Vol. 3 MARTLET MAGAZINE No. 17

The partial abolition of Capitol Punishment and present reframing of laws in such matters as divorce, homosexuality, abortion and contraception would, at least to the liberal-minded, seem a fair kick off for the first year of Canada's second century. Add a National Medicare Plan on the immediate horizon to the growing church element advocating the brotherhood of man to replace eternal life as the basic spiritual ethic and we might well consider that our present era may some day be known as Canada's "Age of Enlightenment."

EUPHORIA '68 the pursuit of happiness and its consequences, before the law

First of a two part series by Ben Maartman

There is one area however in which, we seem to be moving back towards the dark ages. This is the area of narcotic addiction.

For the first sixty years of this century the vast majority of Canadian narcotic addicts were known to have had established criminal patterns prior to ever using narcotics. They were criminals first and addicts secondly and incidentally. But during the sixties there was a sharp increase in young people becoming addicted to heroin prior to any delinquent pattern. Called "primary" addicts, they indicated a reverse in the trend; with them addiction preceeded criminality. Young men and women who should have been entering a useful adulthood were instead entering prison. These people are being increasingly joined in prison by another non-criminal group; people who use marijuana, hashish, LSD and associated drugs.

While all levels of government are showing liberalization in the approach to most social problems the sad fact is that during the sixties there has been introduction of the policy of charging chronic offenders as Habitual Criminals which carries with it the indeterminate sentence. It was initiated in Vancouver Magistrate's Court primarily to deal with the problem of drug addicts. Over half of the people convicted as Habitual Criminals in all of Canada are drug addicts, the majority from Vancouver. Linked with this we have a long range Federal Government policy of Penitentiary expansion. In 1966 the Penitentiary Service budget was $31 million a year while an additional $15 million was allotted for building expansion for **each** of the next ten years. At the same time the National Parole Service budget was $740,000 annually. This budget leaves little doubt as to the penal intentions of the Federal Government. Little wonder that the last United Nations world-wide penal survey ranked Canada 42nd in progressive penology.

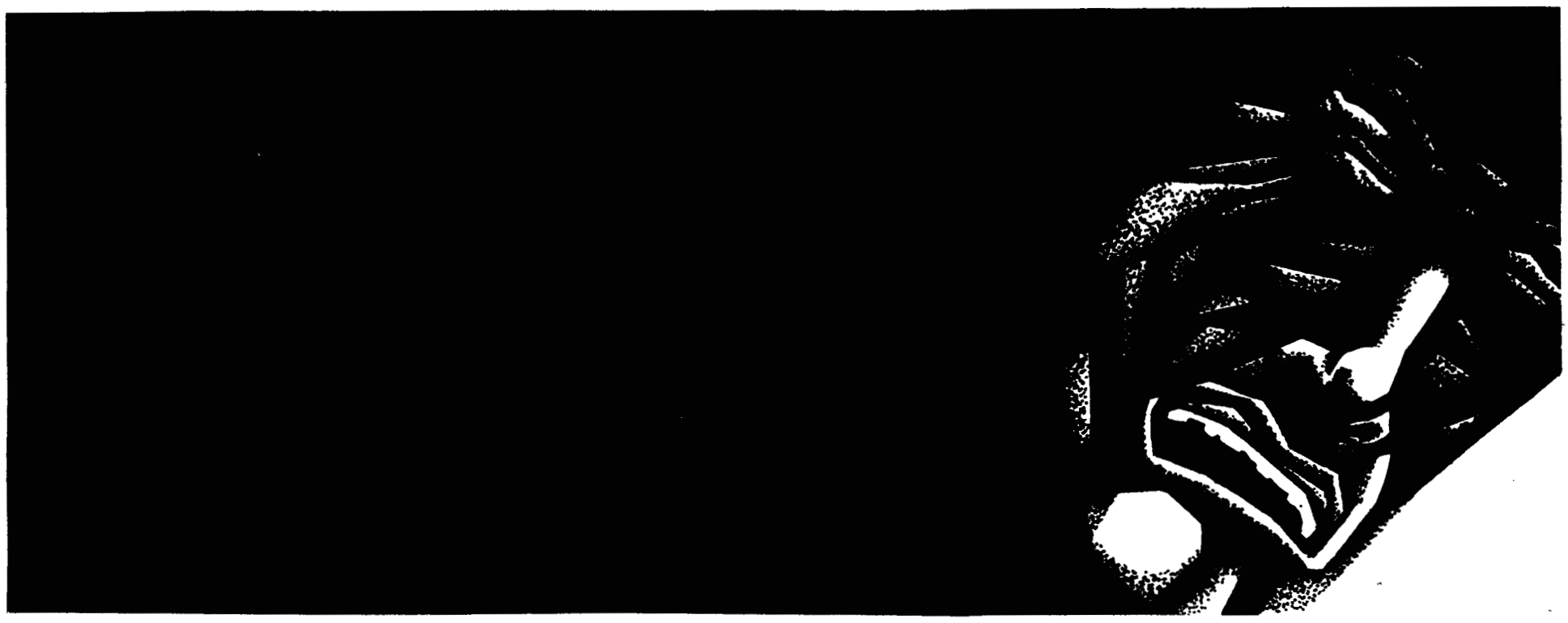
Approximately ten million dollars of the Penitentiary expansion budget went towards construction of the "Dominion Institution for Addicts" at Matsqui, B.C. Opened in 1967, it is designed to hold 300 male and 150 female addict inmates. Compared with the high walls of the ancient B.C. Penitentiary the 12 foot wire fence at Matsqui and modern buildings within are something of a penal relief. It was called the "new look in Canadian penology" and eventually is to have trade training to accompany the social training that is already underway.

