reference to drug addiction should be avoided lest there be inclination among those inmates selected for treatment to feel that drug addiction was their only problem. The name finally decided upon for the units was Panabode. Literally, Panabode is an abiding or dwelling place for a group with a common bond or union. In this case, the common bond is their drug addiction.

LOCATION AND DESCRIPTION OF BUILDINGS, PROPERTY, FACILITIES

Within Oakalla Prison Farm the male Panabode unit is located north of the main jail between the former Young Offenders Unit and the Westgate unit.[1] Structurally, the unit resembles a modern log cabin approximately the size of a four bedroom home. The building is located near the front of approximately two acres of Panabode property all of

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1 The Westgate unit is the top classification unit within Oakalla Prison and contains those inmates who are believed to be the best prospects for rehabilitation

which is segregated from the larger jail units. It is meant to accommodate no more than eleven male addicts at any one time.

East of the male Panabode is an asphalt surface on which there is a lined court where basketball, tennis, volleyball and such sports may be played. In addition, this hard surface is large enough along the northern sidelines of the court to allow for such outdoor work projects as lawn tables, chairs and children's playhouses. Several of these projects might be under construction at one time without endangering games participants on the courts.

Immediately behind the Panabode hut is a small workshop which is only 16 feet by 30 feet. Power equipment in the shop included a table saw, a jig-saw, two sanders, a lathe, a jointer-planer and a drill press. In addition there is an adequate supply of hand tools. Work projects in the shop include everything from small and simple children's toys to ashtrays, elaborate small tables and lamps. When the weather demands that all panabode inmates work inside the work shop it will be obvious why conditions are considered crowded and conducive to neither good work nor good morale. It has been encouraging news for both staff and inmates to learn recently that they will be allowed to build a cement basement for the work shop onto which it will be moved. It is understood that this construction will commence immediately and will allow considerably more room for tools, equipment and supplies, as well as for improved working conditions generally.

Further behind the unit and the asphalt games surface is a small soccer field which continues part way behind the former Young Offenders' Unit. This field is levelled off the side of the hill on which Oakalla Prison Farm is located so it remains well drained. This field has been the property of the Young Offenders Unit but since that unit has ceased to exist as such, it is reasonable to assume that the Panabode unit will have the use of the field.

The Panabode poperty to the West and North of the soccer field has been cultivated and provides a very helpful gardening project during the spring and summer months. Inmates of the Panabode reportedly have taken considerable pride in their garden and last year contributed 4000 pounds of vegetables for the Oakalla kitchen.

The Panabode hut itself is an attractive modern building 25 feet wide and 60 feet long. An attractive and compact kitchen, 12 feet square, contains a modern electric stove and refrigerator. There is a large sink and adequate cupboard space which still allows for good lighting. The kitchen is located in the north-east corner of the building and contains a rear entrance to Panabode on the north side. A room the same size and located next to the kitchen in the south-east corner of the building serves as an office. It contains a large office desk and chairs, a steel filing cabinet, a large steel medicine and supply cabinet, cupboard space for stationery and other office supplies and book shelves with a small supply of selected literature and pamphlets for both staff and inmates.

Immediately next to the office and kitchen is an L-shaped room which serves as a dining room - living room area. There are additional magazine shelves in this room and adequate living room and dining room furnishings which include a combination radio-record player and a considerable supply of records. The front entrance into the Men's Panabode opens into this room.

The bathroom is located in the middle of the building on the north side. It has a shower, two toilets and two wash basins.

Directly opposite the bathroom but opening into the living room area is another small glass office. At present this office is used mainly for the storage of small toy craft and such sports equipment as tennis balls and racquets, volleyballs, softballs, baseballs and gloves, and boxing gloves All told, there would appear to be an adequate supply and quality of sports equipment.

Approximately half the Panabode hut is given to the dormitory. Each inmate has a semi private area with a place for personal clothing and permissible effects, his bed, a small writing desk and a lamp. There is a third entrance in the middle of the West end of the dormitory for emergency use only. Emergency fire fighting equipment is strategically located throughout the entire building.

PHILOSOPHY OF THE PANABODE UNIT

The writer could not find in the policy mannual or in administrative memoranda where the philosophy or purposes of the Panabode unit were actually spelled out. However, judging from observations and existing policy, it would appear that the program is offered for selected male drug addicts who it is felt are more accessible for rehabilitation and who are motivated to abstain from crime and the use of drugs;; who it is felt will benefit from the association, socialization and program offered by the Panabode unit and its staff. The program includes such features as educational and informative films, guest speakers, religious services, counselling, educational courses, work and recreational activities. Through such program and activities, argument and entreaty are united in an effort to dissuade inmates from the undesirable courses of their past. Perhaps something further is remonstrated for the addicts when there is set forth the danger and guilt, as well as the consequences of continuing the same asocial and antisocial courses of action which have led them to addiction and to prison.

An attempt is made to give the inmate better insight into himself and his manner of functioning,and to provide him with a better outlook on and respect for society and his role as one of its members. As indicated above, education is made available to the inmate through correspondence courses. Some individual help is provided in this learning process although the unit does not have a qualified teacher at present.

In addition to the foregoing, it is popularly believed in the

community as well as in the prison itself, that a considerable amount of research is being carried out in the Panabode unit. It is somehow considered that dynamically significant information is being gathered continuously; that new and improved methods of preventing and treating drug addiction are being sought and tested; that adequate and well trained staff under carefully planned supervision and direction are carrying out bold new experiments in never-ending search for some of the answers to the profoundly baffling problem of drug addiction!

These views may not represent a very accurate assessment of the research that is commonly thought to be carried out within the Panabode unit. However, one is led by political statements, newspaper reports and articles in correctional, sociological and social work journals, to believe that a considerable amount of research is being carried out.

ADMINISTRATIVE STRUCTURE AND PERSONNEL

The administrative structure of the larger prison is reviewed here superficially because it does have implications for the administration and personnel of the Panabode unit. The senior administrative person within Oakalla is, of course, the warden. From the warden down, the adminisration is divided into two areas - treatment and custody. Next to the warden therefore are the deputy warden of treatment and the deputy warden of custody. Each deputy warden is in charge of his respective area of either treatment or custody.

Next to the deputy wardens, continuing down the line of both treatment and custody, are the assistant deputies, the senior correctional officers, and the senior prison guards. Staff below this level are known as guards. They may be temporary guards or serving their probationary period of six months. There are five classifications of guards after they have completed their probationary period of service and continue on permanent staff. In all areas of the prison other than in the Panabode unit, the male guards wear prison uniforms. There is secretarial, stenographic and switchboard staff serving both custodial and treatment officers. In addition there are book-keeping and business office staff but neither of these two staff groups have much to do with the Panabode unit.

Within the Panabode unit the officer in charge is a social worker with a Bachelor of Social Work degree.[1] He is the only staff member required to wear a prison uniform. Personnel under him, both treatment and custodial, wear a grey suit much like that which might be worn by any business man. At present there is only one treatment person in the Panabode other than the officer in charge of the unit and he has been developed from the ranks of custody. It is noted however that custodial personnel within the Panabode concern themselves to a considerable extent with treatment aspects of program. While this is commendable in one respect, treatment personnel should have better qualifications, a diversified background and training appropriate to the roles and responsibilities they are expected to assume.

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1 The officer in charge of the Men's Panabode is Joseph E. Clegg. His rank in this capacity is that of Senior Prison Guard

One of the unit's former treatment personnel has recently been assigned to the duties of the discharge follow-up officer. He is not a trained social worker although he does have two years of university education towards a degree in theology. In addition to the two treatment personnel there are three custodial officers. A part-time prison psychiatrist is official director of the Panabode rehabilitation and research unit but functions largely as a consultant.[1] A medical Doctor,[2] two part-time dentists and a psychologist are all qualified professional people on the staff at Oakalla and represent significant services, both direct and consultative, for the Panabode staff and inmates.

CLASSIFICATION

Rather than discuss the classification process generally, it will simply be discussed as it effects those addicts who might be selected for the Panabode treatment program. Perhaps classification is a misnomer because drug addicts are not classified at present; they are simply allocated to the east wing of Oakalla Prison.[3]

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1 The psychiatrist who is director of the Panabode Research and Rehabilitation unit is Dr. G.H. Stevenson.

