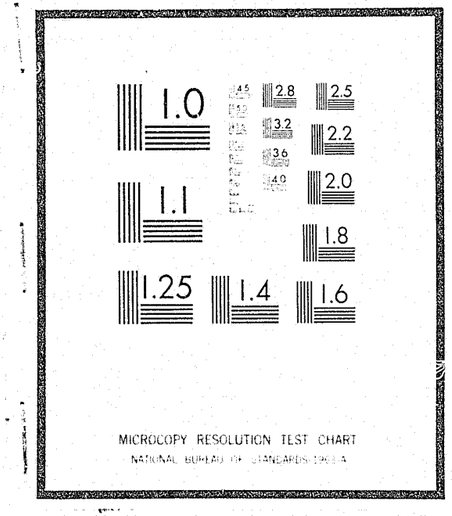

DRUG ADDICTS and YOU

A Handbook for Correction Personnel

They wanted to take the easy way out...

It's up to us to show them the way back in...

And it isn't easy.

But it can be done.

This Handbook tells how others help drug addicts kick the habit.

It also tells what <u>you</u> can do...

and why.

WHAT IS DRUG ABUSE?

Drug abuse is many things.

It is the heroin user injecting his bag of heroin, the methedrine user high on "speed", the 12-year-old sniffing model airplane glue.

But it is also the adult starting his day with an amphetamine for a needed "pick-me-up" and ending it with several drinks to "unwind" and a barbiturate to put him to sleep.

The problem of drug abuse reaches deeply into our values, aspirations, and fears.

It is an emotionally charged area for almost all of us.

Drug abuse is a serious, growing problem here, and in many other countries.

--"Students and Abuse"
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WHAT IS A DRUG ADDICT?

A drug addict is a person who has never learned to trust another human being.

Whenever he feels scared, as people sometimes do, he feels he has no one to turn to for comfort or advice. He cannot stand being anxious for very long. And he doesn't know how to get relief in a constructive way.

But there *is* something he can count on to make him feel better, at least for the time being. This something is...*his fix*.

The addict will never -- he *can't* ever -- change, until somebody convinces him that a human being can bring him more security than drugs.

But who can get through to him with this message?

It may be anyone: a psychiatrist, a social worker, an ex-addict, a physician, a hospital volunteer, a clergyman, a nurse.

It may be a correction officer.

It may be *you*.

IS THERE ANY HOPE FOR THE DRUG ADDICT?

Yes!

There are hospitals and treatment centers throughout the country which successfully help some addicts kick the habit for good.

There are also self-help treatment centers run by ex-addicts, which help addicts give up their dependency on narcotics.

In addition, there are treatment centers which help some addicts substitute less harmful drugs for heroin and morphine.

These will be described later in this handbook.

As yet, nobody knows enough about drug addiction to help *all* the different types of people who become "hooked". Every day, experts are searching for newer and better treatments which might be more effective for greater numbers of narcotics users. The breakthrough may come at any time.

But even before we can begin to help any addict with any treatment, we must be able to understand him. We have to know what drives him to "solve" his problems with a fix.

Although we don't yet know all the answers, of one thing we may be certain.

The addict turns to narcotics to escape pain and anxiety.

But what he finds, after a short span of pleasure, is even greater pain and anxiety.

HOW DID THE DRUG ADDICT GET THAT WAY?

The drug addict wasn't born that way.

No, he started out as we all do: an infant completely dependent on some adult for his very survival. Whoever tended to him had to provide him with food, clothing and shelter. Without such care, no baby can live long enough to grow up physically.

But it takes more than food, clothing and shelter to grow up *emotionally*.

For this to happen, we have to learn at least five basic "facts of life" quite early in our childhood.

1. We have to learn that we can't have everything we want the instant we want it.

2. We have to learn there are some things we may want with all our hearts that we can never have. Not because we are unworthy of them, but because natural laws or human laws do not permit it.

3. We have to learn that if we look hard enough, we can always find a healthy substitute for what we cannot have, which will make us happy too.

4. We have to learn that to get the things we want, we must work for them. There won't always be somebody around to give them to us.

5. And most importantly, we have to learn that working for what we want brings us the most gratifying

feeling a human being can ever achieve;
the feeling of *self-respect*.

Who teaches us such necessary lessons?

Normally, parents do.

In our early childhood, they encourage us to begin learning these facts in small, easy-to-take steps. With their guidance and praise for our fumbling efforts, we keep at it until we master the simplest tasks first. Then as we grow stronger and more experienced, we succeed at more complicated ones.

An early step, for instance, may be to feed ourselves. A later one, to tie our shoes. Still later, we do our homework. At a further stage we might help with household chores. And still later, we earn our allowance.

With each skill we master, we become more competent and self-reliant. We also become more confident that -- with enough practice -- we can make a go of most of our undertakings. Best of all, we are able to do what most other children our age do. And this makes us a desirable member of the groups with whom we live, study, work and play.

Being accepted by others gives us the self-esteem we must have to resist temptations that could lead us into anti-social and self-destructive behavior.

In normal circumstances, we also learn another essential lesson. We learn that when we have a problem, as people occasionally do, we can turn to someone older or wiser who will help us solve it. That person may be

our own parent, or a teacher, or a professional, or a relative or a friend. The important thing is that we *know*, from many good experiences, that no matter what our trouble is, we are *not* alone. On the contrary, we have learned that we belong to the community of knowledgeable, dependable and friendly human beings who are glad to provide us with help in our time of need.

Growing up with such a background, we become an adult who knows how to build a satisfactory life for himself and his family. Marrying, making a living, eating good food, buying nice things, educating our children, going away on vacations, having parties, planning for the future, are part of our day-to-day activities. We may not even feel we're particularly lucky to have such a life. Doesn't everybody?

No, not everybody.

And, certainly, *not* the drug addict.

WHAT MADE THE DRUG ADDICT CHOOSE A LIFE OF SELF-DESTRUCTION?

When we discover the answer to this, we may know better how to help him give it up.

We do know that drug addicts, like alcoholics, come from all strata of human society: from the rich, from the poor and from the middle-class. "Hippies", who are large users of drugs, come primarily from the wealthy and middle classes.

The essential conditions for addiction seem to be that: drugs must be readily available; the individual turning to them must suffer from excessive tensions; and drugs must appear to him as the best way to gain relief from his unbearable discomfort.

And, to cap it all, the addict's family consciously or unconsciously *encourages* his use of drugs.

Psychiatrists have determined that the rather severe emotional problems of addicts may be diagnosed as: character disorders, borderline conditions and schizophrenias.

