## Archived Content

Information identified as archived is provided for reference, research or recordkeeping purposes. It is not subject to the Government of Canada Web Standards and has not been altered or updated since it was archived. Please contact us to request a format other than those available.

## Contenu archivé

L’information dont il est indiqué qu’elle est archivée est fournie à des fins de référence, de recherche ou de tenue de documents. Elle n’est pas assujettie aux normes Web du gouvernement du Canada et elle n’a pas été modifiée ou mise à jour depuis son archivage. Pour obtenir cette information dans un autre format, veuillez communiquer avec nous.

This document is archival in nature and is intended for those who wish to consult archival documents made available from the collection of Public Safety Canada.

Some of these documents are available in only one official language. Translation, to be provided by Public Safety Canada, is available upon request.

Le présent document a une valeur archivistique et fait partie des documents d'archives rendus disponibles par Sécurité publique Canada à ceux qui souhaitent consulter ces documents issus de sa collection.

Certains de ces documents ne sont disponibles que dans une langue officielle. Sécurité publique Canada fournira une traduction sur demande.
REPORT TO THE COMMISSIONER OF PENITENTIARIES
CONCERNING RECOMMENDATION NO. 45

of the

HOUSE OF COMMONS SUB-COMMITTEE ON PENITENTIARIES

IN CANADA

B. A. BOYD, M.D., D.Psych., F.R.C.P(C)
formerly Medical Director
Mental Health Centre
Penetanguishene, Ontario
Copyright of this document does not belong to the Crown.
Proper authorization must be obtained from the author for any intended use.

REPORT TO THE COMMISSIONER OF PENITENTIARIES
CONCERNING RECOMMENDATION NO. 45
of the
HOUSE OF COMMONS SUB-COMMITTEE ON PENITENTIARIES

B. A. BOYD M.D., D.Psych., F.R.C.P.(C)
Formerly Medical Director
Mental Health Centre
Penetanguishene, Ontario

This Recommendation states: "The social therapy
technique developed by the Oak Ridge Division of the Mental
Health Hospital at Penetanguishene is the most promising known
for assisting offenders in self-reformation. This technique
should be introduced into both maximum and medium security
institutions immediately to the extent that it is possible to
separate entirely the inmates in social therapy from the rest
of the prison population. New institutions should be built
with the need for small completely contained units in mind."

In the past ten years there have been a number of reports
containing recommendations in regard to our prison services.
The report of the Canadian Committee on Corrections (Ouimet)
appeared in 1969. The Swackhamer Report of the Commission of
Inquiry into certain disturbances at Kingston Penitentiary
during April, 1971, appeared in 1973. The general program for
the Development of Psychiatric Services in Federal Correctional
Services in Canada (Chalke) appeared in 1973. The Solicitor-
General published "The Role of Federal Corrections in Canada"
in 1977. There was also in Britain the report of the Committee
on Mentally Abnormal Offenders (Butler) published in 1975.
Some of these reports have been critical that many recommendations from previous reports appeared to have been ignored.

In 1978 the Director General of Medical Services for the Canadian Penitentiary Service and the Director General of Inmate Programs asked me to carry out a feasibility study in regard to the introduction of Oak Ridge social therapy programs into certain selected prisons. As a Forensic Psychiatrist I had been involved for about 20 years with the problems of mentally disordered offenders and the problems of controlling dangerous offenders. In 1969 I accompanied Mr. Barry Swadron from Ontario to Newfoundland on the field trips for the Ouimet Committee. In 1977 I accompanied officials from the Federal Department of Justice on field trips from Ontario to British Columbia for the study into recommendations of the Law Reform Commission concerning mental disorder and the criminal process. In 1977 I accompanied the House of Commons Sub-Committee on their visits to seven American prisons in Washington and California. I have had the opportunity of visiting most of Canada's maximum security penitentiaries as well as many of the medium security facilities and many of the Provincial prisons. For 18 years I was Superintendent and then Medical Director of the Mental Health Centre at Penetanguishene which includes the Oak Ridge Division for disturbed male offenders. Recently for the Canadian Penitentiary Service, I visited National Headquarters, Prairie Regional Headquarters, the
Regional Psychiatric Centre at Saskatoon, the New Maximum Security Facility at Edmonton, the Medium Security Institute at Mission, B.C., the Regional Psychiatric Centre at Abbotsford, B.C., and the Medium Security Facility at Workworth, Ontario.

The Oak Ridge Division is a 300-bed psychiatric hospital for male patients from the Province of Ontario. There is a turnover of over 400 patients a year; over half come from the Courts for assessment and most of these are returned to trial. Others come having been found Unfit to Stand Trial or Not Guilty on Account of Insanity and they are held on Warrants of the Lieutenant-Governor. Others have been convicted and come on transfer from the Provincial or Federal prisons, or recently, directly from the Court after sentence. Finally, some patients are transferred from other Provincial mental hospitals if they are too dangerous to handle locally.