2 The doctor in charge of the medical aspects of the prison and also a qualified psychiatrist is Dr. R.G. Richmond.

3 For more detailed information on "Classification", reference is made to the thesis of Beighton, Alan L. Classification of the Criminal Offender, Master of Social Work thesis, University of British Columbia, 1958

Any person who is convicted under the Opium and Narcotic Drug Act and sentenced to Oakalla is allocated to the east wing of the prison. Any person sentenced to Oakalla who is a known drug user or who has had a previous conviction under the Opium and Narcotic Drug Act will similarly be allocated to the east wing regardless of the nature of his present offense. Any inmate can request withdrawal treatment and will be sentenced to east wing as will any inmate, regardless of his offense, who is obviously undergoing withdrawal.

The east wing unit of Oakalla Prison is composed of a hardened recidivating group of inmates which includes the addicts stated above and also those incorrigibles who will not fit into classification and program as offered in other units of the jail.

SELECTION FOR THE PANABODE PROGRAM

It has been stated that the east wing of Oakalla prison contains a generally hardened, resentful, recidivating group of inmates. There will occasionally come before classification officers young inmates who have not been long addicted to narcotic drugs and who have not developed the criminal tendencies so common to a large percentage of addicted persons. Influenced by this, their age, conviction, length of sentence, the probation report and other factors, the classification officers may sometimes judge that an inmate otherwise destined for east wing unit may be a good prospect for the Panabode treatment program. Such cases will be brought

to the attention of the officer in charge of the Panabode unit by both formal and informal methods.

The treatment officers of the east wing will sometimes be approached by inmates wishing to enter the Panabode. These officers may support such requests or may suggest other names as more suitable.

As prospective candidates come to the attention of the officer in charge of the Panabode unit, they are interviewed by him and a brief social history taken. The inmates behavior, work, attitude towards rehabilitation and his estimated ability to reform are included in the history.

When there is about to be a vacancy in the Panabode unit through discharge of an inmate, social histories of the most suitable east wing candidates are discussed by the prison psychiatrist and the officer in charge of the Panabode unit. The prison psychiatrist is responsible for setting up the program to be followed at the Panabode unit but the officer in charge of that unit has considerable influence as to which inmate is selected. Usually, there is agreement on which east wing inmate should be selected and a joint recommendation is submitted to the administration for their stamp of approval. Where there is disagreement between the prison psychiatrist and the officer in charge of Panabode, the decision is usually made by the Deputy Warden of treatment.

Upon transfer to the Panabode unit the new group member is introduced to the others and is then oriented to the unit. An effort is made to

make the new member feel welcome and as comfortable as possible during this initial period. From the beginning of orientation however, new members are expected to show their mettle. Many new privileges and advantages are acquired but considerably more is expected of them in return. The length of time an inmate may spend in the Panabode unit will depend on the length of his sentence or the remaining portion of it, but it is not likely that an inmate would be accepted into the Panabode unit, particularly on his first offense, unless he could benefit from at least four months of the program.

After a fair trial placement the new member who is not felt to be capable of helping himself or who is unduly disrupting of the group is returned to the east wing. He is given to understand from the beginning that the program is treatment oriented and that anything which does not contribute to treatment will not be tolerated.

POLICY AND PROCEDURE

Some of the specified policy and procedure of the male Panabode is discussed here for the purpose of clarifying in some degree the manner in which the unit and its entire program are administered.

FOOD - Meals are prepared by selected inmates. All food served is good food and is as well prepared as it would be in the average home. Staff are expected to partake of meals with the inmate group while they

are on their regular shift.

CLOTHING - The inmate's clothing and personal effects are numbered and checked on his admission to Oakalla. These are not returned to him until his discharge from prison except on rare occasions. On admission to the Panabode unit each inmate is provided with a complete issue of bedding and clothing. This issue is inspected from time to time and each inmate is responsible for the care of his own issue. Clothing which has been issued but which can not be produced by the inmate is dealt with in the Warden's court unless that inmate is obviously not guilty of the loss or damage to his issue.

LAUNDRY - All dirty laundry is conveyed to the main jail laundry at 8 A.M. each Monday and is picked up the same Monday afternoon. Inmates receive the same clothes back again and are expected to use some acceptable identification system.

MAIL AND COMMUNICATIONS GENERAL - Inmate mail, incoming and outgoing, is censored and recorded in the individual report book. Inmates are allowed to write four letters each month but may receive all outside mail sent to them. The main jail rules apply also to the mail of Panabode inmates in that people in the institution may not be discussed nor may the affairs of the institution. All questionable or unacceptable material is cleared through the officer in charge of the unit. It is a Panabode rule that all communications, requisitions, work orders on Panabode business, and all inmate requests be cleared through the officer in charge of the unit unless he is on annual leave, in which case this matter must be cleared through the senior custodial officer on the day shift. If communications are

marked "confidential" they are handled by the treatment officer. Any communications marked "private" are the concern only of the addressee.

DRESS - Shirts must be tucked in and buttoned to, but not including the top button. Dress must be complete and neat in all areas except the dormitory and the washroom. Shorts may be used in sports and sunbathing activities only. Shirts may be removed in hot weather in the rear work areas only.

SPORTS - Inmate sports activities will not involve Panabode members with inmates from Young Offender's Unit or the East Wing unit. Panabode inmates may try out for Westgate teams which play some of their games outside the prison. Westgate runs this program and Panabode inmates and staff may only attend the Westgate sports activities under their direction. The Westgate and the main prison field may be used but must first be cleared through the officer in charge of Westgate. There are to be no sports activities or conspicuous noise of any kind during church parades on Sundays.

CHURCH - It is the definite wish of the director of rehabilitation - Dr. Stevenson that all inmates attend a weekly church service of their own choice (there are only a Roman Catholic and a Protestant service each Sunday.) This is not compulsory but is considered desirable and beneficial. Sports activities, including sunbathing, are not allowed during church service. Radio and other noise must also be minimized during this period.

MEDICAL - A brief report is to be made in writing of any injury to either inmates or staff. All medication is supplied by the prison doctor except for minor cuts or scratches. Inmates or staff members who

are injured should be reported promptly to the hospital. Inmates receive a medical examination on admission to Oakalla and a statement is made by the prison doctor as to the inmate's ability to participate in program, work and sports. There are no routine medical check-ups after the initial one and further medical attention must be requested. When specialist consultation or treatment is advisable the inmate is transferred to the Vancouver General Hospital.

DENTAL - Inmates receive prophylactic dental attention from dentists who visit the jail twice weekly. Fillings and extractions are done at no cost to the inmate but dentures, bridgework and other than preventive or emergency dental attention must be paid for by the inmate or some responsible person.

LIBRARY - Each inmate may borrow two books from the Westgate library. These may be exchanged for two other books. Some individual selection of books and magazines is made available through a check with the Westgate officer in charge of the library on each occasion that books are requested.

NARCOTIC ADDICTION FOUNDATION - Any inmate interested in residence at the Narcotic Addiction Foundation or in the Foundations' after-care assistance is to be reported to the officer in charge of the Panabode unit who will submit a report to the Foundation.

CUSTODY - The male Panabode group are to be supervised at all times and as often as possible inmates must be kept in one group. The officer in charge of custody during a shift is responsible for the supervision and good custody of the unit as well as for the protection and safety of visitors.

Inmate misbehavior of a minor nature which does not automatically require Warden's Court proceedings has to be handled immediately by the staff member involved. The method used must have a two-fold purpose. First, control of the situation must be maintained. Secondly, any incident should be dealt with so far as possible in a manner contributing to the growth and understanding of the misdemeanant. Therefore, if an inmate is misbehaving he should be immediately taken aside from the group and told about it in a fair but firm manner. If he continues to misbehave, he is again told about it and is told as well that if he continues he is placing the staff member in a position that involves no alternative but to take action.

This action must always include submission of an adequate report on the incident to the officer in charge of the unit. If this officer is present at the time when action must be taken, the inmate should be paraded before him. If the senior officer is not on duty, the incident should be discussed with the officer on duty in charge of custody for the unit. Unless warden's court appears necessary, the erring inmate is reported to the officer in charge of the unit who will take the necessary action.

Where Warden's Court or isolation placement is involved, the senior custodial officer on duty presents the problem inmate to Warden's Court as soon as possible on the date of the incident. If the warden or deputies are not present the matter has to be brought before an assistant

deputy. If no assistant deputies or higher officers are on duty, any isolation placement is done through the senior officer on duty with Warden's Court to follow as soon as possible.

The entire group of inmates must be supervised at all times. When the group retires, periodic checks must be made, but there must also be a constant alertness maintained. In counting the inmate group after lights-out officers should make certain that it is an inmate they are counting and not a roll of blankets. Checks should be made for movement, breathing and other signs of life.