However the old institutional problem remains in that as yet no one has discovered how to teach a person to live adequately in society by removing him from it. The inmates have individual cells and although these are painted in various pastel shades the inmate is aware they are also equipped with the most modern electronic locking devices. The treatment staff would like to teach self-control to the inmates when in fact everyone knows that the real control is provided by an officer in a glass cage with a panel of buttons. In the B.C. Penitentiary bowel control was left up to the inmate. Cells are provided with toilets. At Matsqui there are tiers where an inmate is dependent on an officer pushing a button before the man is released to go to a toilet. The new penal look in the push-button era.

It must be said for Matsqui that at least it segregated a large number of drug addicts from non-addicts in the B.C. Penitentiary, thus reducing the element of contagion when addicts and non-addicts are doing time together. It was also superficial recognition that drug addicts need treatment. The only trouble is that as yet there is no known cause or cure for heroin addiction or known treatment that provides control. The prison hospitals at Fort Worth, Texas and Lexington, Kentucky have treated addicts for over 30 years and as far as can be determined their abstention rate after a period of five years following treatment has been around two percent; approximately the same percentage of addicts anywhere who voluntarily decide to abstain.

The prospect for the Canadian taxpayer is to put up over 300 million annually for law-enforcement plus multi-million dollar budgets for the Federal Penitentiary Service as well as the Provincial Prison Services, yet there is no government program whatsoever to stem the flow of recruits to crime, to addiction and to support the ever-growing crime syndicate. The Federal Government has put up the salary of one psychiatrist at Matsqui while it follows a policy which effectively excludes thousands of doctors across Canada from treating what is essentially a medical problem. Basic to this policy is the premise that **addiction** is a crime

(continued on page two)



Euphoria '68

(continued from page one)

calling for punishment rather than a sickness calling for treatment. Products of this policy are an increase in the army of addicts both in and out of prison; a self-perpetuating program of increased police budget, increased prison budgets increased crime and, according to ex-R.C.M.P. Commissioner, George McLennan, an increase in the Crime Syndicates to the point where, "If we do not take strong preventative measures now it may soon be too late."

Instead of building more prisons it is time that the Federal Government thought of some new formulae rather than more and more of the same one that has proven such an abysmal and costly failure for so many years.

The only apparent alternative is for the government to eventually take the plunge and accept the fact that addiction is essentially a medical problem requiring medical treatment and to shape policies accordingly.

This requires recognition that treatment can only be provided by a physician and that improvements in treatment can only be attained when the doctors eventually are given sufficient freedom to commence treating addicts.

Narcotic addicts with no known exceptions are the strongest advocates of a change of medical practice in Canada which would allow the family physician to prescribe narcotics according to the British medical practice, namely:

1. Where patients are under treatment by the gradual withdrawal method with a view to a cure.

2. Where it has been demonstrated that after a prolonged attempt at cure that the use of the drug cannot be safely discontinued entirely on account of the severity of the withdrawal symptoms produced.

3. Where it has been clearly demonstrated that the patient, **while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.**

Addicts, and other people who advocate that Canadian doctors be allowed to follow British medical practice, point out that there are at least four times as many known addicts in the city of Vancouver alone than in all of Britain. They point out that because the doctor can prescribe narcotics to addicts that there are no syndicates nor the crime that is required to support syndicates and illegal drugs.