Of course, the history of every addict -- just as the history of every other individual -- is unique.

We all have different combinations of parents, sisters, brothers, friends, teachers and other individuals who influence us. We also have different inborn aptitudes and personality traits. So in a way, we cannot speak of what happened to "the" drug addict. Each human being is in a class all by himself.

On the other hand, no matter how different their specific backgrounds may have been, each drug addict

does share *similar types* of experiences.

For instance, something in the way he has been brought up teaches him to distrust other people.

Furthermore, he has never been given the opportunity to develop confidence in his ability to achieve anything useful, either for himself or for others.

He may also have been emotionally starved, because of rejection, or a smothering overprotection.

Somehow, he has remained an *emotional* infant. He feels totally dependent upon someone else -- usually his mother, or his father, or some substitute-parent -- to decide for him what he can have out of life.

What made him this way?

PORTRAIT OF A DRUG ADDICT'S FATHER

Not every child with such a mother grows up to become a drug addict.

In fortunate circumstances, a relatively healthy aunt, or a grandmother, or an older sister may play the role of a better mother than his real one.

Or an effective father (or father substitute) may help his youngster separate from such a clinging, devouring mother. This father shows his child what it's like to be a man; one who achieves self-respect as well as the respect of others, through constructive activities.

But the child who later becomes an addict does *not* have such substitutes and supports.

Often, there's no man in the house at all. If there is, he is so weak that his influence is absent, or turns out to be as destructive as the mother's.

For instance, the father -- feeling too inadequate to cope with the possessive, over-demanding mother -- may withdraw altogether from his role as head of the family.

Or, taking the opposite course, he may become an "ogre" who shouts, raves and threatens physical abuse to get his own way.

He may also make extravagant demands upon his child for performance, and then mercilessly ridicule him for his inevitable failure. This father feels his masculinity is at stake, and he cannot tolerate any independence in his child.

TO WHOM CAN THE CHILD OF SUCH PARENTS TURN FOR HELP?

To his mother, who he feels wants to swallow him whole?

To his father, who rejects him, perhaps beats him, and even worse, makes him feel utterly worthless?

Obviously, he can turn to neither. He can trust neither.

But he is, after all, human. And humans need *somebody* -- for companionship, for emotional support, for a feeling of belonging.

The child is in a bitter quandary. Lonely and isolated, he feels desperate. Yet he is distrusting of human contacts: they fill him with even more tension than he already has. Ordinary life situations frighten him. Being with most people terrifies him. This makes him abnormally dependent upon anyone who offers him the hand of friendship which he *is able* to accept.

And the drug addict's tragedy is this: that the first hand of friendship extended to him that he is *not afraid* to take...*holds a fix*.

Another harsh aspect of the drug addict's fate is that -- in some strange way, as has already been mentioned -- his parents may *promote* his use of drugs!

They do not give him concrete help in his dilemma. Instead, they cover up; they deny that he has a problem; they are more concerned with protecting *themselves*.

In a variety of subtle ways they let the child know that he is *not* to ask for help, for to do so might reveal *their own inadequacies*.

WHAT IS DRUG ADDICTION?

When he becomes addicted, the individual's body begins to function *differently* from a non-addicted person's.

The addict finds that he needs more, and larger, doses of the drug, to get the same "kick" he enjoyed when he first started. His body has developed a tolerance for the drug. This means, his body has gotten used to the fix, and no longer reacts to it as in the beginning.

But, at the same time, the individual now *needs* the drug his body has gotten used to, in order to feel comfortable. If the necessary dose is withheld, he becomes sick. His body torments him with sweats, shakes, nausea, diarrhea and sharp abdominal as well as leg cramps.

But even worse, the addict becomes *psychologically* dependent upon the drug. He has developed a *habit* of using drugs to *escape* from the pain of his emotional problems, rather than facing and trying to solve them.

And, to cure him of his drug addiction, we must first cure him of his need to run away from his personal challenges.

For this reason, drug addiction may be described as a *symptom*. This means, it is a sign that something is disturbing the addict that he may not be aware of, and that he certainly doesn't know how to solve.

Some emotional problems are relatively simple to treat. These may be behavior disorders: such as truancy, temper tantrums, hitting people, lying and petty thefts. Other emotional problems may be caused by one of a variety of Schizophrenias, which require more complicated treatment.

Only medical and psychiatric examinations of the specific individual can determine whether his emotional disturbance is simpler, or more severe.

In many instances, it appears that the emotional problems of drug addicts might have been relatively simple to treat, had they sought professional help before they turned to drugs.

To understand the relationship between a symptom and its cause, let us take as an example, the familiar toothache.

When a tooth begins to hurt, it is a *symptom* that something is wrong, which might be easily remedied with a visit to the dentist.

But some people are more afraid of the pain of dental treatment than they are of the toothache itself.

So, to get relief, they take aspirin. If it works, they stay away from the dentist, hoping that the tooth will get better by itself.

But what actually happens? As we know, if they wait long enough, the tooth may become so decayed that it can no longer be saved by a simple filling. Instead, it requires the extreme treatment: extraction.

Applying this example to the drug addict, we may say that before he got "hooked", he experienced emotional pain in the ordinary stress and strain of living. His pain may have taken the form of feelings of inadequacy, insecurity and anxiety.

Perhaps he didn't know what to do about a predicament at school, or in connection with his work, or in relation to his family. Often he was the kind of child who, when

he got into trouble in school, his parents bailed him out without his having to change his behavior to avoid such trouble in the future. He was never made to face a situation if it were the least bit difficult. If he wanted to stay home from school, he did. If he didn't feel like studying, his parents didn't bother to find out why.

If it had occurred to him to seek guidance from a professional, or from some other person who could give him sound advice, he might have discovered a realistic way out of his troubles. At least, he would have been shown how to start coping with them in a manner that could eventually bring him real satisfactions, and help him to grow up emotionally.

But, as we have seen, the potential drug addict does not trust anybody enough to ask for this kind of help.

How could he? He has never been able to count on his own parents for the kind of advice that would help him to face life courageously. He has come to accept the fact that he cannot depend upon them for useful information about anything. In fact, their behavior towards him is illogical and confusing, so that -- in order to endure the chronic anxiety of living with two such authorities -- he has learned to deny that he has any emotional problems whatsoever.

Understandably, he tends to think that all other authorities are as untrustworthy as his own parents. Instead of reaching out for close human relationships, he resorts to fantasies for his major satisfactions.