While every effort is to be made to cooperate with treatment officers and program, custody is the first concern of the unit. The officer in charge of custody makes the custody decisions and is to remember that the first consideration is the effective operation of the unit for good custody, security, supervision and safety. The inmate group should not be taken on errands about the grounds unless no other alternative is feasible. Staff should run errands alone as a general practice.

JOINT INTERVIEWS - These are interviews arranged by the officer in charge of the Panabode unit with a relative or a close friend of the inmate. Such interviews begin approximately three months before the contemplated discharge of the inmate. The inmate is first interviewed alone in preparation for the joint interview and he selects the person with whom he hopes to have such interviews. This person might be a wife a father or a mother or, if no close relatives exist, a close personal friend may be selected. The officer in charge of Panabode then has an orientation interview with the relative selected by the inmate preparing

that person for the joint interview and the manner in which it is to be conducted. A date is then set for the joint interview. The inmate and relative then meet as arranged for an interview in which a staff member is also present. The staff member will only contribute to the interview if he can make a positive contribution or suggest subject matter that should be discussed preparatory to the inmate's discharge. The staff member may find himself frequently in a position where he is able to offer valuable counsel and advice which is very much appreciated by the interview participants. Once these joint interviews have been set up they may then continue on a once-a-week basis. A staff member is present at all arranged interviews.

OUTSIDE VISITORS - All outside visitors must be cleared through the officer in charge of the Panabode unit or the Deputy Warden of Treatment or the prison psychiatrist. Outside visitors are to cleared in and out of the gatehouse and escorted to and from the prison's visiting room. All such visits are recorded and filed.

THE OFFICE - The Panabode office is to be kept locked when not under direct supervision. It is out of bounds except by special permission.

PHOTOGRAPHS - Photographs of family or friends are acceptable on shelves of the individual inmates cabinets. Other pictures, pin-ups, or crude pictures are not allowed on the wall of the hut although certain pictures may be cleared by the officer in charge of the unit.

PROGRAM

The Panabode group arise each morning except Sunday, at 7:00 A.M. They dress, tidy their own private quarters and wash. Breakfast is at 7:30 A.M. The entire group spend the period from 8:00 to 8:15 tidying and cleaning the Panabode hut. Work begins at 8:15 A.M. and as a rule is either in the woodwork shop or in the garden. Woodwork projects are sold to staff at cost plus a small profit which goes towards the Oakalla Welfare Fund. This fund is used generally for the purchase of sports equipment and comforts for the inmates.

There is a fifteen minute coffee break for the group at 9:30 A.M. They then return to their work projects until lunch time at 11:30 A.M. One hour is allowed for lunch. The group then clean the hut and return to the day's work projects. Each morning of the week, Monday through Saturday, follows in the foregoing manner except for such interruptions as general clean-up or other periodic projects or prodedures. Work continues each afternoon, Monday through Friday, until the 15 minute tea break at 3:00 P.M.

Following tea break on Monday afternoons there is a general discussion group which may last until supper at 4:30 P.M. These discussions usually concern matters of common interest to the group or topics of current public interest. They are given focus and supervision by the officer in charge of the Panabode unit or some treatment person designated by him.

During this period on Tuesday, Thursday and Friday afternoons there are educational films and discussions and mental health films which are also followed by discussion. These too are supervised and conducted by the officer in charge of the Panabode or by some person designated by him.

Each Wednesday afternoon following tea break, the prison's Protestant minister visits the group and either speaks to and with the group or shows religious films, after which there is general discussion. Religious support is also extended to the group when on Tuesdays, the prison's Catholic padre visits to have lunch and a discussion with the group.

Each day supper is served at 4:30 P.M. After supper there is general clean-up of the hut again and each day the time between 5:00 P.M. and 6:00 P.M. is free time or may be given to participation in sports activities.

On Monday, Wednesday and Friday evenings between the hours of 6:00 and 9:00 the Panabode inmates share a gymnasium and hobby program with the inmates from the Westgate unit. The group gives an hour and a half to games and gymnastics for physical fitness. The other hour and a half is given to hobbies of the inmate's choice. These might include leatherwork, copperwork or other metal work, the small woodwork projects such as lamps, ashtrays or ornamentals. There is also a very active and enjoyable music group composed of those who play musical instruments. They practice in

groups and often make tape recordings of their arrangements.

Tuesday and Thursday evenings between the hours of 6:00 and 7:30 the group members work on their education. Each inmate is expected to take at least one correspondence course while at the unit. From 7:30 to 8:30 P.M. on Tuesday evenings there have been general discussion groups but this period is about to be changed although it is not settled as to what use it will be put.

Thursday evenings from 7:30 to 9:00 the Panabode inmates use for their outside visitors program. Outside visitors might be doctors, lawyers, politicians,dentists, business men and such. This program, aside from being informative for the inmates, has the purpose of subtly indoctrinating the group with some of the advantages of successful social adjustment.

The period from 9:00 to 10:00 each evening is free time for the group but all are required to retire at 10:00 P.M. and are supposed to remain quiet after 10:20 P.M.

Saturday afternoons and Sundays are free time for the Panabode group. Rising on Sunday mornings is at 9:00. Catholic church services are held at this hour and Protestant services are held later in the day. Only one Catholic and one Protestant church service is held each Sunday. Members from all jail units attend these services if they choose but attendance is usually very sparce.

There is usually a feature moving picture for the group every second Sunday afternoon.. Otherwise they can read, work at their hobbies, participate in sports activities or use this free time as they wish.

Frequently, during the weekend free time, there are joint interviews for the inmates. These interviews represent a step towards working with the inmate's family. In these joint interviews, a member of staff, the inmate and an important relative, discuss problems, misunderstandings and areas which need concern and adjustment. It is usually the inmate's wife or parents who are involved in these joint interviews.

Inmate sport activities do not involve interaction with East Wing inmates although some activities are shared with the Westgate inmates. Panabode inmates may try out for Westgate teams which participate in outside community games. Nearly all Westgate teams have Panabode inmates on their roster.

Work,recreation and educational program as scheduled is mandatory for all inmates who are medically able to participate. The entire Panabode group must work or operate together as a group except on rare and carefully cleared occasions and the group must be supervised at all times. The way in which inmates participate in program is quite important as it reflects the attitude and intentions they have regarding their future.

Each month two sets of rating scales are completed on each inmate in order to provide an assessment of his efforts and progress during the

month. One rating scale attempts to measure the inmate's conduct and interaction in group activities. Components of this scale are: attitude towards authority, attitude towards other inmates, attitude towards self improvement, attitude towards rehabilitation, attitude towards responsibility, appearance and personal habits, participation in group program, how group reacts to his presence. The other rating scale attempts to measure the inmates performance and attitude towards work. Components of this scale are: amount of work done, quality of work, guidance necessary, attitude towards responsibility, attitude towards authority, attitude towards other inmates, attitude towards self improvement, attitude towards rehabilitation. Two staff members complete each rating scale on the inmate and the average score is determined for a more reliable picture.

Another factor which enters monthly ratings is a simple statement completed by the inmate wherein he is requested to -

> "List the names of the three inmates of the Panabode (male) whom you would most prefer to work alongside, to attend hobby classes with and to sit next to you at the meal table."
>
> 1. .....
> 2. .....
> 3. .....

To give inmates incentive for better achievment, a sliding scale of pay has been established on the basis of their scores. Attitudes, performance and interaction with the group are measured and final scores take into account the individual's capacity and any exceptional improvement. Those with a total score between 80 and 100 per cent receive 30¢ per day; those with a score between 65 to 79 per cent receive 20¢ per day; and those with a score anywhere from 0 to 64 per cent receive 10¢ a day.

DYNAMICS OF THE TREATMENT PROCESS IN PROGRAM

The general purposes and treatment goals of the Panabode unit have only been presumed in a general way by the writer as it could not be found within the prison that they were clearly stated. Nevertheless, an attempt is made here to describe briefly the extent to which program embodies and fulfills the treatment goals which were presumed.

It seems to be expected by those involved in the treatment program that films on mental health subjects, attendance at religious services, talks from and discussions with outside visitors of stature in the community - all help to create an uneasiness in the inmate with regard to his asocial and antosocial behavior including his problem of drug addiction. It is believed that segregated group living and constant association with each other gives the group a sense of identity and unity permeated by a healthy motivation to refrain from the use of drugs and to become useful and contributing members of society.