In 1961 we began to introduce therapeutic community concepts into Oak Ridge with group therapy, patient councils and more patient responsibility for the management of their programs. With the arrival of Dr. E. T. Barker in 1965 the development of programs was accelerated and since then Oak Ridge has attracted world-wide fame and attention. A series of articles listed in the bibliography describe the programs.

The research program has concentrated on the prediction of dangerous behaviour. In the past ten years in the
Province of Ontario there has been a tendency to look upon the offender with a severe antisocial personality disorder, or the "psychopath" as 'mad' rather than 'bad', and an increasing number of these difficult offenders have been transferred from the criminal justice system to Oak Ridge either during trial by a verdict of Not Guilty By Reason Of Insanity or after trial. Eighty per cent of the Oak Ridge patients have been involved in the criminal justice system. The Oak Ridge population is really very similar to that found in maximum security and some medium security federal correctional institutions.

The House of Commons Sub-Committee visited Penetanguishene immediately following visits to the federal correctional institutions. They were amazed at the contrast and hence in Recommendation No. 45 they urged that the program be adopted in federal maximum and medium institutions.

ADVANTAGES OF A SOCIAL THERAPY UNIT MODEL

1. Security

There have been two escapes from the Oak Ridge building in the past twenty-five years, both of which were outside "jobs". In one case a hacksaw blade was smuggled in with cookies; two patients filed through the bars and escaped. A bagpipe band was visiting the patients' yard at the time and no one noticed the sound of filing. In the other case a man
pretending to be the brother of a bank robber on remand for examination produced a gun and took the patient with him when he left. Over this time there have been no riots, homicides or hostages. Suicide averages one per three years which is about a tenth the usual rate for this type of patient. In recent years Oak Ridge has been rejecting convicted prisoners who do not appear psychiatrically treatable, but in the earlier years they took the most difficult patients from Kingston and showed that they were able at least to contain them safely. The architecture of Oak Ridge is not even medium security by federal penitentiary standards. The security is dynamic rather than static and depends to a large extent on the sense of social responsibility of the patients. The attendant staff were naturally apprehensive at first that increased patient power would jeopardize security but time has shown that the security aspects of their responsibilities have become easier with the new programs.

2. Morale

Fifteen years ago when I made rounds through Oak Ridge it was a painful experience. One patient after another would come up to me insisting that he was wrongfully held and demanding his release. As in some prisons, the patients spent much of their time discussing past offences and planning future ones. The attendants spent much of their time searching the patients and their rooms and often turned up contraband and
weapons. In recent years when I have made rounds, the patients ignore me. If I say, "Joe, how is it going?" Joe is likely to reply, "I'm a lot better but not ready to leave yet and I have to get to a therapy meeting." The attendants too have much more sense of value and pride in their work.

3. Recidivism

Of the Lieutenant-Governor's Warrant patients who have left Oak Ridge, only one in ten is returned or convicted of a subsequent offence. Such offences have rarely been against the person. Of the other patients who leave, four out of ten have returned or been convicted, usually of property offences. The chance of failure has been analyzed in terms of age, diagnosis, offence, family background, criminal record and psychiatric history. It is still very difficult to predict future criminal behaviour in the individual patient. As it has not been possible to devise adequate control groups, it is impossible to state with certainty how these patients would have done in the community had they not been exposed to the Oak Ridge program. It seems only reasonable, however, that for patients to spend their day analyzing why they were unable to adjust in society and practicing better social skills rather than building up their hatred of authority and mistrust of our system, ought to give them a better chance of a successful social adjustment on the street.
4. Economy

People often assume that a successful program for the treatment of mentally disordered offenders must be very expensive. Oak Ridge has shown this not to be the case. The per diem cost of the Mental Health Centre, Penetanguishene, is the lowest of the twelve provincial mental hospitals, and the Oak Ridge Division has a lower per diem rate than the other (Regional) Division of the hospital. The staff-patient ratio at Penetang is 1.1 including such support services as Business Office, Administration, Dietary, Grounds, Transport, etc. The equivalent ratio for Oak Ridge patients is less than one to one. The Mental Health Centre, Penetanguishene, is a psychiatric hospital under the Ministry of Health of Ontario. The programs are under the direction of psychiatrists with the help of psychologists, social workers, nurses and other professional health personnel. The residents are patients and they are considered to be psychiatrically ill at least in a broad sense. In the social therapy programs the philosophy and techniques could equally well be described in non-medical terms. A vocabulary centered around concepts of training or of socialization would be equally applicable. In the penitentiary service the programs could be introduced much as they exist into the regional psychiatric centers, or they could equally readily be adapted to prisons not designated as psychiatric centers. I was struck by the similarities between the social
therapy philosophy and that seen in the living units at Mission and Workworth. Basically the social therapy programs do not operate on a "medical model" in the narrow sense.