Still, like the individual with a toothache, he *does* suffer from inner agony -- and he seeks some kind of relief from it.

The moment he discovers that he can get at least temporary release through narcotics, his comparatively simple and private problem is in danger of becoming an extreme and public one.

Because once he becomes "hooked" on narcotics, he begins to destroy not only *himself*.

No, his inescapable need to obtain more and more of these illegal, expensive drugs, forces him to become destructive to *society* as well.

WHAT IS THE LIFE OF A DRUG ADDICT LIKE?

For an addict, life is *hell*.

Once he is "hooked", he spends most of his time and energies on one goal: getting enough drugs to support his habit without interruptions.

This is a full-time job with lots of overtime. It often prevents an addict from going on with his education, or from keeping a job. In fact, he is relieved that he no longer has to work, or to face any responsibility.

He pays no attention to nourishing food, and begins to suffer from bad health. He is frequently sick: either from an overdose, or from the effects of involuntary withdrawal when he can't afford his next fix. No wonder statistics indicate that his lifespan is often shortened.

The addict knows little about life besides trouble, in between his "kicks". He is generally on bad terms with his family; and almost always on bad terms with the law.

And how could it be otherwise? He would have to be a rich man to support his habit without stealing or other crimes against property. A heroin addict, for instance, may have to spend as much as $75 to $100 a day to meet his cravings for the drug!

Many authorities say that the addict's criminality is not a direct effect of the drug itself; but is a result of his need to get an inordinate amount of money to support his habit.

Still, in this connection, it is revealing to note that parents of many addicts have great hostility towards

people and society. They stimulate similar antagonistic feelings in their children, which are then projected onto other individuals in the normal community.

In his criminality, the addict gets back at authority, which he fears and resents. He expresses his anger at the ones "in charge" by outwitting them, cheating them, stealing from them, and otherwise damaging them. But, in doing so, he puts his own fate in jeopardy.

This is because he suffers deep feelings of guilt for his anti-social behavior, which cause him to seek punishment, either from others or from himself.

The mixed emotions of intense anger and intense guilt cause the drug addict to develop a life pattern known as sado-masochistic. And as long as this persists, he will continue to defeat *himself*, no matter what he does to others.

WHAT DOES THE DRUG ADDICT GET FROM A FIX THAT "HOOKS" HIM?

Following his first fix, which may be somewhat upsetting, later ones make the potential addict feel like the person in the song:

"Ah, sweet mystery of life, at last I've found thee!"

The narcotic gives him release from anxiety, respite from responsibility; it gives him the peace he can never get from being with people.

With the drug, he is able to withdraw from the world he cannot cope with; yet experience an illusion of well-being such as he never got at home.

Here is how one confirmed addict puts it in his own words:

A PERSONAL DESCRIPTION OF THE IMMEDIATE SENSUAL EFFECTS I EXPERIENCE FROM AN INTRAVENOUS INJECTION OF HEROIN

The feeling is essentially one of great contrast...contrast between: the mental anxiety, depression, anticipation, the physical discomfort of muscular tension and numerous minor body aches, watering eyes, post-nasal drip and flowing mucous membranes (all culminating in the sharp sting of the needle); and, the sudden relief of all these symptoms coming in a lazy, warm tide which begins to envelop my body within about forty-five seconds after the solution has begun to leave the needle and enter the bloodstream.

The sensation is very much as if the body had taste buds in every individual cell and were ingesting a warm, sweet, pungent, mothers' milk. Occasionally I experience a strange form of sexual excitement, purely physical in nature, which manifests itself by an erection and a tingling sensation around the groin lasting for several minutes. (This is rarely accompanied by any mental-sexual activity such as fantasy or desire.) There is a mild feeling of excitement, as if in anticipation of something, which often concentrates itself around the area of the heart and upper abdomen...much like the sensation known as "butterflies". With it, now, there is a similar feeling of anxiety, but under this condition it is very pleasant.

All these euphoric experiences generally remain at a peak level for about five minutes, then they gradually begin to fall off; however, there are other effects which are retained for a much longer period.

The effort normally required to defend myself against anxiety, to resist the effects of worry and pessimism in my outlook toward daily trials, challenges and responsibilities,

is so sharply reduced as to make it, for the present, actually pleasurable to review these things. As a result, my mind becomes quite active and free-flowing, for a time which often extends to several hours, and I frequently find myself engaged in mental games which are usually quite productive, both intellectually and creatively.

Often, in this state, I aggressively attack work which may have piled up during the day before, when I was experiencing withdrawal symptoms of extreme anxiety and discomfort (as described in the first paragraph), and therefore not much able to perform well normal daily functions and adequately meet my usual responsibilities...this is especially true of any job requiring creative or physical effort.

Generally after from two to five hours (the time depending upon many variables) I become progressively more emotionally sensitive, even to the point of crying at the slightest provocation. During this period I frequently have daydreams recalling a host of experiences during my childhood, most of which are of the most seemingly insignificant nature; and are usually events which were hardly, if ever, thought of since the day of their occurrence.

Dreams elaborating on such happenings also occur quite often while sleeping at night or in early morning hours.

This generally leaves me in a state of great mental depression and anxiety concerning the various chores of living, and I become irritable and non-productive, thus returning gradually to the state I was in preceding my "taking-off" several hours earlier.

You will note from the above description that the drug *temporarily* alleviated feelings of emptiness, depression and other undesirable symptoms experienced by the addict; and that this transient relief was followed by even greater anxiety than the addict had felt prior to taking his fix.

Many addicts agree that while they are on drugs, they feel that they can do anything, everything. No longer an insignificant worm, they feel like a conquering giant. They have it made.

And they will not give up this illusion for any reality.

Unless they can be persuaded that a human being offers them something better than their fix.

What, for instance?

Perhaps, a helping hand that leads them to a new and truly *gratifying* -- instead of always frustrating -- way of life.

To get the addict even to *want* to kick the habit, you have to prove to him that...

1. He can live without his fix.

2. The world can be as friendly to *him* as it is to non-addicted people.

3. He *can* succeed at something socially acceptable which also brings *him* deep personal satisfaction.

4. *You* believe in this...and in *him*.

WHY IS IT SO HARD FOR THE ADDICT TO KICK THE HABIT?

We don't know all the reasons. But we do know this.

If you take drugs like morphine and heroin long enough, you develop a *physiological* dependence upon them, as has already been described. This means that when you try to stop, your whole body kicks up a storm. You develop leg, back and abdominal cramps. Your muscles twitch. You vomit, get diarrhea, run a fever.