Program is designed to engender this motivation by providing the opportunity and facilities for inmates to acquire new knowledge, abilities and skills through educational, work and hobby classes. These phases of program are all designed to improve the inmates ability to contribute to society in a positive way and to gain satisfactions therefrom.

FOLLOW-UP OF DISCHARGED ADDICTS

The male Panabode unit had one person who functioned as a post-discharge follow-up officer. He was qualified in that he had a B.S.W. degree but only worked in this capacity for six months. With the exception of this six month period, the Panabode unit has provided no follow-up care or attention for its discharged inmates since the program's inception in 1956. As of March 1960, however, the unit again has a discharge follow-up officer. He has been developed from the custodial staff of the male Panabode, has worked as a treatment person in that unit and now has taken on the duties of discharge follow-up.

The duties involved in his position do not appear to be very well outlined yet, and one gets the impression that he is left considerable freedom as to which follow-up duties and responsibilities he should assume. At the present time this officer is speaking to school students, service clubs and prospective employers throughout the Lower Mainland. It is this writer's impression that these talks are an attempt to inform the public of the problems with which the addicted person is faced on his discharge from prison. These problems might include rejection, condemnation, little chance to locate gainful employment, no one to turn to for acceptance, friendship and concern but former associates and criminals who can only influence him in returning to his former habits of crime and addiction.

There is much despair for many addicts during the first days

following their discharge from prison. In clarifying for public groups the situation of the discharged addict from prison, the follow-up officer is also making a concerned appeal to them to accept these persons for employment, to accept them socially and include them in healthy activities, to help them through the many difficulties which exist and arise for them following discharge from prison. The follow-up officer also concerns himself with finding suitable and satisfying jobs for discharged addicts. When there is no close friend or relative who can assist, the follow-up officer must also be concerned with finding a suitable place for the discharged addict to live.

The friendship, help and concern offered addicts during the early days following release from prison can do much to support, motivate and encourage them in a positive direction and might provide them with enough security and satisfaction to enable them to avoid the use of drugs. In a superficial manner, the foregoing represents this writer's impression of the main duties, concerns and responsibilities of the Panabode's discharge follow-up officer.

CHAPTER IV

THE PANABODE UNIT FOR FEMALES

The Panabode Unit for Females will be discussed in much the same manner as was the unit for males. Because of the similarities that do exist between the two units, more brevity is given to the discussion of the female unit.

LOCATION AND DESCRIPTION OF UNIT, PROPERTY, FACILITIES

Built in 1956, at the same time that the male unit was built, the female Panabode is located only a few feet directly west from the main Women's Jail. The Women's Jail itself is located in the south eastern sector of Oakalla Prison Farm approximately 80 yards from the Men's Jail. The female Panabode is the same size as the male unit and is structurally similar in all respects so far as this writer could determine. A possible exception is that there is slightly more privacy in the dormitory area of the Women's Panabode, with individual cubicles being separated to the ceiling whereas the male cubicles are only divided to a height of five feet, leaving the upper portion of the dormitory clear. Because of this one might get the impression that the dormitory is not as large in the female unit.

The Women's Panabode is able to accommodate only ten addicts compared to the eleven which the male unit accommodates. An automatic washer and dryer and a power sewing machine occupy in the women's unit the area which would otherwise accommodate another inmate cubicle.

In the women's unit, the room used as the office is the central glassed-in room near the unit's main entrance. Furnishings are similar to those of the male Panabode unit.

While one would not be critical of the cleanliness and tidiness of the men's unit, it is not so well kept and cheerful as the women's unit. The reason for this could probably be reduced to "the woman's touch" which adds considerably to the atmosphere in the women's unit. It is perhaps difficult to break down this difference between the two units but some of the writer's observations regarding the female unit concerned its brighter and more cheerful curtains, the greater detail given to every aspect of the cleaning, the well kept floors, the better preparation of meals, the spray of flowers, and the more orderly appearance of the unit while maintaining a relaxed lived-in or home-like atmosphere.

Other than the unit itself, the female Panabode does not have much additional property as does the male unit. A lawn which is a few feet wider than the building itself and approximately fifty feet in length is bordered with some shrubbery and flowers and all this is kept up by the unit's inmates.

For recreational purposes the female Panabode has the use of the main ball field immediately west of the unit and also uses another field south of the Women's jail to play ball, grass hockey and such field games. In addition to these two areas, the Panabode women have the use of the gymnasium in the Women's Jail and also share the use of the men's larger gymnasium. There is an asphalt badminton and volley-ball court immediately north of the Women's Jail and the female Panabode also shares the use of this court when weather permits.

PHILOSOPHY OF THE PANABODE UNIT

The philosophy, goals and purposes of the female Panabode are not spelled out as was the case in the male Panabode. Although the women's program is more diversified than is the men's, the female Panabode itself does not have the staff that the male unit does. This is probably due to the fact that on the female side, Panabode inmates have a great deal more interaction with the other inmates of the Women's Jail than Panabode inmates on the male side have with those of the Men's Jail. Female Panabode inmates take hair dressing, school correspondence courses and home nursing side by side with the other inmates of the Women's Jail. Most recreation is also carried out together with inmates of the Women's Jail.

The amount of interaction between the female inmates of Panabode and those of the main Women's Jail makes it difficult to separate the philosophy, goals and purposes of the two units since they are so intertwined. In a general way, however, one might say that the philosophy, goals and purposes of the female Panabode are somewhat similar to those of the male unit. There is no social worker on the female Panabode staff and the prison psychiatrist does not provide much individual attention to inmates. One is inclined to assume therefore that there is not the same opportunity for female panabode inmates to gain insight, self-awareness and guidance to face the future.

One would expect a pilot project like the Panabode unit's to include in its purpose something of significant research value. However, information on individual inmates of the female Panabode is sparce, as is recording on their progress and development while at the unit. While there would appear to be a better effort on the part of female Panabode staff to keep track of discharged inmates and to determine whether or not they are again using drugs, little else is recorded that would be of real research value.

ADMINISTRATIVE STRUCTURE AND PERSONNEL

Perhaps the administrative structure within the Women's Jail does not have the same significance for the female Panabode that it does in the male Panabode. The person in charge of the Women's administrative structure at Oakalla Prison is the Senior Matron. Her rank would correspond to that of the Assistant Deputy Warden on the male side. Because of her position, she has to concern herself with both the treatment and the custodial aspects of corrections. She is directly responsible to the Warden of the male prison in the performance of her function.

There is only one staff member per shift in the female Panabode or a total of three personnel. Only the afternoon shift Matron is considered a "treatment" person as she is in charge of the unit's group activities. During the day, the Panabode matron is responsible to the senior matron of the Women's Jail. In turn, each Panabode shift

matron is responsible to the acting Senior Prison Matron for the corresponding shift. While the prison psychiatrist is also Director of the female Panabode Rehabilitation and Research Unit, he does not work as closely with the female unit as he does with the male unit. The reasons for this may be many and varied but as a result the unit receives much of its direction from the Senior Prison Matron and rather than taking on a separate and unique purpose and program, it is more like an additional facility of the Women's Jail.

In defence of the training opportunities offered to the female Panabode inmates, it should be mentioned that the persons conducting the courses in hairdressing, school correspondence courses and home nursing are all qualified. For certification, examinations may be written either within the prison or outside on completion of their courses.

The inmates and staff of the female Panabode have the same access as the male Panabode to the direct and consultative services of the Prison's medical doctor, dentists and psychologist.

The discharge follow-up officer from the male Panabode has been acting in the same capacity with the women's unit since March, 1960. He has not been as active with the discharged inmates of the female Panabode as he has with the males. However, before March 1960, there was no follow-up care or attention for these discharged persons so his role with regard to the female Panabode at least represents a step forward.

CLASSIFICATION

The classification process, as it is believed to exist within the Women's Jail at Oakalla Prison, will be described here in only a superficial manner and with the purpose of outlining how eventually an inmate may be selected for the particular program of the female Panabode unit. Classification is a continuing process based on observation and study of the individual and aiming at the diagnosis of her delinquency or maladjustment and the prescription of activities which it is hoped will lead to her rehabilitation.

The female population of Oakalla Prison has varied between 80 and 120 inmates in recent years. For a prison this size, classification will very much depend on the nature of the prison population at any one time. In addition, classification must be related to the program and facilities of an institution.