PROBLEMS

1. The Prison Subculture

One of the outstanding features of the social therapy program is that it has largely controlled the subculture which prevails in so many prisons. A new inmate going into a typical prison really has very little choice but to adopt the prison subculture. For these reasons, it is extremely difficult, if not impossible, to establish a therapeutic community within a large existing prison. The social therapy program at Oak Ridge began on one ward (38 patients) in 1965 and gradually spread to involve four wards (150 patients). That is half the patient population. In the early years the patients involved were under considerable pressure from the larger body of patients. The early attendants involved were under even more severe pressure from the attendant culture at large. The first attendants to tackle the new programs even ran the risk of being socially ostracized in town by reason of the more traditional attendant culture. It is thus essential that beginning programs be isolated both geographically and socially from traditional prison culture. This would be much easier to do in a small new prison. Within a larger prison it
would be almost impossible to prevent the involved inmates from having social contact in the yards, workshops, dining rooms and recreational areas. It would be even more impossible to segregate the staff involved from the influence of the usual prison culture.

The programs would have to be developed by a very small number of dedicated professional staff who had the skill to deal not only with the inmates but more importantly with the correctional officers or living unit officers and with the local administration. It is essential that the staff have the understanding and support of the local administration.

2. **Staff Training**

Within a psychiatric regional center the basic training of the staff should probably be as psychiatric nursing assistants. Within a living unit the basic training should be in one of the social sciences, or staff should at least possess a demonstrated ability in dealing with and handling people. Specific training for instituting social therapy programs could probably best be achieved by having such staff spend a period of time observing and, if possible, working in the Oak Ridge Social Therapy Unit. A basic period of a week would probably be essential to give any staff a working knowledge of how the programs operate. Further in-service training programs could be organized within the prisons themselves, involving lectures, films and seminars.
3. Security Versus Therapy Concepts

In all secure institutions there is a potential conflict between those primarily responsible for security and those primarily responsible for developing training or treatment programs. Naturally whenever the slightest conflict between these goals arises, security immediately has the upper hand and treatment and training are impotent. It is, therefore, essential to have the full cooperation of those responsible for security if any successful progress is to be made in developing treatment and training programs. Oak Ridge has the advantage of having no separate security staff. The twin responsibilities of security and treatment lie with the attendant staff as indeed they also lie with the professional staff, the administration and the patients. Even in Oak Ridge, from time to time, the concern about security can threaten treatment programs. After visiting a local mountain, Dr. E. T. Barker carved out ten commandments on "Introducing New Programs in Old Institutions--The Penetang Approach." Commandment No. 2 is that whenever treatment is to move forward, additional steps for security should temporarily be taken to alleviate anxiety. Another commandment (No. 5) states that in dealing with a patient, the attendant is always right, especially when he is wrong. The sixth commandment states that too many professional staff could wreck the developing programs. It would probably be extremely difficult in the federal penitentiary service to
eliminate security staff as such, and invest their responsibilities in treatment personnel. Perhaps it would be more possible to involve the security staff in treatment responsibilities, but this entails problems of position specifications, staff attitudes and unions. I have heard a number of knowledgeable people express the view that it will be impossible to develop truly therapeutic programs within the bureaucracy of the prisons because of a basic punitive attitude and the deeply entrenched attitudes of many correctional officers. Perhaps this is not so.

4. Coercion and Informed Consent

In our society the normal citizen has a right to accept or reject any suggested treatment. The psychiatric patient is probably in a somewhat different category in that his very illness may have impaired his ability to consider the consequences of accepting or rejecting suggested treatment and thereby give consent. It may, therefore, be easier to impose treatment upon a patient in a regional psychiatric center than it is in the prisons at large. Many authorities feel that treatment is much more likely to succeed if it is accepted voluntarily by the patient but there are good reasons to argue this thesis in some cases. There is probably no social structure in our society more coercive than that of the prisons and this coercion is usually of a very destructive type. When a man has offended society to the point of losing his liberty, it
may be justified to bring some coercion upon him to adapt his ways so that he will be less dangerous upon release. It has been said, "You can lead a horse to water but you cannot make him drink"; however, you can tie him up at the water hole until he becomes thirsty (Boyd). This is one of the advantages of the controversial indeterminate sentence. If the man knows that he is not going to leave until he changes, it is a strong motivation for him eventually to wish to change. In most of the better treatment programs such as those at Fort Steilacoom and Abbotsford, the patient knows that if he does not cooperate he can be transferred to the regular penitentiary. Recently this threat has also been used at Oak Ridge with convicted prisoners. In recent years the civil rights movement has taken an increasing interest in the plight of prisoners, and government institutions have to be extremely careful that they don't appear to abuse the rights of patients or inmates.