In addition, your *psychological* torments may be even worse. You've been told so much about the excruciating agony of withdrawal, you fear it more than the thought of death.

It takes a strong character, with a powerful determination to succeed, to endure this mental and physical anguish for the 48 to 72 hours it takes before the most severe symptoms subside.

But strength of character and determination are precisely *not* the qualities the drug addict has ever been trained to cultivate!

On the contrary, as we have seen, the individual who drifts into the narcotic way of life shows the following characteristics:

1. He has little tolerance for frustration, and must have what he wants when he wants it.

2. He has little ability to endure pain, and must have instant relief.

3. He doesn't trust other people, especially

"squares" like you and me; and he won't let anyone like us get too close to him.

4. He is afraid of and hostile to authorities, and doesn't know how to cope realistically with them.

5. He can't stick to any task that requires sustained effort, or self-control.

6. He is unable to concentrate and therefore has great difficulty learning anything new.

7. He doesn't know how to make sensible decisions, either in his own interests, or in the interests of others.

8. He is so preoccupied with his own needs and problems, he has little energy left over to be concerned with anyone else.

SO WHAT CAN WE DO TO HELP THE DRUG ADDICT?

When you talk to a drug addict -- as you must if you are going to help him -- you find that despite all his other failures, there *is* one area of success in his life.

This is: his ability to "cop" drugs; to get the cash for a fix.

He may not have been able to stay in school. He can not maintain a family, or be a cooperative member of one.

But he *can* steal, hustle, "con" -- and with incredible effectiveness. Among his own kind, this achievement is admired and highly praised. So this facility gives him the only self-esteem he has ever attained.

When you try to take away from him this only source of self-respect, he will fight you with his entire being.

Unless you offer him something in return he recognizes is *better*.

When you try to help the drug addict, you must come to him with a program that convinces him he *can* succeed in something other than getting a fix.

To create and administer such a program, *you* must believe it is *possible* for an addict to become, and *remain*, an *ex*-addict.

Most people, unfortunately, do *not* believe it.

And it is *this negative attitude* which helps make the problem of drug addiction so difficult and complicated to solve.

WHAT OTHERS ARE DOING ABOUT IT

HOW SOME DRUG ADDICTS ARE BEING HELPED TODAY

Fortunately, pessimism about drug addiction is *not warranted* by the latest facts.

A growing number of drug addicts *are* being treated successfully today.

There is a health department in every city that will give practical guidance to the drug addict seeking help. If the department cannot provide the therapy he needs, it will refer him to appropriate agencies.

Furthermore, while it *once* was true that few drug addicts had access to the variety of special programs and services he needs to help him rebuild his life constructively, the Narcotic Addict Rehabilitation Act of 1966 *now* makes it possible for a complete range of rehabilitation services to be made available to many addicts right in their own home communities.

Under this law, an addict charged with a non-violent federal offense may volunteer for commitment to the Surgeon General of the Public Health Service, who arranges for his examination, treatment and rehabilitation.

An addict *not* charged with an offense -- or his relative or other interested individual -- may also apply to the Surgeon General for treatment.

And a convicted addict may be committed to the Surgeon General for treatment up to a ten-year period.

In each instance, *after care* of the addict, following his release from the hospital, is considered a key

aspect of his rehabilitation.

More recent legislation also provides that states and communities may receive -- through the National Institute of Mental Health -- federal support for special training programs as well as funds for the construction, staffing and operation of new addiction-treatment facilities on a joint federal-state basis.

Some of the treatment centers that help addicts today include:

LEXINGTON, KENTUCKY

Under the Narcotic Addict Rehabilitation Act of 1966, the hospital at Lexington, Kentucky now receives only those addicts sent there by law for examination, treatment and rehabilitation.

If accepted, the addict remains at the hospital for six months. During this period he is withdrawn from drugs, receives medical treatment if necessary, is given thorough personality and intelligence evaluation; and he is encouraged to participate in a broad range of programs which include psychotherapy, vocational training and recreation.

At the end of six months he is assigned to prolonged after-care treatment in community agencies.

CALIFORNIA REHABILITATION CENTER PROGRAM

California passed a law in 1961, as did New York in recent years, establishing a rehabilitation program, and making participation in it compulsory for drug addicts.

Each staff member of the California Rehabilitation Center works with no more than thirty individuals, which permits every professional to give the addict concentrated attention. Services include counseling, supervising the addict's progress, helping him get a job, and supporting each step of his efforts to make the transition from his former life to non-addicted living.

Upon his arrival, the addict is given a variety of examinations. He receives intensive testing, which includes intelligence, educational achievement, vocational aptitude and personality evaluation. An exhaustive history of his life -- his social and criminal history -- is taken.

His treatment program, which takes into consideration his specific personal history, is based on group-centered activity.

For instance, he meets with the other residents on his ward and a staff member for an hour, five days a week, for group discussions. Here the participants talk about their problems in group living: their conflicts and tensions while working and eating with the others. They discuss sexual problems, social fears and anything else that is on their minds. Group members are encouraged to be candid about their feelings about themselves, as well as about each other.

For some part of the day, work therapy is assigned

to some; others attend school; still others receive vocational training.

Important as this intensive program is, it is considered only the *beginning* of the addict's retraining and re-education. *After care and follow-up* are regarded as essential to his total rehabilitation.

NEW YORK STATE REHABILITATION PROGRAM

The New York State Narcotic Act of 1966 is an amendment to the 1962 Metcalf-Volker Bill, which provides for the creation of a Narcotic Addiction Control Commission within the Department of Mental Hygiene in New York State.

The Commission is charged with the responsibility of developing and operating services and facilities for prevention, treatment and research in the field of narcotic abuse.

Under this law, treatment and rehabilitation responsibilities of the Commission are restricted to individuals who are dependent upon heroin, morphine, opium and other addicting drugs.

An addict may receive help from the Commission by volunteering at any time, or after he is charged with a crime. A parent, wife, husband or other concerned individual may also ask the courts to have an addict placed in the program. A court may send an addict who has been convicted of a crime, to the Commission.

In each instance, the addict must be processed through the courts to assure that his rights are understood and protected, and a court order is issued.

Certification (the court order) gives the Commission supervision or jurisdiction of the addict for up to three years. (If the addict is convicted of a felony, the period is five years.)

Under this program, the addict is withdrawn from narcotics, receives physical care to restore his health, and is evaluated so that a rehabilitation program may be designed for his special needs.

Treatment may include individual therapy, group therapy, counseling, classroom work and recreation. In addition, he may be prepared for a job so that he can make a living when he is ready to return to the community.