Generally speaking, program at the female section of Oakalla is divided into two areas; the vocational and work program and the socialization and group living program. The vocational and work program is that program which takes place each Monday through Saturday, between the hours of 7:00 a.m. and 3:00 p.m. The "teams" and "classes" of this part of the program include maintenance, carpentry, sewing and mending, occupational therapy, kitchen, laundry, cosmetology, power sewing, home nursing and school (correspondence courses). Members from various classifications participate in this phase of the program, both

addicted and non-addicted persons of varying age groups, backgrounds and delinquency records.

However, for the socialization and group living aspects of the program, classification is more in evidence and, at present, is organized in the following manner:

Huts 1, 2 & 3	-	(separate cottage units) For the use of rural and native girls with short commitals of up to six months and with the main problem of alcoholism.
Cottage "D"	-	For non-addicted girls who are first offenders at Oakalla and who are considered to be good custody risks and more accesible to reform.
Cottage "E"	-	For young first offenders to Oakalla. They have a history of delinquency and usually have been formerly in the Girl's Industrial School.
Group 3	-	Drug addicts in their early twenties considered more accessible to reform.
Group 4	-	Less reformable and older confirmed drug addicts. They are a recidivating group with some deviants but are generally an active group.
Group 6	-	This is the admission group and would include those individuals for orientation to the jail and program, those individuals isolated for misbehavior or other reasons, those awaiting trial or transfer to Kingston Penitentiary, suspensions from other groups for poor behavior and persons who are ill or receiving medical treatment.
Group 7	-	This group consists of older women addicts and on the whole is a rather inactive group.
Group 8	-	This group consists of younger addicts and other non-addicted persons who are considered to be more accesible to reform.

These groups remain separated from one another during the socialization and group living phase of their program except for recreation periods, when some groups will combine their recreational activities with those of another group.

SELECTION FOR PANABODE PROGRAM

From the foregoing discussion of classification, it will be seen that there are addicted persons in each of groups 3, 4, 6, 7 and 8. It will also be seen that the groups where there is more likely to be positive motivation and concern for rehabilitation will be groups 3, 6, and 8. This does not always follow, however, as people do sometimes change their attitude, outlook and behavior. Occasionally, individuals who at one time were most inaccessible, defiant, hostile and generally difficult to control, may mellow somewhat, change their attitude and outlook and become well motivated to reform and to refrain from the use of drugs. The door must always be left open for such persons through continuous and objective evaluation and classification or reclassification.

Certain staff members, in carrying out the continuous task of evaluating the inmate's behavior, work habits, attitudes and outlook, will bring to the attention of the senior prison matron the names of individuals who might, in their opinion, be suitable candidates for the Panabode unit. Some of the staff who might be involved in this regard would be the Classification Officers, the various group matrons, the Padre or the Priest and the Matron in charge of custody.

It is understood that suitable candidates for Panabode receive psychological tests and that they are also seen by the prison psychiatrist for his evaluation of their attitudes, motivation and general suitability for the Panabode unit. His recommendations are returned to the senior prison matron who makes the final decision as to which individuals should be transferred to the Panabode unit. The Panabode matron does not takepart in the selection of individuals for the Panabode program.

It is difficult to determine the actual care and detail that is given to the task of selecting suitable candidates for the Panabode program but in a general and superficial manner, the foregoing represents the selection process for the female Panabode as it is understood to be carried out at this time.

It should be remembered too that at times such as the present, when the total female prison population is only 84, it may be difficult to select out of this number, 10 girls who would be suitable for the Panabode unit.

POLICY AND PROCEDURE

Policy and procedure is not spelled out specifically at the female Panabcde. However, most of the rules and regulations pertaining to the main jail apply here, and all procedures must be in line with the policy and practices of good custody.

Because there are no specific policies and procedures for the Panabode unit, pertinent policy will not be discussed here, but will be included or reflected in the section which follows on program.

PROGRAM

Under Classification, it was mentioned that the Program within the Women's Jail was divided into two areas. This also pertains to the Panabode unit as in many respects this unit functions like the other groups in the Women's Jail. The two areas of program are the vocational and work program and the socialization and group living program. The former program takes place daily, Monday through Saturday, between the hours of 8:00 a.m. and 3:00 p.m. The latter program takes place generally from 3:00 p.m. to 8:30 p.m. daily and on the week-ends.

For the vocational and work phase of the Panabode program the group is divided into three sections. One is composed of those individuals who are taking supervised school correspondence courses. Any course may be taken that is offered by the Province's High School Correspondence Course Division but the courses most often taken are typing, shorthand, bookkeeping and English. The school program is under the direction of a qualified school teacher and examinations may be written in all courses for certification.

As indicated earlier in the thesis, individuals from all areas of classification in the Women's Jail may attend the same school program. However, social interaction in this group is kept to a minimum.

A second Panabode section is composed of those individuals who wish to attend the various work departments. At present these work or vocational areas consist of carpentry, sewing and mending, occupational therapy, cosmetology, power sewing and home nursing. Qualified vocational staff direct these work programs and many individuals attain a degree of advanced proficiency in one or more of these work areas during their stay in prison.

The third group is usually made up of three individuals who remain at the Panabode during the hours of the vocational and work program and concern themselves with kitchen duties and preparing meals, the laundry needs of the unit, and the housekeeping and home making aspects of the unit. The three individuals who remain in the Panabode to care for the aforementioned areas usually rotate on a weekly basis to assume in turn the three areas of responsibility.

The following will indicate the daily routine at the Panabode Unit during the vocational and work phase of the program:

7:00 a.m. Everyone must be at the breakfast table but for those who are ill. Girls may have their hair in pin curls only if wearing a bandanna.

7:30 a.m. Dishes are washed and the kitchen left tidy.

8:00 a.m. The vocation and work program commences. Students go to the prison's school building, other girls go to their various work departments. Girls who remain in the Panabode begin their duties of maintenance, laundry and kitchen. All these duties are supervised by the day-shift Panabode matron.

KITCHEN DUTIES -

Meals are planned and menus kept. Cupboards, sink, refrigerator and stove are cleared. The refrigerator is defrosted each Monday and the cooking commences at this time.

9:30 a.m. Nourishment is served to the entire Panabode group which returns to the unit for a 15 minute break at this time. Supplies from the main building are checked following this.

11:30 a.m. Lunch is served for the group. Grace is said by the kitchen girl.

12:00 a.m. Lunch dishes are washed and garbage pails are emptied and scrubbed with disinfectant.

12:30 p.m. Supper vegetables and desserts are prepared. The floor is washed and waxed, if necessary. The kitchen must be tidy by 3:00 p.m.

HOUSEKEEPING AND HOME-MAKING DUTIES

7:30 a.m. Breakfast table is cleared and wiped.

8:00 a.m. The floors of the Activity Room and offices are swept and polished and are scrubbed and waxed on Saturdays. Furniture is dusted and windows kept clean. Sewing duties are also carried out during this time.

11:15 a.m. Table is set for lunch.

11:30 a.m. Lunch for the entire group.

12:00 a.m. The table is cleared and wiped. Help is given in washing the dishes and the kitchen must be tidy by 12:30 p.m.

12:30 p.m. The group returns to school and vocational classes and housekeeper commences sewing until 2:30 p.m.

2:30 p.m. Floors are mopped, ash trays emptied and washed and the room left tidy for 3:00 p.m.

LAUNDRY DUTIES

8:00 a.m. The laundry worker works through to 2:30 p.m. but for the morning nourishment and lunch breaks. She does the unit's laundry and ironing. All clothes must be put away by 2:30 p.m. and the washer and dryer are to be cleaned and aired after use.

DORMITORY ROUTINE

7:30 a.m. Cubicles are mopped and dusted and ash trays emptied and cleaned. Beds are neatly made (hospital style) and no clothes are left around. One blanket may be left folded at the foot of the bed.

6-8 p.m. Fridays - Each girls cleans her cubicle, scrubs the floor, waxes and polishes. Cubicle and walls are also dusted and mirrors and windows cleaned.

10:00 a.m. Saturdays - The entire dormitory is prepared for inspection. Drawers and cupboards are tidied and cleaned. Girls are not supposed to loiter in the dormitory after cleaning is finished.

12:30 p.m. Dormitory Inspection

Bathroom - Bathroom floor is washed with disinfectant each Saturday, or more often if needed. It is swept and polished every day. Garbage is emptied and burned outside. Toilets and basins are washed with disinfectant each day, as is the shower. Towels are folded neatly. Other articles of clothing are not supposed to be left in the bathroom. The bathroom is also inspected each Saturday but is always kept tidy and clean by the girls. This is supervised by the Panabode matron.