Critics of this approach say that the British estimate of their addict population is open to question as they do not require addicts to register and they do not have the same type of law enforcement as in Canada and the U.S.A. In the British Home Office there are less than a dozen people engaged in trying to control illicit traffic of narcotics.

Be that as it may, no one questions that compared with Canada and the U.S.A., Britain really has no serious narcotic addiction problem. The critics state however that this is not due to superior laws in Britain because the laws in the three countries are basically the same. They say it is not due to superior medical practice in Britain but rather due to different social and cultural factors, or, as the U.S.A. Senate Sub-committee in the March 4, 1965 Report on Organized Crime and Illicit Traffic in Narcotics," pointed out, "In Britain the rate for major crimes is one eighth to one tenth of ours. England's handful of addicts are, unlike our vast multitudes, mostly addicted to morphine or cocaine, as painkillers, following serious illness. It is not the system, but the sociology of the community that is likely to accelerate or to retard its addiction rate."

Although it would seem that British medical practice which allows a physician to treat addicts and prescribe narcotics under certain circumstances must have some bearing on the absence of this problem in Britain, let us assume, along with the critics that the major factors in producing addicts in Canada and the U.S.A. are "social and cultural."

It seems unlikely that there are going to be any sudden and dramatic changes for the better in our social and cultural situatioin and therefore if there is to be no basic change in our approach to the narcotic problem. We can only watch the continuation of adolescent boys and girls joining the addict community, participating in wholesale prostitution and crime to support the Montreal narcotic syndicates, periodically going through costly court procedures followed by more costly incarceration which invariably does far more harm than good to the individual.

The building of the penitentiary at Matsqui and the attempt to pass it off as a treatment institution is one current aspect of our approach to narcotic addiction. Another recent aspect is the passing of new laws supposedly designed to make Matsqui more effective as a treatment centre. The new legislation, already reported to be on the books and to be made effective at a future date when Matsqui is fully functional, calls for a mandatory five year sentence for any person arrested on a criminal offense and on examination is found to be an addict. On the second occasion there is a mandatory Indeterminate sentence, which means that a person will only be released from prison when the Parole Board sees fit or when he dies.

This is very drastic legislation to meet a very drastic problem. But to enact it and sentence a person to indeterminate imprisonment **not** for an offence committed but for a health condition, while the medical profession is effectively excluded from treating that condition, is surely about the last possible — but too familiar — step of increased sentences with the inmate being just that much worse off when he is eventually released. It can only be predicated on the assumption that the state of addiction itself is purely a crime and that the only cure is imprisonment or fear of imprisonment.

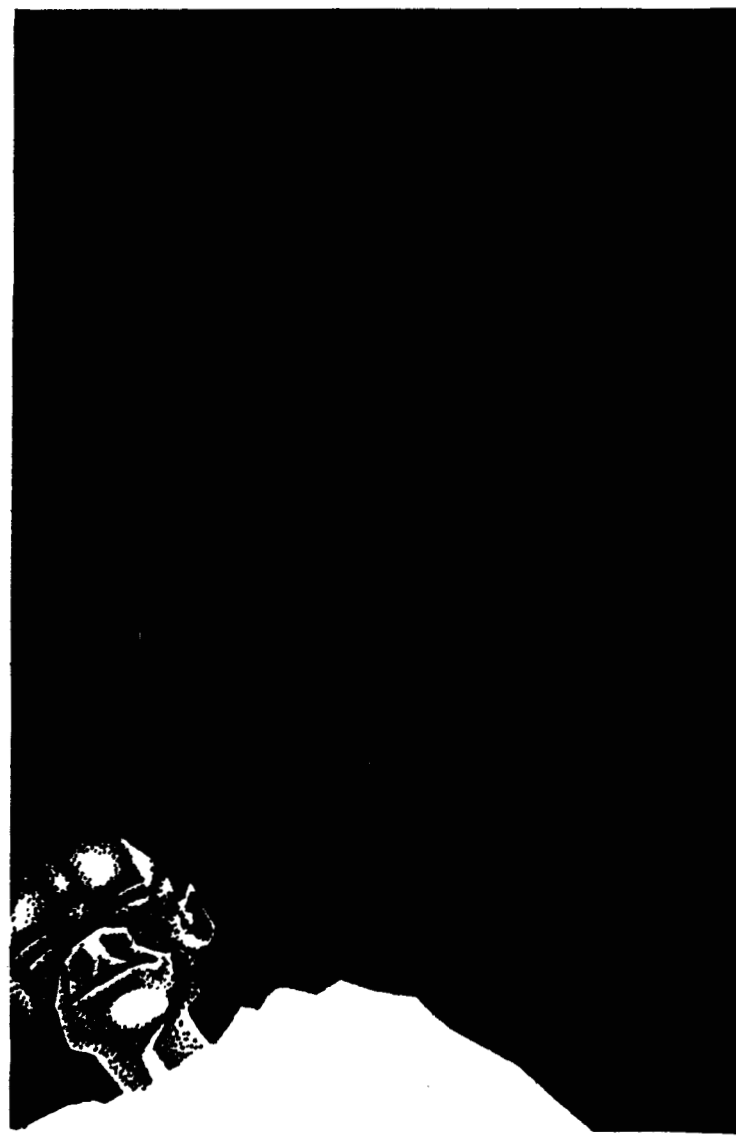
The exclusion of the general practitioner from the long term treatment of addicts is not a matter of statutory law but rather that of law enforcement practices adopted by the R.C.M.P. and combined with medical practice as laid down by the medical associations.