It is impossible to do "easy time" in a therapeutic community. There is hardly a patient who doesn't, on occasion, wish he could opt out, and yet later the majority say they are glad it had not been possible.

I understand that the State of Michigan Superior Court pointed out that no incarcerated patient can give free informed consent. You probably saw "The Clockwork Orange." As a suitable compromise, social therapy units within the penitentiary service should probably accept only patients applying
for this program but there might perhaps be a suitable time limit, say one month, of consistently wanting to opt out before the patient could be transferred at his request out of the program.

5. Confidentiality of Records

The confidentiality of health records is presently a serious concern in our society. Mr. Justice Horace Krever of the Ontario Supreme Court is presently chairing a commission into this subject. The confidentiality of psychiatric records is an even more delicate issue, as the personal behaviour and life of our patients are much more extensively documented. The problems in a therapeutic community are even more complicated. The individual file of a patient describes his interactions with other patients; some of this may disclose criminal behaviour and innocent third parties. Much of it is hearsay. The psychiatric team needs this information, but its disclosure could have devastating consequences even if disclosed to the patient. Social therapy units designated as psychiatric treatments would have somewhat more protection than the same programs in prisons generally.

6. Inmate Power and Authority

In the traditional prison culture, the power and influence wielded by one patient on another can be devastating and malicious. No doubt for this reason it is a stated policy
of the penitentiary service that no inmate can be given such power over another. In a therapeutic community, the most powerful pressure to change comes from the peer group, and in this sense patients must be given the opportunity and indeed the responsibility to exert strong pressure on their fellow patients in a constructive way. I heard a number of staff, particularly in the living units, support the thesis that this power is an important part of their program. This is a problem that will have to be worked out administratively within the penitentiary service. In a social therapy program, if a patient's behaviour or thoughts are deviant it is the responsibility of his peer group to identify this deviation and to report it to the community. In Oak Ridge, when there is deviant behaviour, a Clarification Committee of fellow patients clarifies the event and reports to the group. A Sanctions Committee then decides if privileges should be withdrawn. A Treatment Committee may recommend a change in treatment program to the professional staff, and a Staff-Patient Liaison Committee makes sure that the staff is aware of the occurrence. This system gives tremendous power over a patient by the peer group and is essential to the functioning of a therapeutic community.

When new patients are admitted to Oak Ridge, they spend their first month studying papers on mental mechanisms, group dynamics, group-disrupting techniques, and their rights
under The Mental Health Act. This is all done in groups under the supervision of experienced patients. As they move into therapy programs, these groups too are monitored and supervised by fellow patients. Patients also operate the videotape equipment that records and plays back much of this action. Thus, patients play a major role in operating the programs and in doing so, are able to develop a sense of personal responsibility.

TECHNIQUES

It would be impossible for head office to order the implementation of a social therapy unit in a field prison or hospital without the local authorities being convinced and, indeed, enthusiastic that such programs are desirable and attainable. Therefore, if head office were inclined to support the development of such programs, it would seem wise to invite the local clinical and administrative officials to give the proposition serious consideration. This should probably include a visit to Penetanguishene and an opportunity to see the programs in operation, and some of the films that have been made describing the program (F Ward - Norm Perry; the BBC film shown in Britain; the Canador film; and The Thin Line). They could spend time probably with Dr. E. T. Barker, the chief architect of these programs, and myself.

It is important that these programs be adapted rather
than adopted. The needs of each individual facility vary and it is important that the staff of an institution feels that what they are doing is their program rather than adopting the program from another center. If it were decided that one or more centers would attempt to institute the programs, then an exchange of staff, possibly in both directions, between them and Oak Ridge would be desirable.

When the Social Therapy Program for Disturbed Women was developed at St. Thomas, Ontario, it was started with the help of about four patients from Oak Ridge who had progressed to the stage that they did not need the maximum security of Oak Ridge, but were not yet ready for the street. Other hospitals have expressed an interest in using former Oak Ridge patients to help develop social therapy programs. This is a model which might also be considered by the Federal Penitentiary Service. There are a number of patients in Oak Ridge who are serving federal sentences, who could help develop programs in the penitentiary, provided they did not have to return to the usual prison culture.

INMATE POPULATION

It is very difficult to estimate how many inmates of federal penitentiaries might benefit from a social therapy approach. Probably about ten per cent are schizophrenic, retarded, or otherwise psychiatrically ill, and require a more
orthodox psychiatric approach. Something up to ten per cent have the prison subculture so engrained that they would not likely benefit from a therapeutic community, except possibly to help contain them. Perhaps forty per cent have had a long history of failure to adjust at home, at school, at work, in marriage, or even in prison. These men suffer from a variety of personality disorders, and the therapeutic community approach is probably the best way to contain them safely and also to offer them the opportunity of learning to become mature, responsible citizens.