Each addict is encouraged to proceed at his own pace. If he should need to repeat any part of the program, he may do so until he masters that particular step and is *really* ready to advance to the next one.

The goal is to prepare him for after-care. When he reaches this part of the program, he is helped to move back into the neighborhood. He is assigned to a community-based services center when all the staff members who have been treating him feel that he can take on the responsibility for his own behavior without close supervision; that he can cope with his every-day problems without resorting to drugs; that he has the discipline to work towards a useful future; and that he has the desire and self-control to get along with others.

THE SYNANON COMMUNITY

A number of years ago, an ex-alcoholic, Charles E. Diedrich, started Synanon, a place where addicts can live permanently.

The program is based on the belief that addicts have never had a chance to grow up. Here they are given their first opportunity to do so, properly.

But first, they must see themselves as they actually *are*.

This means, they must become aware of all their weaknesses and alibis, rather than see themselves -- in fantasy -- as unappreciated heroes.

Once they are willing to face themselves, they are ready to change. They are then encouraged to build a useful life through their own efforts. The many examples of ex-addicts around them convince them that this is possible.

There is one rule which may not be broken. This is: No Drugs Allowed. Anyone who relapses must leave the community. Ex-addicts, rather than physicians, help newcomers through the withdrawal period.

One method Synanon uses with great effectiveness is "the game". Residents are urged to tell each other everything that is on their minds and in their hearts. The only prohibition is: no physical abuse. Verbally,

anything goes. And in such an accepting atmosphere, anger erupts like a volcano!

The advantage of "the game" is this: once the addict is purged of his rage, he is free to give his energies and wholehearted attention to building a more orderly life.

The Synanon community is operated solely by ex-addicts. The work of the entire organization -- from sweeping floors to administration -- is handled by assignments. For every resident, these begin at the simplest level of work: washing floors, cleaning the kitchen, and similar tasks. As skills and performance develop, the member may be given more complicated jobs with more responsibility.

In addition, a variety of assistance is given to the member if he needs to learn to read; or if he has been a dropout from high school but is college material, he is supported in his efforts to go to college ~~if~~ should he so desires.

Synanon does not accept government subsidies because it does not want to risk interference with its program. Residents and their relatives contribute generously to its maintenance. It also receives income from sales of its own products as well as from wise financial investments.

There are now several Synanon communities throughout the country, as well as schools for children of families who live in Synanon. There is even talk of these communities expanding into Synanon cities.

DAYTOP VILLAGE

The philosophy behind Daytop Village is similar to that of Synanon, with one important exception. The ex-addict is encouraged to leave the village after staying in it from a year-and-a-half to about two years.

David Deitsch, a former Synanist who set up Daytop several years ago, believes that after so much re-education, the resident should be able to resist the temptations of drugs, even when he is on his own.

Prior to "graduating" from Daytop, the resident is sent into addiction areas where he tries to persuade the addicts to come to Daytop for treatment.

The program is open to any addict who can abide by the strict rule: "No Drugs".

Private voluntary agencies, as well as anti-narcotic government departments, provide financial support for the "graduate's" work among addicts. To be sure he stays off the habit, the government requires him to be urine-tested periodically.

PHOENIX HOUSE PROGRAM

Started by Dr. Efren Ramirez, former Commissioner of New York City's Addiction Services Agency, the Phoenix House program -- like the ones at Synanon and Daytop Village -- is designed to help the addict develop a sense of responsibility for his own behavior, and a feeling of obligation towards his community.

Committed addicts are sent to Phoenix House after detoxification over a period of months at the designated correctional institution.

Today there are several Phoenix Houses in New York City to which addicts may come voluntarily.

Each Phoenix House is a small "therapeutic community." About a hundred addicts live, work, eat and play together under the direction of a trained staff, most of whom are ex-addicts.

Two strict rules are: no violence and no drugs.

The addict begins to solve his emotional problems immediately upon arrival at a Phoenix House. After breakfast he attends a meeting where residents learn what's new in the house, what is scheduled there for the day, and what the work assignments are.

For part of the day he works at a job. This may be: building or improving some of the facilities; getting meals; answering the phone. As he demonstrates his reliability and his willingness to take on more important assignments, he gets them.

Some time each day residents attend a seminar or group discussions. These are concerned with problems of addiction; others are about events going on in the city. Group members are encouraged to air their gripes. In addition, residents participate in "encounters" three times a week, where they have a chance to loosen up with people, and test their ability to relate to others.

When residents are ready, they enter the final part of the program, known as "Phoenix Re-entry". Part of their work is paid for as a staff job. A resident in "Phoenix Re-entry" might be assistant director of another Phoenix House, or he might run a purchasing department, or work in one of the Neighborhood Phoenix Centers where addicts, who come in off the street, are prepared for assignment to a Phoenix House.

The rest of the resident's time is devoted to getting equipped to earn a good living. He may undertake more training in his present trade, or new training for a different trade which he prefers. He may be helped to complete his education, if that is what he wants. Or, if he has the abilities and the desire, he may study the Phoenix program in depth, and prepare himself for a well-paid professional job in rehabilitation.

Phoenix Houses are supported by a combination of municipal and private funds.

METHADONE TREATMENT

Methadone is a synthetic drug which some authorities believe ends the addict's craving for heroin and other opiates.

True, the addict becomes just as dependent upon methadone as he was on heroin and morphine.

But methadone doesn't give him the false sense of "high" as the other drugs do.

Reports, which are still incomplete, indicate that when "hard-core" addicts -- who can't kick the habit any

other way -- are given methadone together with counseling, they are able to stay off heroin and morphine, which enables them to keep a job, complete their studies, and in other ways function as non-addicted individuals.

Doctors who recommend the methadone treatment for certain "hard-core" addicts reason this way: the addict should be regarded as a very sick person who must have his shot to stay alive. In this way he resembles the diabetic, who must have his daily dose of insulin. Society doesn't stigmatize the diabetic for this. And if you can regard methadone as "a kind of insulin", this reasoning makes some sense.

Methadone is still in the research and experimental stage. Its use is not accepted by all authorities. One might even call it the "support the habit" treatment, because patients do become addicted to the drug.

On the other hand, since the addict on methadone can be "ambulatory", and go about his daily business like an otherwise normal adult, it may be considered a temporary solution to the complex problem of "hard-core" addiction. At least, it takes the addict out of criminal activities he may otherwise engage in to get money for narcotics.