The socialization and group living part of the program is that program which takes place between the hours of 3:00 p.m. and 8:30 p.m. daily, Monday through Friday, and on week-ends. It is the only part of the program which is unique to the Panabode. Even in this area of the program there is considerable interaction with other groups from the Women's Jail.

On Tuesday evenings there are "Legion of Mary" meetings with Father Corcoran for the Roman Catholic girls and a Protestant film or discussion with the Protestant Chaplain. Individuals from any or all of the other groups within the Women's Jail might also be found at these sessions.

In the hours from 7:00 p.m. to 9:00 p.m. there is a mental health film and discussion once a week. This discussion is for the entire Panabode group and is conducted by the Panabode treatment matron on the afternoon shift.

Two days a week, from 3:00 p.m. to 10:30 or from 6:00 to 7:00 p.m. there is badminton in the Women's gymnasium. This activity is only for the Panabode group.

On Friday evenings from 7:00 p.m. to 9:30 p.m. there is a First Aid Course, proficiency in which may be credited towards St. John's Ambulence Certification. Other individuals from the Women's Jail might also be taking this course.

Softball, other field games and occupational therapy are fitted into the other free hours of program in a flexible way while utilizing the program time as such. Saturday afternoons are free time for the girls.

On Sundays, breakfast is at 9:00 a.m. Roman Catholic services are at 9:30 a.m. and a Protestant service is at 1:30 p.m. From 3:30 p.m. to 5:00 p.m. there is letter writing and after 6:00 p.m. there is usually outside entertainment which the entire male and female prison enjoy in a segregated manner in the Men's gymnasium, which also serves as the prison's main auditorium.

Mail and communications generally are dealt with in the same manner in the Women's Panabode as in the Men's. Medical and dental attention is also the same as that in the male unit. There is a fairly well stocked library in the Women's Jail from which Panabode inmates can select desired reading. Joint interviews and outside visitors are dealt with in the same manner as in the male section.

As with the male Panabode inmates, there is a sliding scale of pay for female Panabode inmates based on their attitudes, performance and interaction in groups. The rate of pay decided upon is not arrived at in the same manner as it is in the male unit but simply depends on the attitude and observations of the group matron or matrons who have charge of the individual in program.

DYNAMICS OF THE TREATMENT PROCESS IN PROGRAM

Generally speaking, the same things can be said of the dynamics of treatment in the Women's Panabode as was said of them in the Men's unit.[1] The Women's unit is not segregated to the same extent, however, and their sense of identity and unity does not seem so strong as a result.

The work phase of program for inmates of the Women's Panabode is much more diversified and is more inclined to create incentive than is the men's. Qualified vocational and educational staff place many desirable goals and achievements well within reach of those who are well motivated.

It is remembered, however, that when one talks of the work program for the Women's Panabode, one is really talking about the program of the Women's Jail in which the female Panabode inmates participate. Lack of personnel and facilities in the Women's Panabode prevents that unit from carrying on a segregated program of its own.

FOLLOW-UP OF DISCHARGED ADDICTS

It is understood that the person newly appointed to the position of Discharge Follow-up Officer for the male Panabode will be assuming the same responsibilities for the female Panabode. It should be noted, however, that the female Panabode has not had a discharge follow-up officer since the unit

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1. See Chapter III, Page 63

came into being in 1956.

As the writer's impressions of this Officer's duties and responsibilities have already been given in Chapter III[1], they will not be dealt with further in this section. The writer would hope, however, that the follow-up officer might be able to spend some time each week in the female Panabode where he can become more than superficially acquainted with prospective rehabilitees and where they can learn to regard him as a meaningful figure and helpful resource to them.

1. See Chapter III, Pages 64 and 65.

CHAPTER V

PROGRAM AND POLICY: CONTINUING NEEDS

There is perhaps a special relevancy and urgency to studies the nature of this thesis. The writer makes this observation in the realization that the Panabode units within Oakalla Prison Farm represent two of but three treatment facilities in the entire Province of British Columbia through which an attempt is made to cope with the present drug addiction problem! The male and female Panabode units together can only accommodate a maximum of 21 addicts at any one time and it is believed that the number of addicts active in treatment at the Narcotic Addiction Foundation in Vancouver could not greatly exceed this number. These three treatment centres with all their limitations of staff, funds and facilities cannot possibly cope realistically with the problems of an addicted population unofficially estimated to be between 1500 and 2000! It is time that Vancouver and the Province of British Columbia started thinking and acting in broader terms than such pilot projects.

THE PANABODE UNITS AND FACILITIES

The fact that the Panabode units are located within the confines of a correctional setting places many obstacles in the way of treatment

and its potential effectiveness. This is principally because the primary concern in such settings must be for custody, but the fact that inmates are cut off almost completely from any interaction with the community and sometimes bitterly resent this, interferes considerably with the attainment of treatment goals.

The male Panabode is better located than is the female unit. It is better segregated from the male prison and has more property and facilities for Panabode program and activities. This enables male Panabode inmates to carry out more work and activity without contact with other units of the main jail. This writer is not critical of the interaction that does exist in sports, gymnasium and hobby craft activities between the male Panabode inmates and those of the Westgate unit. At the same time some of these activities could be carried out separately if the male Panabode had more room and facilities. Perhaps when a full basement is constructed under the present workshop there may be room for material and hobby craft in the Panabode buildings and perhaps a separate period in the main gymnasium could be arranged for the Panabode group. It is not necessarily advocated however that the Panabode inmates remain segregated from the Westgate unit in sports activities.

The female Panabode unit has no additional property, buildings or facilities other than the unit itself. It is located so near to the Women's Jail and there is so much interaction between its inmates and those of the Women's Jail that it might almost be considered another facility of

the Women's Jail. The program of the female Panabode[1] revealed the extent of association between Panabode inmates and those of the Women's Jail. It is felt by the writer that program is quite good within the Women's Jail and if funds will not allow for qualified staff and adequate facilities for a well rounded and segregated female Panabode program, then by necessity and not by choice there must be interaction between the two buildings. It might fairly be said however that the present degree of interaction between the Women's Jail and the Panabode unit tends to undermine the advantages of the more segregated phases of the Panabode program.

The kitchen of the Women's Panabode faces out over the east wing[2] of the Men's Jail. It is suggested that a tall trellis with leafy vines or some evergreen trees should be placed along the north border of Women's Panabode property to prevent window writing and other forms of communication between the unit and the east wing of the Men's Jail.

TREATMENT AND PROGRAM

It was noted in earlier chapters that the philosophy, goals and purposes of the Panabode units were not stated. It would seem to be a helpful guide for the staff if these matters could be clearly stated -

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1 See chapter IV, pp. 75 - 80

2 See chapter III, pp. 48,49, for a discussion of Oakalla's East Wing

in a general way at least. It does not seem possible that one could ever evaluate the efficiency and effectiveness of a treatment program without first knowing the treatment goals. Even general treatment goals could be elaborated upon after careful assessment (psychological, social, psychiatric and medical) of each inmate, when an individualized treatment plan could be stated and embarked upon, taking into account the particular needs, capacities and aspirations of each inmate. These too should be carefully spelled out in recording and, if necessary, changed for a continuing and pertinent treatment focus.

At present all "treatment" for the addict accrues from the socialization and group living aspects of the program. However, if we believe what we have said earlier about addicts[1] it does not seem likely that the addict will resolve his own particular personality problems to any great extent in a treatment program which is only group oriented. During his stay in the Panabode unit, program may help the addict to get along better with others, to be more tolerant perhaps and to function co-operatively within the group, but it does not provide him with the help he needs to resolve his own particular personality problems. He is "left hanging on the fence" in that he has very seldom had the opportunity or the help to resolve any of his personal problems. As a result, he is very much the same person with the same basic problems and attitudes on discharge that he had when he came to prison. It is the writer's impression that this is due in part to the fact that the emphasis is on "the group as a whole" with little if any opportunity for the individual to gain insight and

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1 See chapter II, pp. 23,24, for a discussion of three general groups or types of persons who become addicted.

understanding of himself. Were such help and advice readily available, it is believed that the individual would use it more frequently and even effectively. It is realized that a great many drug addicts do not respond very well to psychotherapy. For them, focus on the group as a whole might be more effective. It would seem however that there are times when all or most addicts would not only respond to psychotherapy but would very much appreciate some individual attention and help with personal problems. This would demand the services of both a full time psychiatrist and an alert and sensitive Social Worker. These two persons should be free to offer their respective services and not be tied up with administrative responsibilities.