SEXUAL OFFENDERS

Recommendation No. 59 of the Parliamentary Sub-Committee says: "There should be several separate institutions for the treatment of sex offenders since their therapy needs are distinctive from those of other offenders with personality disorders. Admission should be on a voluntary basis." The usual reason for segregating sexual offenders is to keep them alive, as they are likely to be seriously abused in the usual prison subculture. It is debatable whether their actual treatment needs differ significantly from other prison inmates with personality disorders. The social therapy program that I saw at Fort Steilacoom in the State of Washington, was the second best that I had seen in North America, but they very carefully screened out offenders who are not highly motivated, offenders
who have killed or shown sadistic tendencies, and offenders who have shown a tendency to escape. A program for sexual offenders should probably include elements of the overall program aimed at personality development and personal responsibility, as well as specific sex education, social skills training, and the opportunity for aversive therapy. The use of castration or antitestosterone drugs is still controversial but may have a place.

WHERE TO BEGIN

It would be necessary to start with a small number of inmates (e.g., ten to twenty) and build up gradually, possibly to one to two hundred. Small units are uneconomical and cannot offer the variety of programs for work and play.

It would probably be advisable to have a pilot program within a regional psychiatric center and another within a medium or maximum security prison following a living unit philosophy. Abbotsford has the advantage that they have already incorporated a number of therapeutic community principles. Edmonton has the advantage of being a new institution without an established prison subculture. Some staff from many of your institutions have already visited Oak Ridge, and might be glad to have a further week at Penetanguishene and an opportunity to give serious consideration to the possibility of adapting Oak Ridge programs to their own institutions.
BIBLIOGRAPHY


Buber Behind Bars, Dr. E. T. Barker and M. H. Mason, Canadian Psychiatric Association Journal, 1968.

The Insane Criminal as Therapist, Dr. E. T. Barker and M. H. Mason, Canadian Journal of Corrections, 1968.


Introducing New Programs in Old Institutions - The Penetang Approach (Experience from the maximum security division of Penetang), Dr. E. T. Barker.


Buber Behind Bars, Dr E.T. Barker et M.H. Mason, Canadian Psychiatric Association Journal, 1968.

The Insane Criminal as Therapist, Dr E.T. Barker et M.H. Mason, Revue canadienne de criminologie, 1968.


Introducing New Programs in Old Institutions - The Penetanguishene Approach (Experience from the maximum security division of Penetanguishene), Dr E.T. Barker.
PART I