THE BRITISH SYSTEM

Legalization of drugs is sometimes referred to as "the British System." At one time, drug addicts in Britain could legally obtain a daily dosage of their drug for about 15 cents, by presenting a physician's prescription

to a pharmacy. The doctor, who was permitted by law to prescribe drugs for addicts, was expected to keep the dosage as low as possible while he tried to get his patient to withdraw from the habit eventually. Most importantly, the British government hoped that the low cost of drugs, plus their availability under the law, would in time eliminate black markets as well as reduce crime.

Did it work? Not too well! But why not?

One reason may be the tolerance factor. As we have said, addicts need more and more of their drug to get the same kick and relief from it. So British addicts were compelled by their craving to resort to deceit in order to obtain more than their prescribed daily dose. What did they do?

They went to several physicians and got more than one prescription. They also printed up their own prescription forms which they forged with doctors' signatures. They even robbed, mugged and used the money they stole to buy more drugs on the black market.

Ironically, the availability of drugs seemed to cause an increase in the number of addicts as time went on.

Consequently, this system had to be terminated. Today only an accredited treatment center may prescribe drugs for addicts in Britain. Every week prescriptions are mailed to the pharmacy, which is authorized to give the addict only a single day's dosage.

And even as we are doing, the British are still looking for a better answer.

Incidentally, such a system was once tried in our own country for a short period during the early 1920s. Called the "Clinic System", it failed here too, and for the same reason. The addict just does not have a limited appetite for drugs. What satisfied him today may not be enough to make him happy tomorrow. As time goes on, he needs more and more narcotics to get the same feeling of relief and comfort.

This is what constitutes his personal problem: getting more and more of a drug that seems absolutely indispensable to his survival. This is what is so overwhelming to him, and, as a result, so overwhelming to society.

CAN DRUG ADDICTION BE "CURED"?

The idea that drug addiction is a chronic disorder which can never be "cured" is appealing -- not only to many professionals, but to addicts as well.

This theory has been applied to alcoholics in Alcoholics Anonymous. And some psychiatrists believe it must be true also of the syndrome of Schizophrenia. They hold that phenothiazine drugs (like Thorazine) and electric shock treatments are to the schizophrenic what insulin is to the diabetic.

There is no research which supports this notion. Still, it is a comforting thought to some addicts, alcoholics and schizophrenics, as well as to large sections of the professional community. It means that failures in theory and in treatment can be excused.

But there *is* something to be said for this philosophy. It does help certain individuals modify behavior that has previously gotten them into trouble, if they get the necessary support.

For instance, it helps many alcoholics give up the kind of drinking habits which may be fatal to them, with the encouragement and example of other alcoholics who have agreed never to "take another drop". It brings schizophrenics to a state of remission and helps them function with somewhat less anxiety than before, although they may need continuous treatment. And it helps some addicts stay on a maintenance dose which is not detrimental to them; while at the same time they can give up criminality and work towards a better existence.

This is all to the *good*.

WHAT ARE WE LEARNING FROM ALL THESE EXPERIENCES WITH DRUG ADDICTS?

We are learning that drug addiction -- while it remains one of the most challenging human problems of our time -- is *not* a hopeless one.

There are many different methods being tried today. Some work very well with some addicts. None work very well with all addicts. The search for the kind of help needed for a variety of addicts goes on.

But while the methods discussed here offer no ideal solution, each of them has contributed something valuable to our knowledge about addicts and addiction.

Lexington, which is now a Clinical Research Center operated by the National Institute of Mental Health, has provided us with the bulk of our knowledge concerning the chemistry, physiology, neurology and mental pathology of addiction.

Psychologists and psychiatrists have presented an accurate description of the addict's personality and his relationship with his family. Together with sociologists, they have given us a useful picture of the environment that nurtures the addict and his addiction.

Drug maintenance programs like methadone have enabled us to cope with those addicts who so far cannot respond to methods that demand complete withdrawal.

Self-help programs like those at Synanon, Daytop and Phoenix House have proven beyond a doubt that some addicts *can* be rehabilitated.

WHAT YOU CAN DO ABOUT IT

CONTINUED

1 OF 2

WHAT DOES ALL THIS HAVE TO DO WITH YOU...THE CORRECTION OFFICER?

The drug addict <u>can</u> be helped.

This is the important message of this Manual.

Every day more physicians, psychiatrists, nurses, social workers, psychologists, and other professionals on the team engaged in the rehabilitation of addicts, are discovering this.

And *you* are another important member of this rehabilitation team.

If *you* understand why addicts may be afraid of, or resentful of, or angry at you...

If *you* can reach that hidden core in every addict that desperately wants to respect himself, but doesn't know how to go about earning this self-respect...

If *you* begin to win the addict's trust in you as a human being who wants to help rather than hurt him...

If *you* in your own heart really believe he can be helped in some degree at least...

Then *you*, too, can play a major part in turning the addict back from hopelessness, and setting him firmly on the road to rehabilitation, so that he can eventually have a decent life and play a constructive role in his community.

Of course, this is no easy task.

Addicts, as we know, have been forced by their consuming need for drugs to become expert at lying, cheating, stealing, resisting, and in every imaginable way *frustrating* the efforts of all authorities who want to help them.

In the beginning of their imprisonment, all they want is their freedom, so they can get their fix. They will promise anyone anything if they can "con" him into helping them get out.

So it is only natural that people dealing with addicts become disappointed, impatient, and eventually disgusted; then lose all their interest in him, and even want to punish him for his upsetting behavior and his refusal to cooperate in his own behalf.

But, if you understand the addict better than he understands himself, *you* really have the upper hand!

You can then anticipate his reactions, and not be surprised or caught off-guard by anything he does. Instead, you can plan ahead what *you* will do to prevent him from getting away with his old tricks.

At the same time, you try to get across to him the idea that you are here to help, and not to hurt him. You will not hesitate to let him know that you are aware that he is trying to "con" you. But you will not punish him for this or hate him. You will devise rational ways to prevent him from being destructive.

It will take time, it will take effort, it will take thought, it will take patience, it will take self-control, it will take determination and dedication to help the addict *in spite of* his hostility and self-destructiveness.

And it will also take training...and a detailed rehabilitation program for you to be effective.

2. It was revealed that correction personnel have a high degree of priceless knowledge about drug addicts. This is not surprising, in view of the amount of time they spend with addicts. But what *is* surprising, and terribly wasteful, is that they are generally not able to make the best possible use of their special knowledge. But why not?

3. And here we come to one of the most startling discoveries of this pilot training program. It was found that correction officers didn't feel free to talk to each other about what they know!