The foregoing applies to both the male and the female units where there is very limited opportunity for individual inmates to gain psychiatric or social work help. There is no social worker on the female Panabode staff and some inmates of this unit serve their time and are discharged without ever seeing the psychiatrist. This is not necessarily a criticism of the prison psychiatrist because this writer is not aware of all the demands made of this person. It is, however, a criticism of the program.

It is the writers impression too that the research aspects of the program are being neglected. There is need for closer direction and supervision of this phase of the unit's functioning. It would seem that the concern or focus of research in such a pilot project as the Panabode, should be primarily in one of two areas; a) Either that of attempting to show clearly what the difficulties, problems and needs would be in a larger

community treatment and rehabilitation unit for drug addicts, or, b) that of attempting to show just what can be accomplished with ideal personnel, facilities and program. It is argued that research in the Panabode units is not making a substantial contribution to either of these areas.

It would be helpful for instance, to know how many persons had passed through the Panabode programs and whether or not they have returned to the use of drugs. Even if they have returned to the use of drugs, it would be helpful to know how long they had abstained and for what expressed reasons they returned to the use of drugs. Strangely enough, the Panabode units did not even retain a nominal list of the persons who had passed through their treatment program. Such a list has now been prepared from the memory of the officers who have been in charge of the unit however it is not known if this list is complete. But for a few exceptions, none of the discharged addicts has been contacted or heard from following his discharge unless he was returned to prison for another offense. It is to be hoped that the newly appointed follow-up officer may be of help in this regard. Again personalities are not necessarily criticized here as shortage of staff and inadequately trained personnel may not be able to do the desired job effectively. Nevertheless there are real short comings in the area of research.

The group living and socialization aspects of program appear to function quite well in both units and the writer was truly impressed with the amount of participation in discussions. These discussions revealed a great deal about the character, attitudes and outlook of the participants. It might be well to record in more detail and in a well focussed manner

the addicts progress as observed in group discussions. There is not enough care and detail given to this matter at present.

The work program consists largely of woodwork for the men and in the winter months this phase of program is carried out in very crowded quarters which are neither good for the quality of work nor for the morale of the group. It is hoped that expanded facilities will help this situation but there is still a great need to broaden the work program to include projects and crafts other than woodworking.

PERSONNEL

The person in charge of the Panabode for males is a "senior prison guard". Although he is the only social worker on either the male or the female unit, he is the only one who wears the uniform of a prison guard. This in itself erects barriers to communication and good working relationships as there is a strong tendency throughout the prison for inmates to align themselves in a united manner against staff. The uniform represents "staff" rather than concerned treatment personnel. It is considered that as the only social worker in either unit, the Panabode senior prison guard has too many administrative and custodial responsibilities to do an effective job of social work. It is suggested that if there is only going to be one social worker on the Panabode staff, he might better assume treatment duties, the preparation of inmates for discharge back to the community and generally, the duties now assumed by the unit's discharge follow-up officer, who is not a social worker. Administrative and custodial duties of the

units could then be assumed by some other custodial or treatment person. If given adequate direction and supervision, such a person would not need to have research training although this would be desirable.

There is need for more and better qualified treatment personnel. Present male staff who are involved in treatment must be commended for their efforts and their pursuit of further training and qualifications. Custodial staff should be encouraged to take vocational training which would more adequately prepare them to supervise and guide work projects.

While the observation might be neither accurate nor a matter of much concern, the writer in his many visits to Oakalla Prison thought he could detect the existence of a certain degree of conflict between "custodial staff" and "treatment staff." Though this is not evident to the same extent in the Panabode units it would seem that in a prison, good program must go hand in hand with good custodial measures and practices. There is a valid place for both, and administration should concern itself with any conflict that does exist between the two segments of staff.

With regard to the Panabode for female addicts it will be recalled that there is only one staff member per shift in this unit and only one of this staff of three can be considered a treatment person. Program and interaction of the female Panabode unit is so intertwined with that of the Women's Jail that the unit at present is little more than an additional facility and classification of the Women's Jail. Here again the writer would suggest that the staff of the Women's Panabode needs more direction and guidance from both the prison psychiatrist and from the administration

of the Women's Jail. It is considered too that the unit is in need of the services of a social caseworker.

It is also suggested that there be some exchange of staff between the male and the female units. It is believed that the presence of a female staff member in the male Panabode would cut down on the bad language of both inmates and staff and that it would add considerably to the atmosphere of the unit while affording inmates the opportunity of interacting with a female figure. It would be desirable also for female inmates to be afforded the opportunity of interaction with a desirable male figure. It is further suggested that exchange of staff between the two units would afford each unit maximum opportunity to benefit from positive aspects of the other unit. At present there would appear to be certain shortcomings in communication between the two units. Each unit has features and information which could be used to benefit and better the functions of the other.

The duties and responsibilities of the discharge follow-up officer could well involve the most important aspects of treatment. He attempts to return the addict to an outside living and work situation which is satisfying and as void of unnecessary stresses as possible. The writer would suggest that this officer should be a qualified social worker and that he spend a considerable portion of his time in the Panabode units. He should be able to offer sound casework help to addicts. He should be a familiar figure to all Panabode inmates, particularly those who are preparing for discharge. He is the inmates' liaison between the prison and the community. As such he must be able to find and create good employment and living situations for the addict on his return to the community. He must be able to recognize and resolve family and interpersonal problems

which will reduce to a minimum stresses of the situation to which the addict will be returning. His job would be very challenging, full of pitfalls, set backs and failures, but the satisfactions of working through a successful rehabilitation would indeed be great.

THE PROCESS OF SELECTION

Undoubtedly there already exist certain criteria for selection of suitable candidates for the Panabode treatment programs. However, these criteria appear to be rather nebulous. It is suggested that considerable attention should be given to the setting up of criteria for selection, as there would appear to be some danger at present that the selection process allows too much freedom for sympathetic identification with those addicts who should not be exposed to the influence of the hardened and cynical recidivists of the east wing. (It will be recalled that in Oakalla, all addicted inmates, whether or not they are convicted under the Opium and Narcotic Drug Act, are allocated to the east wing of the prison unless they are suitable for and can be accommodated in the Panabode unit.)

The writer questions the motivation that prompts some east wing inmates to request transfer to the Panabode unit. By comparison with the Panabode unit, the east wing is a morbid, rigidly controlled unit lacking much of the program, liberties and comforts of the Panabode. It is considered that some east wing inmates have no healthier a motive than that it would be much better for them if they could do their prison time, or as much of

it as possible, in the Panabode unit. It will be obvious that the foregoing refers to the situation in the Men's Jail.

There would not be the same degree of spurious motivation in the Women's Jail. By comparison with the Men's Jail the Women's is very clean, bright and cheerful and there would be little other than the desire to avail themselves of the Panabode treatment program to motivate the addicts to seek placement in that unit. This is not to say that selection is more carefully and appropriately carried out for the Women's Panabode as there is probably more subjective involvement in the female selection process than there is on the male side.

Before criteria for selection can be set up there will need to be a careful description of the treatment goals. Only when this is accomplished can criteria for selection be established since the two are of necessity very much related. It is acknowledged that, should treatment goals and criteria for selection be carefully spelled out, there would still be a need for judgement as to which prospective candidate(s) would best fit in with the current Panabode group. The character of the group will of course change with changes in its membership.

It is observed that the treatment program for addicted persons in Lexington, Kentucky, after years of careful research and study, has worked out a systematized and effective set of criteria for selection. It is not necessarily suggested that the same criteria could or should be used in selection for the Panabode programs. The Lexington criteria for selection do contain much valuable information, however, which could be altered or otherwise used in setting up systematic criteria for selection

related to the particular treatment goals of the Panabode units.

LEGISLATIVE PROPOSALS

There are many reasons why we should re-assess the laws which have been established in Canada to cope with our problems of drug addiction. The most obvious reason for doing so is that these laws have not been effective in curtailing addiction. Indeed, this social menace has continued to spread alarmingly, particularly here in Vancouver. Sooner or later we must also admit to ourselves that the best efforts of our police departments have failed to prevent a steady flow of illicit narcotics to addicts and that prison sentences, even severe sentences, have not discouraged addicted persons from resuming their use of narcotic drugs.