IMPLEMENTATION PLAN
<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>CODE</th>
<th>DURATION</th>
<th>START</th>
<th>FINISH</th>
<th>FLOAT</th>
<th>OPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>FORM WORKING GROUP</td>
<td>1-10</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>REVIEW EXISTING DATA</td>
<td>10-15</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>DUMMY</td>
<td>1-5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>WRITE REQUIRED PSC</td>
<td>5-15</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>DEVELOP WORKING MODEL</td>
<td>15-20</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>DETERMINE STAFF REQUIREMENTS</td>
<td>20-25</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>REVIEW EXISTING STAFF</td>
<td>25-30</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>DEVELOP REQ'TS FOR ADD. M-Y</td>
<td>30-35</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>RECRUIT ADDITIONAL STAFF</td>
<td>35-65</td>
<td>10</td>
<td>12</td>
<td>22</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>TRAIN STAFF</td>
<td>65-70</td>
<td>3</td>
<td>22</td>
<td>25</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>TRANSFER STAFF</td>
<td>70-185</td>
<td>1</td>
<td>25</td>
<td>26</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>DETERMINE STAFF TRG. REQ'TS</td>
<td>25-40</td>
<td>3</td>
<td>7</td>
<td>10</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>DEVELOP STAFF TRG. PACKAGE</td>
<td>40-45</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>ARRANGE FOR REQ'D TRAINING</td>
<td>45-65</td>
<td>2</td>
<td>18</td>
<td>20</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>DEVELOP INMATE PROGRAM</td>
<td>20-50</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>DEVELOP INMATE EVAL.CRITERIA</td>
<td>50-55</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>DEVELOP INMATE EVAL.PROGRAM</td>
<td>55-60</td>
<td>4</td>
<td>13</td>
<td>17</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>DEVELOP TRAINING PACKAGE</td>
<td>60-65</td>
<td>2</td>
<td>17</td>
<td>20</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>DEVELOP DISCUSSION PAPER ON INMATE PLACEMENT</td>
<td>15-25</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>CONSULT WITH OFFENDER PRGS.</td>
<td>75-80</td>
<td>1</td>
<td>6</td>
<td>12</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>DEVELOP POSITION PAPER</td>
<td>80-85</td>
<td>3</td>
<td>7</td>
<td>13</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>CONSULT WITH NPB</td>
<td>85-90</td>
<td>1</td>
<td>10</td>
<td>16</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>NPB DEVELOPS POSITION PAPER</td>
<td>90-95</td>
<td>6</td>
<td>11</td>
<td>17</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>DEVELOP POLICY &amp; GUIDELINES FOR GRADUATE PLACEMENT</td>
<td>95-185</td>
<td>3</td>
<td>17</td>
<td>23</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>SURVEY SUGGESTED FACILITIES</td>
<td>10-130</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>DETERMINE REQ'TS TO PROVIDE DISCRETE ENVIRONMENT</td>
<td>130-135</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>DEVELOP REQ'D MODIFICATION</td>
<td>135-140</td>
<td>8</td>
<td>4</td>
<td>5</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>INCORPORATE REQ'D MODIFICATION</td>
<td>140-145</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>ACCEPT FACILITIES</td>
<td>145-185</td>
<td>1</td>
<td>24</td>
<td>25</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>ARRANGE FOR PUBLIC RELATIONS (PR) COVERAGE</td>
<td>10-150</td>
<td>4</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>PREPARE REQ'D BRIEFINGS</td>
<td>150-155</td>
<td>4</td>
<td>5</td>
<td>14</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>BRIEF REGION &amp; INSTITUTION</td>
<td>155-160</td>
<td>1</td>
<td>9</td>
<td>18</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>BRIEF UNIONS</td>
<td>160-165</td>
<td>1</td>
<td>10</td>
<td>19</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>BRIEF COMMUNITY</td>
<td>165-170</td>
<td>1</td>
<td>11</td>
<td>20</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>EVALUATE FEEDBACK</td>
<td>170-175</td>
<td>2</td>
<td>12</td>
<td>21</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>BRIEF NHQ STAFF</td>
<td>175-180</td>
<td>1</td>
<td>14</td>
<td>23</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>PREPARE RELEASE FOR OPENING OF FACILITY</td>
<td>180-185</td>
<td>2</td>
<td>15</td>
<td>24</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>DETERMINE OPTIMUM SIZE</td>
<td>15-100</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>DEVELOP CRITERIA FOR GROUP</td>
<td>100-105</td>
<td>4</td>
<td>3</td>
<td>13</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>DEVELOP BASIC GROUP PROGRAMS</td>
<td>105-110</td>
<td>2</td>
<td>7</td>
<td>17</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>ARRANGE FOR PEER GROUP</td>
<td>110-115</td>
<td>2</td>
<td>9</td>
<td>19</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>SELECT REMAINDER OF GROUP</td>
<td>115-120</td>
<td>2</td>
<td>11</td>
<td>21</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>DEVELOP TRANSFER SCHEDULE</td>
<td>120-125</td>
<td>1</td>
<td>13</td>
<td>23</td>
<td>14</td>
<td>24</td>
</tr>
<tr>
<td>TRANSFER INITIAL GROUP</td>
<td>125-185</td>
<td>2</td>
<td>14</td>
<td>24</td>
<td>16</td>
<td>26</td>
</tr>
</tbody>
</table>
PART 2

SYNOPSIS OF SUBCOMMITTEE RECOMMENDATION 45
Recommendation 45 of the Sub Committee on the Penitentiary System in Canada can be implemented within Correction Services Canada.

The initial project should be assigned to the Regional Psychiatric Centre - Pacific as the location providing the best chance of success. Active support from the staff at National Headquarters, Regional Headquarters Pacific and to a degree from the Institutes in the area will do much to ensure the success of the Project.
IMPLEMENTATION OF RECOMMENDATION 45
OF THE
SUB-COMMITTEE ON THE PENITENTIARY SYSTEM IN CANADA

Recommendation 45 requested that the social therapy concept developed by the Oak Ridge Division of the Ontario Mental Hospital be introduced into both maximum and medium security institutions immediately to the extent possible.

BACKGROUND

The Sub-Committee visited the Oak Ridge Division of the Ontario Mental Hospital, Penetanguishene and later invited Dr. B. A. Boyd to appear in front of the Sub-Committee, which he did on 8 March 1977. From the Report, the Sub-Committee, feels that the social therapy concept as developed by Dr. Boyd would prove useful in reducing tension and provide a means where peer group control could be developed and used to the advantage of the inmate and the Corrections Service.

There are several areas covered by the Sub-Committee and Dr. Boyd which should be reviewed and in some cases may required a decision prior to use within the Corrections Service.

"Freely Give Consent" - This subject was brought up by Dr. Boyd and the Sub-Committee members. The discussion covered the use of drugs, shock treatment and other practices during patient treatment and the need for patient consent. They discussed the patient's ability to judge what was best for him and the real inability for anyone committed to be in a position to "freely give consent". There is always the implied or real threat, that if you don't consent you won't get out. This may not be as implicit within the Corrections Service but it is there.