They couldn't express their doubts, their feelings of frustration, and their ideas for improving the routines, so that work with the addicts might be more successful. They hesitated to make suggestions to mental health personnel, whom they recognized to be well-meaning, but whom they often found ineffectual so far as rehabilitation of the addict was concerned.

4. The project disclosed another strange, yet very human, predicament. Correction personnel and mental health personnel -- who are hired to work in the same institution for the same purpose: that of helping rehabilitate drug addicts -- are not able to communicate with each other!

While both live physically in the same world, their outlook on their mutual problem is so different, they might as well inhabit different planets.

Yet, if they could only open their minds to each other's point of view, each could have something invaluable to offer the other. The mental health worker, with his unique knowledge of why human beings behave as they do, could teach the correction officer techniques developed by the mental health field for reaching an emotionally disturbed individual who cannot trust you. The correction officer, on the other hand, could teach the mental health worker the *real* facts about drug addicts and drug addiction, and he could give valuable suggestions as to daily care.

What happens to the drug addict when these two important groups of authorities cannot cooperate with each other? The effect on him is often as destructive as was his childhood experience at home. *There*, his parents fought with each other too. Instead of working together for his welfare, they used him as a pawn to win their personal battles against each other. Being caught in the middle between two authorities struggling for power was a major factor in his growing up confused, hostile and anti-social.

But when two important groups of authorities like correction officers and mental health personnel *do* learn to cooperate with each other, they can put their heads *together*. Then they can devise the best course of action to help the addict switch from messing up his life with drugs, to building up his life without them.

The Correction Officer as a Constructive Authority

We have learned that licking the problem of drug addiction requires this basic development: wherever the addict is housed, *that* place must become his "therapeutic community". If a prison happens to be his abode, then *this* is where the addict's rehabilitation must begin.

If prison is a place where he is punished instead of helped to rehabilitate, we are simply wasting the institution personnel's time, the community's money, and the addict's opportunity to be given a new outlook on life.

Punishment only deepens the problem by confirming the addict's feeling that authorities are 'squares", rotten and not for *him*.

Only understanding -- and appropriate corrective measures based on understanding -- can make his stay in prison productive.

Only understanding will open up channels for communication and dialogue.

It helps when one says to the addict: 'This you can do, and that you cannot do.'

It helps when one is consistent: rewarding the addict for doing what's expected; restraining him but not punishing him when he does something destructive, or gets out of line.

Sooner or later, the addict gets to understand such consistency. He then interprets your behavior as meaning that you are neither a 'patsy' nor vindictive; but in a wonderfully new experience for him, you are a *fair* person.

To help you achieve such a consistent approach when the addict misbehaves, or 'acts out' the role of a bad boy or a bad girl, you must be concerned with what he is doing to hurt *himself*, as well as what he is doing to hurt society or others.

The Correction Officer "Tells it like it is"

The training project referred to previously, arranged for correction personnel to meet in small groups, and honestly to express how they felt about what was happening in their relationships with drug addicts and with other institutional personnel.

And here are some of the discoveries that you can apply in your own work:

1. Most correctional workers have the same feelings of frustration and conflict while working with addicts. This is immensely reassuring to each individual worker, and can supply the courage to go on working constructively while you are looking for better methods and techniques.

2. Expressing what you really feel and believe, helps your colleagues to understand you better. As they gain insight into how you feel, why you do what you do and say what you say, they realize how much you have in common with them. And they develop an even greater respect for you as a human being who is doing his best in a very difficult situation.

3. Frank discussions of specific problems often lead to original solutions of what up to then may have seemed like a hopeless impasse.

Another interesting finding is that, at first, the best kind of group experience for correction officers is to meet in groups with other correction officers. This is because it's easier to learn to be candid and comfortable with 'one's own kind', before one feels free to reveal his true feelings to those viewed as being "different" from ourselves.

So, when considering a program for an institution, include group discussions; and begin by organizing such discussion groups with people in similar job classifications.

After these groups have worked together long enough to bring about significant results (which may take three or four months), then mixed discussion groups should be formed, composed of people from different classifications. These mixed groups should become permanent fixtures of personnel practice.

The question is asked: how often should such discussion groups meet? Experience indicates that for best results, the group should work at least once a week for an hour-and-a-half.

Another important question is: who should be the group leader? While someone with group experience is desirable, it isn't essential. Any individual with leadership ability, who has the respect of his peers, and who has undergone a brief, intensive workshop in professional group interaction processes, may function adequately as a group leader. The leader, however, should not be the boss; but the boss should be a member of the mixed group every so often (not regularly).

Psychologists have found that the use of rewards for desirable behavior in the addicts have proven to be one of the most effective ways in which to set up a constructive atmosphere in a prison.

This has also found to be true in mental hospitals, in children's detention homes, and other types of institutions.

Talk about such a system that can be introduced in *your* institution.

You will find that after the group process described above has worked smoothly, consistently and satisfyingly for a period of time, you and your colleagues are ready to do something *new and better* for drug addicts.

PHILOSOPHY BEHIND A PRISON REHABILITATION PROGRAM

A prison rehabilitation program that really works takes advantage of the addict's craving to "beat the rap". He will do whatever he thinks you want him to do, even if it is for the wrong reason: to get out of jail so he can obtain his next fix.

This very attitude gives you an opportunity to establish a relationship with the addict. You, too, want him to be able to leave, although your intention is that he should gain something while in prison that will help him to undertake a better life once he gets out. So, although your ultimate goals are different in the beginning, you both do start out working for the same purpose: that the addict become ready to leave prison.

An effective rehabilitation program has clear-cut requirements for the addict's behavior during the different stages of his stay. Everyone -- administration, personnel and the addict himself -- must understand that when he is capable of conducting himself in a certain specific way, he will earn special rewards.

Right from the start, he must be encouraged to reach for one concrete goal: to "graduate" from prison into a setting where he will have greater freedom to take greater responsibility for his own behavior.

He should begin learning this important lesson while he is in the correctional institution. Do not be afraid to give rewards: these can be simple -- a smile, an encouragement if he has accomplished a task well.

In implementing such a program, you will be giving the addict the *opposite* kind of experience from what he was accustomed to in relation to authorities in his childhood.

In frustrating experiences at home with his parents, he may have learned to feel: *"I don't know what you want from me because you give me contradictory messages; I don't know how to do what you want; and even when I think I have done it, you never give me what you promised. You never give praise; you always make me feel guilty."*

In a constructive experience with you, he must learn to feel: *"I know what you want from me because you have told me clearly just what it is; I know how to do it because you have taught me how; and I want to do it because you have promised me certain freedoms I yearn for if I succeed, and I can count on you to keep your promise."*

But will it work?