There is no law restricting a licensed doctor from prescribing legal narcotics as he sees fit. However a copy of any narcotic prescription must go to the R.C.M.P. Narcotics Bureau and the R.C.M.P. also have the right to check both the books and narcotics stocks of any practitioner.

Many physicians have helped or attempted to help addicts but the first problem they run into is that the overcrowded public hospitals will not make beds available for addicts to withdraw and the cost of a bed in a private hospital is beyond

the means of most addicts unless they are fairly well up the line in trafficking.

The doctor can place an addict on the 14 day methadon prescription that takes most of the agony out of withdrawal and let him go to his hotel room or home, if he has one; but almost invariably some combination of events occurs. The most usual is that the addict only goes to the doctor when his habit has built up so high that instead of having to steal a hundred dollars worth of goods daily he has to steal double that amount



to pay for his drugs and he just can't make it. More often than not he feels that he is awfully "hot" with the police and that things just can't go on as they are; and for this reason he wishes to reduce his habit to manageable proportions. After a week of methadon his habit is reduced, he has been out of "action" for a week as far as stealing is concerned, he may have taken on a square meal or two and started going to the bathroom again and generally things are looking better. So he uses his second week of methadon to keep his morale up during the day while he returns to shoplifting so he can have a proper fix of illegal drugs at night. Perhaps he'll keep his habit down for awhile and, if he isn't arrested, it may be as much as a month or two before he's back in the doctor's office to repeat the cycle.

Other addicts simply go to the doctor to keep from the sick in the morning while they shoplift, or to keep them going over weekends when the stores are closed. There is nothing more tragic to the shoplifting addict than a long weekend when the stores are closed for two or three days. He's always to be found in the forefront of the Tuesday morning "bargain-sale" rush.

A minority of addicts go to the doctor wishing and intending with heart and soul to withdraw from drugs forever. For some unknown reason they generally seem to sweat out withdrawal to the fourth day and are past the physical crisis point and then suddenly, at any time of the night or day, they'll head for the pusher as fast as a taxi can take them for just one "last" fix before they "complete" withdrawal forever, and that ends that.

A fourth small category is the old time addict who makes no bones that he would like to use drugs for the rest of his life but has just got out of prison and cannot face doing more time. For this reason has found a job and is trying to go straight but suffers constant urges to use drugs, perhaps has taken a fix or two or at least tells the doctor that he has. He wants some form of medication to contain his urges and, hopefully, also get some "glow." This is the legitimate case of a person calling for medical help to enable him to work and stay away from crime. The doctor can and often does prescribe some form of narcotic medication to take the peak off the urges and to help him sleep. But the trouble is that there is no end to the urges and if the doctor continues to prescribe a form of narcotic he will eventually be warned by the R.C.M.P. to discontinue maintaining a known addict on narcotics or his name will be forwarded to the College of Physicians and Surgeons.

It is at this point where British medical practice differs from Canadian and American. If the British doctor feels that he has done everything he can to try and withdraw the patient completely from the use of narcotics and that "it has been clearly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued," then the British doctor can continue prescribing maintenance doses of narcotics.

The medical associations in Canada and the USA flatly consider it poor medical practice to maintain any patient on a narcotic for purely psychological reasons and, if a doctor persists, they are empowered to withdraw his license to practice.