"Civil Rights" - This cry is being heard more and more. It can be used as a means of refusing to participate in a program or as a lever to get into a program which appears more desirable. To what extent a person's civil rights may be infringed on in a social therapy program is doubtful but is has been used in the past to refuse treatment.

"Control Group" - If this program is going to be assessed to determine its effectiveness, a control group or standard will have to be established. In the Oak Ridge Model according to Dr. Boyd this became impossible due to the individual's ability to claim their rights were being violated by not receiving the same treatment as the project group. Again, there would appear to be a problem of what to do with the "control group" if identified with the project, when the project group is considered capable of being let out on the street. There is no statistical data in support of the Oak Ridge Project.
"Use of Drugs" - While Dr. Boyd indicated that in the existing social therapy program the use of drugs was minimal, they are still used in the later stage of the program. To what extent would this be acceptable within:

(a) a Regional Psychiatric Centre

(b) a maximum/medium security institution

Direction of Program - It would appear that the program duration could vary from four to five years with five years being the more viable figure. Dr. Boyd expressed the timing as such, the first year indoctrination and bucking the system, in the second year they start saying the right thing, in the third year they start believing in what they say and in the fourth year the staff starts believing what they say and by the fifth year we can get the Board to believe it. Based on this time frame with only one group per year which would not be cost effective, we would have between 80 and 120 inmates in the active program.

Isolation of Inmates - According to Dr. Boyd for this pilot project or any other to function with a hope of success the inmates must be totally isolated from the other inmates in the institution, i.e., accommodation, messing, recreation, programs must in no way allow contact with other groups within the institution. This could place a considerable strain on the functioning of any existing facility.

The Graduate - What is to be done with the inmate who has been declared successful. If he is ready for parole there would appear to be little or no problem other than ensuring through NPB that an adequate follow-up system is available. The problem graduate is the inmate who may have a further 10 to 15 years to serve. If he is placed back into the existing system he is lost. In the case of Oak Ridge, being a mental hospital they have in the past approached the Parole Board and turned their graduates unto the street based on the assessment that he is cured. What action can be taken within our system to arrive at a useful solution? Initially they would be useful in "seeding" new groups but this would not be a practical long term solution.

Inmate Selection - This presents the easiest solution to the "graduate" problem in that initially you select inmates who will be eligible for parole on completion of the program. While this would solve one problem it would probably open up the "civil rights" question.

Implementation - Dr. Boyd expressed to the Sub-Committee that while he was able to start his project 15 years ago, conditions have changed in respect to management techniques, civil rights and others to the extent, that he does not feel sure he could start today and accomplish the same results. Implementation can be done, he feels, but it will not be as easy or as spectacular as Oak Ridge.
The major requirements for implementation are:

(a) The project commence with a small select group, preferably four to five patients who are ready to graduate from Oak Ridge but otherwise would have to return to the prison system. Additional members be selected at the rate of three to four per month and be integrated into the project until the group size reaches 20. Additional groups to be formed to meet the project needs.

(b) The project be located in a facility which will allow the project groups to be completely isolated from the institution's other inmates. This would entail separate accommodation and no contact during meals, programs, recreation or other activities. A separate facility would be the best solution to meet this need.

(c) The staff would have to be selected from personnel who are in agreement with and capable of understanding the aims and intent of the projects. Administrative support will have to be prepared to run interference between the operating staff and possible outside interference.

(d) The initial training of the Oak Ridge staff was the basic nurse's aid course as given in Ontario complemented by an additional period of on-the-job training at Penetanguishene prior to moving to the Oak Ridge Division. Arrangements should be made for staff to spend one to two weeks at Oak Ridge for on-the-job training prior to being assigned to the project.

(e) Care be exercised in selection of inmates to ensure that each prospective "patient" knows what the project is about and has the choice of becoming a member or not. With proper care at this time "consent" and "civil rights" should be satisfied until such time as the program becomes universal. Initial selection should consider need for "seed personnel" and existing parole regulations to prevent the necessity of returning a graduate back into the prison system.

(f) If it is acceptable that the Oak Ridge concept is a proven fact no evaluation will be required. It must be pointed out, that there is no data available in support of Oak Ridge and its success rate appears to be based on the assumptions of the Medical Director. The use of a control group during the initial phases of the project is considered essential. One possible way of overcoming the problem encountered at Oak Ridge would be to select a "twin" for each patient chosen within the existing system and arrange to monitor his behaviour pattern for comparison purposes. There would appear to be no reason why he should be informed as he is not actively involved in the project.
The attached arrow diagram charts and tables show the major steps in implementing the "social therapy" concept into a facility within Canadian Corrections Service. Detailed planning will be carried out by the sub-groups and if necessary could be incorporated into the master chart. This decision will be made by the coordinator for the project. The time frame in this instance was based on a start date of March 1, 1979 with the facility staffed and ready to function August 30, 1979. Time frames used when arriving at milestones may vary during actual planning necessitating a revision to the completion date.