For some addicts, yes.

Experience in programs like the Phoenix House have shown that some addicts can and do learn a new way of behaving with people. They do lose their feelings of distrust.

They succeed in this because -- instead of being returned to their former environment which had originally pushed them into the drug addict -- they have been helped to enter a normal environment where socially-useful behavior is appreciated and rewarded, where work is an honorable task, and where individual initiative is valued.

There will still be addicts who relapse and have to come back for repeated treatment. And still others may not respond at all.

But this we *can* safely predict.

Discovering how you feel about yourself, your colleagues, and your work with drug addicts -- and sharing these feelings with others who are in the same boat -- will open up for you a new and more enjoyable kind of relationship with everyone on the job.

The successes (modest though they may be at first) that you will achieve as you become more familiar with this cooperative approach to drug addicts and their problems will encourage, compensate and reward you for your day's labors more deeply and more gratifyingly than any work experiences you may have ever known before.

Until now, the general belief has been that prison cannot be rehabilitative. Today, there is every reason to believe that, with adequate programs, it <u>can</u> be.

BEST-KNOWN DRUGS

Thumbnail Sketches

BEST-KNOWN DRUGS

Thumbnail Sketches

Narcotics refer to opium and other pain-killing drugs made from it, which -- when taken repeatedly -- are addicting. These include morphine, heroin, paregoric and codeine.

Certain synthetic drugs such as Demerol and Dolophine are also classed as narcotics.

Taken in prescribed doses, a narcotic produces sedation, as well as relief from pain.

The two most abused narcotics are heroin and morphine.

HEROIN, the most popular of opiates, is derived from morphine. But it is stronger than morphine, and is therefore more addicting. Pushers prefer it because it is more profitable than morphine. Illegal in the United States, it is smuggled in and made available to addicts for a high price.

At first, heroin makes the user less tense and frees him from his fears. The early feelings of "high" may be followed by apathy. Hunger, thirst and the sex drive are diminished. About 18 hours after his last fix, the heroin abuser suffers from withdrawal symptoms.

MORPHINE, like heroin, is a white powder with no odor. Medically prescribed, it is used to ease pain, or it may help a suffering individual to get some sleep. But an overdose can cause death.

Addicts mix the powder with water, and inject it under the skin with a hypodermic needle. To "main-line" means that they inject the morphine solution directly into the vein. All powdered narcotics are used in a similar fashion.

CODEINE, which relieves mild aches, is used in some cough syrups because it also controls coughing. Some addicts try to get their "kicks" by taking these cough syrups, which they think are not addicting. Unfortunately, if taken often enough, they are.

DEMEROL and DOLOPHINE are two synthetic opiates which were created in laboratories in order to substitute for natural opiates without being addicting. But as it turns out, they have proven to be just as habit-forming as morphine.

BARBITURATES and NON-BARBITURATE HYPNOTICS (Doriden, Placidyl, Noludar, etc.) are depressant drugs which relieve anxiety. With proper medical supervision, they are effective in the treatment of certain mental and physical illnesses.

In uncontrolled doses, the effects of barbiturates are harmful to the powers of concentration and the ability to work. The user may become irritable and argumentative. Or he may fall into a deep sleep when he wants to be awake. Taken without medical advice, barbiturates may cause death through an overdose. And they are physically addicting.

COCAINE, classified as a stimulant, used to be employed as an anesthetic. It is no longer regarded valuable for this purpose. But, for the addict, cocaine does serve a purpose. He absorbs the white, odorless, bitter-tasting powder by sniffing it, or by injecting the solution into a vein.

At first he gets a feeling of pleasure. All too soon, however, this is replaced with symptoms of paranoia. Accusing "enemies" of being "out to get him", in his fear, he may suddenly attack anyone close to him.

Although there is no physical dependence on Cocaine, there is a strong psychological pull which is almost impossible for the Cocaine abuser to overcome without help.

AMPHETAMINES are stimulants which may be prescribed by a physician to combat fatigue, bring about feelings of alertness and self-confidence. However, certain individuals may experience a depression afterwards.

When abused, amphetamines may cause a person to become so over-active that he winds up exhausted. Over-doses may cause temporary insanity which requires hospitalization. If you try to force a heavy user to withdraw from the drug all at once, he may develop a suicidal depression.

Heavy users of amphetamines tend to be irritable and unstable, and may show other symptoms of emotional disturbance.

TRANQUILIZERS (Miltown, Equanil, Librium, Valium, etc.), which are consumed by the billions every year in the United States, are popular because they relieve anxiety and give the user temporary feelings of security.

Under medical supervision, they are effective in the treatment of tension and anxiety. But when over-used, they lead to dependence on the drug. Withdrawal symptoms are severe. Sometimes there are convulsions and the person may even die. Drowsiness is one danger resulting from the taking of tranquilizers, causing drivers who overindulge in them to contribute heavily to the high accident rates in our country.

THE HALLUCINOGENS

Hallucinogens, also known as "psychedelics", create hallucinations. Unlike alcohol, which may also create hallucinations, hallucinogens do not fog the mind. They simply play tricks on it, causing the user's imagination to run out of control.

LSD, an abbreviation for lysergic acid diethylamide, is a powerful chemical created in the laboratory. One ounce can provide doses for over 300,000 users!

It is a dangerous drug; increasing the heart rate, causing a rise in blood pressure and temperature, making the palms sweaty, the body shiver with chills; creating nausea, dilating pupils, and producing irregular breathing. It also causes the user to lose his appetite.

Some LSD users are also driven to suicide or violence; or develop mental derangement.

While not physically addicting, if taken without medical supervision, LSD may cause the user to fall into a panic, or fear of losing his mind. He may even suffer accidental death by jumping from a rooftop because he thinks he can fly.

LSD is believed to produce long-standing changes in the chromosomes of the body, effecting genetic damage to the offspring of the user.

MARIHUANA, when smoked, quickly acts on the brain and nervous system. It is classed as a mild hallucinogen because it may cause hallucinations when taken in extra large doses.

The effects of Marihuana range from depression to elation. The user finds it hard to think clearly or to make decisions. His reflexes don't respond normally and this makes driving dangerous for him.

While there seems to be no physical dependence on Marihuana, repeated use does appear to cause psychological dependence. An even greater danger is that the person who smokes Marihuana may go on to more powerful drugs like LSD or even Heroin.

END