In Vancouver both the B.C. Narcotic Addiction Foundation and private doctors have experimented with prescribing maintenance doses of narcotics with the prescriptions filled at the Foundation clinic and the staff attempting to back up medication with counselling and other help for the patient. There has been some success for varying lengths of time but the experiment has not been going on long enough to be conclusive.

The major problem is that illegal narcotics are always available to supplement the legal prescriptions and it is impossible to know whether or not an outpatient is using these. What usually happens is that the old-time addict who has taken a job is able to tough it out during the week on relatively mild maintenance narcotic medication but on Friday or Saturday night he gets paid, he's lonely and he seeks oldtime friends, either females for sex or males just for company and the next thing he knows he's having "just one little fix," which is usually the beginning of readdiction.

A side problem from the point of view of the doctor who prescribes even short-term withdrawal medication is that the word goes out fast and he'll soon have an office full of addicts.

At present wherever there is a group of addicts, illegal narcotics are always available and it is this fact which makes it not only "poor" but pointless medical practice for a doctor to attempt to either withdraw or maintain an addict on an outpatient basis.

The overall result is that the majority of doctors decline to treat people purely for their problem of addiction. These people in turn, along with the advocates of British medical practice, accuse the doctors of failing to carry out their medical oath. They accuse the R.C.M.P. of taking an active role in medical practice despite the fact that no laws are being broken. They accuse the doctors of allowing themselves to be dictated to by the R.C.M.P.

On the other hand the opponents of British medical practice state that if the Canadian doctors combine to change medical practice as presently laid down by their associations that this will amount to the doctors allowing the addict patient to dictate medical practice.

Under the present circumstances the doctors just can't win. It is certain that as long as illegal narcotics are available that for doctors to prescribe maintenance narcotics would be exactly the same as issuing an alcoholic patient a mickey of whiskey a day in the hope that he would limit himself to this and become a social drinker.

The sad fact is that when the question of any form of "legalized" narcotics arises it invariably takes on "all or nothing at all" dimensions, with the advocates accusing the opposition of being inhuman and conspiring to perpetuate addiction and narcotic syndicates. The opposition paints a picture of drugs being sold wholesale over the counter, of half the population stumbling around in a daze, and they accuse the advocates of being a public menace conspiring to spread addiction to the general public.

to be continued in the next issue of MM

Ben Maartman, the writer of the above article, has ten years' experience as a Correctional Social Worker including three years working exclusively with Narcotic Addicts

A '68 a study in two parts of addiction and the law — next week "a solution"

Satire fades to reveal a stark, horrific, truth

review of "The War Game" now showing at the Fox

by Barbara Trottier

I went to see "The War Game" with a surrep titious flea of skepticism biting around a brair conscious of some gross, coming horror. There WAS horror; and the flea died from shock.

How are we supposed to feel? The film gave me little intelligence about the actual threat of a nuclear attack; personally, I believe it is a doubtful thing. It gave me much more on what reactions would be, how people would supposedly function in such a situation. These struck me as real, valid reactions. The solemn, interspersed comments by a silver-voiced BBC man were only so much satire. Satire tends to fade: scenes that belt you with their vividness and humanity take longer.

What they did was this. The documentary was intended to be a mock-up of what would take place in an English suberb in a nuclear war. At the beginning, they went about it in a very efficient, Dragnet sort of way. Everything was planned, each person marked for a relatively safe little drawer. Then they lay the bomb; the scheme is progressively blown, along with quite a few people. Man cowers, rallies, and is suddenly a savage. No time to say " 'Ere, mate, we're all in this together, see? and you got to . . . " Shoot him if he's in the way. Shoot him. That's the scary part. The rampage of fear. Initially physical disfiguration is revolting, but the impression seems to pass, because it's there already — in Viet Nam, In Korea, in South America; hell, in North America; — but mass hysteria as it would be; this is strange, this is frightening. It is degrading to how we are now; it is the hidden foreignness of ourselves.

Stumbling out of the theatre feeling very sick, we were handed white leaflets — at that precise moment I figured they were sick bags — mimeographed by some women's group for our enlightenment; how we should write to a V.I.P. and protest the Bomb, I mean . . . It was the wrong time to enlighten anybody — we were all too jolted to care. Better sick bags. Few people spoke. The ones with stamina had stayed back in the theatre to find out about love — or something.