The working group under the direction of the coordinator will be responsible for the selection and direction of the sub-groups required to develop policy, guidelines and in producing working papers. This group should be composed of interested headquarters, regional and unit persons with the ability and authority to get the project done.

The attached line diagram shows the critical path to be 1, 10, 15, 20, 25, 30, 35, 65, 70, 185 that is through the staff requirements, recruiting and training phases of the project. Depending upon the requirements to provide a discrete environment for the project, it is most probably that the physical requirements for the unit may become critical that is events 1, 10, 130, 135, 140, 145 and 185. This would be fact if the decisions were made, to place the project in one of the older institutions where considerable construction would be required to meet Dr. Boyd's need to separate project members from the rest of the institutions population at all times.

Events 15, 75, 80, 85, 90, 95, 185 provide for attempting to solve the problem of the inmate who on completion of the project is declared ready to lead a normal life but must return to the prison system. The how, why and when of integrating this man into the system must be solved if the project is to be proved successful. One concept put forward is that all "graduates" should be paroled to the street.

Events 20-50-55-60-65 look at the requirement to develop a basic training concept, develop the implementation package and then develop a means to monitor and evaluate the program against an acceptable standard. One possible means of establishing a rough standard, would be to select patient/inmates in pairs, one would be introduced into the project, the other would remain in the existing system. No need to inform the second inmate that he is part of a project would appear to exist.

Events 10-150-155-160-165-170-175-180-185 were included provide public reaction coverage for the project. This project, due to its nature, will require sound will directed public relations to ensure its success.
PART 3

QUESTION AND ANSWERS
The attached questions were developed during the initial stages of the review of the Oak Ridge concept. Answers to most were obtained as more data became available. Dr. Boyd during his visit here on Feb. 27, 1979. reviewed the questions and expanded and clarified the answers in some cases. These questions could be used with minor changes as a form of survey to obtain reaction to the project.
1. Do you believe that the basic concept is applicable to:
   (a) CCS - maximum security facility
       - medium security facility
   (b) MS - RPC

2. Are there any areas within the concept which, in your estimation, should be
   (a) stressed
   (b) played down

3. (a) Within what areas do you feel the greatest benefit could be obtained?
   (b) Why?

4. What do you consider would be the optimum size for the social therapy group?

5. (a) Do you consider the "peer group" relation valid and is it present in this program?

6. Do you feel that this type of program is valid for all classes of inmates - explain.

7. Do you feel that the group should be controlled as to type of inmate - explain.

8. What would you consider to be adequate time for the average inmate to be involved in this type of program?

9. What do you feel is the aim of this program?

10. Should the inmate selected for this program be eligible for parole on graduation?
11. What do you feel the disposition of a maximum inmate would be on graduation?

12. Do you feel the successful completion of this program will affect the graduate's ability to adapt back into the conventional prison environment?

13. Should admission to the group be selective, with the inmate having final say?

14. To what extent should security be involved in inmate selection.

15. Should security have an overall say in the functioning of the program?

16. To what extent should security be visible?

17. Do you feel that a program of this nature would have the support of the majority of inmates?

18. Do you support a program of this nature - (check one)

   85% - 100% _________
   75% - 84% _________
   65% - 74% _________
   50% - 64% _________
   0% - 49% _________

19. To what extent was it necessary to precondition inmates from Federal Prison Systems?

20. Would this problem exist with a person straight from the court?

21. What do you feel would be chance of success with a repeater?

22. With respect to implementing the social therapy concept within the Federal System, would you set guidelines as to the type of "patient" you would be willing to accept initially.
23. Assuming we have started the program using the group size of twenty, how many groups would you suggest we form during the first year of the project?

24. Assuming the program is functioning is it feasible to move a person from one group to another based on
A) progress / lack of progress in the program
B) need

25. You mentioned that you felt that a hospital was the best environment for this program. Assuming we use nurses aids/guards with O.J.T. at OakRidge - Why?

26. This program which appears to reduced or suppress the aggressive nature of man cause that man problems on the street where at times he must be aggressive to survive. Will this need reduce in time the effectiveness of the program he has taken part-in?

27. In your meeting with the Sub Committee you mentioned trying to set up 5 or 6 medium security institutions, mini OakRidge.
Where you successful in this project?
if yes: Can you provide us with data on how it was accomplished
if no : Please explain why a successful project like OakRidge was not expanded.
HV  Boyd, B.A.
8837  Report to the commissioner of penitentiaries
B6  concerning recommendations no. 45
C.3