Present legislation has created a ruthless, flourishing and prosperous black market; a black market which stoops to adulterating pure drugs with such substances as nescafe, abrasive cleansers, epsom salts, as well as the more common sugars of milk. Because of the severe penalties involved in trafficking, illicit drugs are very expensive. To support his habit the drug addict must inevitably resort to crime. In the city of Vancouver it has been estimated that as much as 85 per cent of all crime is committed by addicts.[1] A brief look at statistics reveals that

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1 Mulligan, W.H. op. cit. pp 59 - 82

in the men's section of Oakalla the proportion of addicts in jail at any one time has varied in the last two years between 16 and 30 per cent. During the same period the proportion of addicts in the female section has varied between 50 and 62 per cent. There are at present roughly three male convictions for every female conviction. The important feature stressed here is that Vancouver's large addict colony of unemployed and delinquent people must surely cost the citizen a large annual sum of money in stolen goods, police and court proceedings, and maintenance in prison.

It is proposed that the Federal Government should be urged to modify the Opium and Narcotic Drug Act to permit the provinces, (at least the province of British Columbia,) freedom to administer narcotic drugs to users through medical prescriptions. This would place the problem of drug addiction in the hands of the medical profession where it is suggested it belongs, rather than leaving it with the various law enforcement agencies. With or without the foregoing proposal the Government of the Province of British Columbia should also be urged to authorize payment to hospitals for the withdrawal treatment of addicts and for setting up rehabilitation facilities.

It is suggested that these two developments would bring drug addicts out into the open where they could be counted and then treated as sick persons rather than criminals. Apart from the very limited treatment resources of prison and the Narcotic Addiction Foundation, there is absolutely no resource or place of refuge for an addict who seeks withdrawal help, regardless of his motivation.

It is ludicrous for a community to affirm its concern with the problems of drug addiction and yet allow little or no avenue to rehabilitation other than through imprisonment! Drug addiction must be attacked on a broad front with the best available resources we have. This attack must involve vigorous and well informed people from all levels of community and up through Provincial and Federal governments. Until this happens we can undoubtedly expect to have with us an ever-worsening problem of addiction. It is frightening, however, to think that the problem has to become even greater and more widespread before some broad measures will be taken for its resolution.

Should legislation ever permit the administration of narcotic drugs to users through medical prescription, the medical profession would have to assure that every conceivable means is employed to induce users to give up drugs and fully to rehabilitate themselves. For those cases who will not give up the use of drugs or invariably return to their use, pure narcotic drugs should be available and in sufficient quantity so that there would not be a need to resort to black market. For such persons drugs other than heroin should be used whenever possible to help them to function at as high a level of efficiency as possible while avoiding withdrawal symptoms. This matter would be a medical concern.

Further reasons for the legalized prescription of narcotic drugs are: 1) Making drugs legally available would remove much of the present intrigue and glamour from their use particularly among the

criminal element. Some addicts to whom I have spoken have also stated, that, having used drugs, they resent the legal prohibition and become the more determined to get drugs. A similar phenomenon was observable in the days of alcohol prohibition.

2) It is a personal belief that far fewer new addicts would be created should drugs become legalized as there would not exist the same need to create new addicts. Few addicted persons would encourage others to use drugs simply for the sake of creating addiction, and open medical advice and attention would be available whenever there might be a need for the use of drugs.

3) The cost of legally available drugs could be nominal and the addict could easily support a modest habit from his wages.

4) The addict would not be in constant turmoil with the police nor would he be sent to jail for his addiction.

5) Not being arrested and involved in lengthy jail sentences, the addict could work more steadily, advance in his work and maintain himself and his family in comparative respectability.

6) Pure drugs would not be so detrimental to the user as would black market drugs, adulterated as they are.

7) The addict maintains that he is less danger under the influence of heroin than he or other people are under the influence of alcohol. Under the influence of heroin he states that he only wants to be quiet and relaxed, whereas the alcohol user is likely to be aggressive, quarrelsome and dangerous.

8) There should be trememdous reduction in the rate of crime,

since much crime at present is as a result of drug addiction.

It might also be mentioned here that the deleterious effects of narcotic drugs, on the individual user and on society generally, are a matter of some controversy. It is commonly claimed that the habitual use of narcotics has unfavourable effects on both the individual and on society, but these effects have almost certainly been exaggerated by the opponents of the use of narcotics. Compared with alcohol the deleterious effects of the opium derivatives are probably qualitatively and quantitatively less than those of alcohol. It is common knowledge too that far more murders, rapes and other crimes of violence arise from the use of alcohol than from the use of all other narcotic drugs combined! In their habit-forming propensities, and in the narrow margin of safety between social use and addiction, the opium group is more hazardous than alcohol. In all other respects, however, alcohol would appear to be more dangerous of the two.

There would be some obvious difficulties and details to be resolved before effecting any plan for the legal prescription of drugs. For instance, if such a plan were tried in British Columbia or even in Canada as a whole, drug addicts would come from other parts where legal sale did not exist and would bring with them additional problems. Also there is the possibility that legal sale of drugs in British Columbia or Canada could create a serious black market problem across the line in U.S.A. where sale of drugs is not legal.

Any plan for dispensing drugs through physicians would have to be very carefully worked out to ensure the accomplishment of its objectives or intent. It is hastily added that such a plan would not mean that the use of drugs should be condoned! On the contrary; it should only mean that we are trying to bring addicts out into the open where every resource should be made available in helping them to withdraw and refrain from the use of drugs. The legal sale of drugs through medical prescription should cut down substantially on the rate of crime to say nothing of the cost of maintaining addicts in prisons, often supporting their families in the meantime.

Should Parliament be willing to permit the legal sale of narcotics in British Columbia, it would probably have to forego its obligations in the United Nations pacts to which Canada is a signatory and in which Canada and the other signatories are pledged to fight drug addiction. It is possible that Canada might still adhere to its United Nations commitments and yet try out new methods of managing its own addiction problem. The methods proposed, however, do appear to be in contradiction to Canada's international commitments.

Whatever methods are employed to cope with our drug addiction problems, there is an urgent need for a vigorous attack on a broad front if we are ever to make more than token gestures towards the problems solution. Concerned and knowledgeable people must face this problem and make an energetic and determined effort to deal with it realistically. Meanwhile, every unhappy, displaced and bewildered drug addict is a living reproach and challenge to us.

Appendix A. - GLOSSARY

Narcotic - comes from a Greek word meaning to be numb. By enlargement, a narcotic drug is a chemical substance which has the power to produce torpor, stupor, sleepiness, unconsciousness, and anxiety, fear and worry.

Opiate - This word comes from the word "opium", and originally meant a preparation containing opium which would relieve pain and induce sleep. The term is used today for any substance that induces sleep, quiet or inaction.

Analgesic - This word refers to any chemical substance whose chief action is the relief of physical pain.

Habit forming drug - The Expert Committee on Drug Addiction of the World Health Organization distinguishes between a habit forming drug and an addiction producing drug. It defines a habit-forming drug as "... one which is or may be taken repeatedly without the production of all the characteristics outlined in the definition of addiction, and which is not generally considered to be detrimental to the individual and to society."

Drug Addiction - as defined by the Expert Committee on Drugs Liable to Produce Addiction of the World Health Organization, ".... is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic.) Its characteristics include:

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

(2) A tendency to increase the dose;

(3) A psychic (psychological) and sometimes a physical dependence on the effect of the drug."

Drugs of Addiction - The term "drug addiction" emphasizes the "overpowering desire or need" (compulsion), obtaining it "by any means", and detrimental to the individual and to the society. Any drugs having the above named characteristics are considered to be drugs of addiction. Some drugs have been considered more dangerous to the individual and to society than have others. Various international conventions have been set up to regulate narcotic drugs by permitting the growth and manufacture only of quantities sufficient to satisfy scientific and medical purposes. The United Nations Economic and Social Council has, as one of its subdivisions, a Commission on Narcotic Drugs, which is the governing body for International Regulation of Narcotic Drugs.

Synthetic Drugs - These are drugs having opiate qualities, which are manufactured from other chemical substances, and are not the direct result of plant cultivation as are the other three groups - the opium group, the cannabis group and cocaine. New synthetics are constantly being

produced and their control by international convention has been an exceedingly difficult task, as each new drug has to be tested for its addictive properties. However, only two synthetic opiates are of importance at the present time from the standpoint of addiction. They are pethidine (demerol) and methadone. The latter, because of its milder addicting qualities, is often used temporarily in the withdrawal treatment of persons addicted to morphine or heroin.

Other drugs - Alcohol, barbiturates and benzedrine -- these are not internationally controlled even though the baneful effects of alcohol are both quantitatively and qualitatively greatly in excess of those produced by other drugs.

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