So we curled up with a glass of port, and listened to Hendrix. And the flea was miraculously resuscitated, along with its thousand brothers. ●

ON HEARING THAT THE STUDENTS OF OUR NEW UNIVERSITY HAVE JOINED THE AGITATION AGAINST IMMORAL LITERATURE

Where, where but here have Pride and Truth,
That long to give themselves for wage,
To shake their wicked sides at youth
Restraining reckless middle-age?

W. B. Yeats

MARTLET MAGAZINE

published every Tuesday

editor ..... Martin Segger

associates ..... Jim Hoffman, Pam Harrison, and Jerri Jelinek

art ..... Martin Springett

poetry editor ..... Jane Foster, Barbara Trottier

secretary ..... Christine Chester

Unsolicited material can be left in the MAG box in The Martlet office in the SUB. MM's office is located in Office 12, J Hut.

two poems by e. littleton . . .

skiers

bobbing, an aluminum bubble
crawls on a spider's strand
to the snows.
mantises . . . spindly,
shelled in primary woollens,
wooden pincers sticking,
we stump
crunching and stiff
to the breathless

abyss; bend and cinch,
straighten, suck thin
air puffs of ice,
then waxed

jets parallel over
wedding dress dunes,
the steel wind
fine-honed
scalpel slim
veers edgeways
and we

shave the stones.

costa del sol

Somewhere north the antiseptic
Swiss whir behind
laundered Alps
and French trains bisect
logical vineyards;
and pitted miles away
Malaga:
heaped and steaming hauteur
of cabbage and rice
dripping oil;
flamenco's belly; burnt
candle-wax
cellar smelling,
cracked shoes
and shredded nylons,
harsh crescendoes piling
to peacock climax
slashed, nostrils flaring.
Follow, then, dry-stripped
rows of olives
staggering across
the ploughed avalanche
to market-fingered
vegetables,
baskets of bottles,
cork snouts poked,
to the neon.
Smash crockery with
touring red-necked Teutons
and the wired
little waiters
shooting steam from
coffee machines
in dark bars' rum
and sea-salt shrimp
stink.
Mandolins ripe as plums,
coiled black iron-work
and intensity of leisure,
the Moor's obsession with
rococco pleasures
and the fierce
black blood
of poverty's ancient passions.
The steeple bell
tolls sternly,
swinging out over
the bowed heads,
lace,
and a whole lifetime of
spit-fire
tightrope dancing.

Seen and Heard

Zabaleta on Campus

Sunday, February 11th, the Victoria Symphony gave one of its all-too-infrequent performances on campus. Guest soloist was Nicanor Zabaleta, internationally-known harpist.

The concert opened with a rather lacklustre rendition of Rossini's Semiramide overture. Mr. Gati seemed to have some difficulty in holding the orchestra to a steady tempo, and was not helped by some blatant inconsistencies in the lower strings. However, the second piece, Handel's Bb Concerto for harp and orchestra, more than made up for the weak opening. Mr. Zabaleta displayed a sensitive understanding of the music's requirements, and Mr. Gati and his orchestra accompanied him with sympathetic awareness.

The Rodrigo, on the other hand, was a disappointment. Although the soloist and orchestra acquitted themselves ably, the music did not come up to the standard of performance given it. Judged in the light of the more well-known Guitar Concerto, this piece shows little of the promise of the earlier work. Filled with mushy Ivesian polytonalities, it has no direction and reaches no conclusion.

The concert closed with a scintillating performance of Kodaly's Hary Janos Suite. Audience and orchestra enjoyed themselves immensely — many left the gymnasium still whistling excerpts from this last number. ●

Combined Media Highlight McLean Recital

There is now some hope that the Fine Arts may be integrated. Hugh McLean, harpsichordist, gave a performance Tuesday evening of Roger Vuataz' Rembrandt Suite — seven pieces based on Rembrandt paintings. He departed from the usual custom of a "straight" musical performance, by using a visual aid: the projection of slides of the Rembrandt paintings on which the piece is based. For anyone who did not recognize the paintings from their names alone, the sight of the pictures made the performance much more meaningful, and for those who did know the pictures well, the performance was made more enjoyable.

The rest of the program was skilfully and sensitively performed. Mr. McLean is an extremely able and knoweldgable musician and showed this, not only in his well-balanced choice of pieces, but in his brilliant technique, his tasteful registration, and his charming and informative program notes.

The harpsichord is a difficult instrument to play. It constantly goes out of tune, its plectra stops working, its stops do not function; Mr. McLean, despite the various illnesses of his instrument, managed to surmount the difficulties and provide a thoroughly enjoyable musical experience. ● MM