PENNSYLVANIA ADULT CORRECTIONAL TRAINING INSTITUTES (PACT)

Law Enforcement and Corrections Services
Office of Continuing Education and Community Services
College of Human Development
The Pennsylvania State University

DRUGS AND TREATMENT PROGRAMS (7504)

A Training Module for Trainers of Personnel

in the Administration of Justice

Designed as Part of the Statewide Training

Program for County Probation and State Parole Personnel

by

CHARLES L. NEWMAN, PROJECT DIRECTOR

STANLEY S. GOEHRING, TRAINING SUPERVISOR

ELLEN S. PIERCE, STAFF ASSISTANT

Supported by a Grant from the Pennsylvania

Governor's Justice Commission #DS-459-73A

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A FORWARD TO THE INSTRUCTOR

This training module, Drugs and Treatment Programs, was developed in accordance with the Pennsylvania Adult Correctional Training (P.A.C.T.) project. It is based on materials present at the P.A.C.T. XXI workshop and aimed at keeping corrections personnel current in the field of drug abuse. This module can be used independently as a short course of several hours' duration or it can be incorporated into the full series which P.A.C.T. has produced.

In order that each module be utilized to its fullest potential, the trainer or instructor first should have a sound background, preferably with field experience in the area in which he will be instructing. Secondly, he should have in-depth knowledge of the bibliographical material listed at the end of the training module, as well as other literature sources. With this basic preparation, the trainer can be in a position to employ the training module as a "road map" for the direction and substance of the course. Throughout the preparation and presentation of the course, the trainer should keep in mind the general objectives of the course as set forth at the outset of the outline.

As the course is presented, each heading and subheading should be treated by the instructor as a theme for expansion. The headings are meant only to provide the structure to the trainer, who should then build on them, expanding and enlarging as the needs of the class are demonstrated and his time and ability permit. Many examples and illustrations should be provided to the class. An abundance of case material and other examples carefully prepared by the instructor is essential.

It is the illustrative material that concretize concepts and enhance learning. The trainer should draw upon his own professional experience as well as the bibliographical material for much of this expansion. Obviously, the trainer should capitalize on the experiences of his class in order to make the material more viable.

While the trainer is preparing for the course, certain chapters and sections of the readings will suggest themselves to him as so basic or important that he will want to assign them to the class. Therefore, the bibliography will serve two purposes: preparation of material for the instructor and training material for the class. No attempt was made on the part of those developing the training modules to dictate what, if any, the class assignment should be. The trainer will know his class and its needs better than anyone else, and should have full discretionary power on assignments, drawing from the bibliographical references or any other sources which he deems relevant.

It might also be helpful in teaching this particular course that a guest speaker who is currently working in the field of drug abuse and has a thorough working knowledge be requested to participate. His expertise in the field will not only lend credibility but will also be valuable in answering questions that will undoubtedly arise.

The films suggested at the end of the module can also be employed as constructive teaching tools. Be aware that the more current the film, the more credible it will more likely be.

It should be remembered and repeatedly stated that the drug problem cuts across all sectors of our society. Amphetamine abuse is as much of a crisis as heroin abuse. There are no absolutes that crime leads to drug addiction or that marijuana leads to a life of drug addiction or a life of crime.

DRUGS AND THE OFFENDER

COURSE OBJECTIVES

(1) To keep probation and parole personnel current in the field of drugs

(2) Increase the awareness of various types of treatment programs so that the officer may more knowledgeably refer clients to such agencies

INTRODUCTION

Drug abuse is on the increase in every segment of our society. Law enforcement, probation, and parole personnel will undoubtedly encounter this problem more and more as time goes by. Though this personnel will not be faced with administration of medical treatment in these cases, they should be aware of the varying treatments and services that do exist. This is essential for adequate referral. They should also be aware of the usual symptomatic behavior associated with the various types of drug abuse and that multiplicity in drug use is common. In all probability, as trained interpreters of behavior, they will be the initial detectors of the problem. Probation and parole officers will be responsible for medical referrals and for long term aftercare services.

NARCOTIC DRUG ABUSE*

There are several treatment modalities, each having its proponents and opponents. It is suggested that each established treatment modality may be beneficial for certain people. There is no single drug treatment

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*See Appendix I for drug descriptions and Table I for summary of existing services in Pennsylvania.

The corrections officer has an important role to play in this increasing problem. This training module will, hopefully, increase his background knowledge and his ability to effectively refer his clients to services available.

approach that is satisfactory in every case. To claim that there is one superior treatment would be a fallacy. The Governor's Council on Drug and Alcohol Abuse has called for a multi-modality treatment approach in its 1973 Master Plan for the Prevention, Treatment and Control of Drug and Alcohol Abuse, Volume 1. This concept envisions several treatment programs aimed at different individuals' capabilities and motivations. It would also end the conflict between treatment types. This multi-modality approach would afford to the person seeking treatment a variety of resources and alternatives. The model would offer a variety of different treatment approaches under one administrative body.

As it is now, there are approximately 77 drug treatment facilities in the Commonwealth of Pennsylvania. Though only 17 of these are Methadone Maintenance Programs, they serve over 50% of the patients receiving treatment. Administration is disjointed in many cases and there is presently no systematic approach to the drug abuse problem.

Prevention programs are the most effective way to deal with drug abuse. Current drug abuse education is either unsuccessful or succeeds in amplifying students' already positive attitudes. So, education must be redirected in such a way that it discourages drug abuse. There are some specific reasons why present prevention programs are failing. These are:

1. Unqualified teachers;
2. Scare tactics are often employed;
3. Materials are sometimes outdated and irrelevant to the current drug scene;
4. Didactic presentations;
5. Little follow-up to the program, if any at all.

Primary prevention should be aimed at nurturing healthy attitudes in young people prior to and during the time they may be faced with a decision involving drugs.

LAW ENFORCEMENT CONTROL PROBLEMS

1. Manpower components are not adequate to keep up with the increasing flow and distribution of narcotics and dangerous drugs.
2. The court system is overburdened by large caseloads so that the drug violator, when apprehended often received only cursory handling. Because of this, arrests do not result in convictions.
3. Without a statewide program of specialized drug violator caseloads, probation and parole personnel are faced with a problem they are not equiped to handle. (The services presently provided to drug abusers by the Pennsylvania Board of Probation and Parole are primarily in Philadelphia. There are several Human Service Aids employed who are better able to relate to drug abusers than the average parole or probation officer. A more comprehensive program is necessary for effectiveness on a larger scale.)
4. Public support of drug laws is often lacking when the penalty seems too harsh for the offense. This is due to the fact that there are grave inconsistencies in the drug laws. (For example, the penalty for the personal use of Marijuana carries the same penalty as the distribution of Hashish.)

DRUGS AND CRIME*

The evidence that links drug use to crime is inadequate. No drug by itself has been proven to "cause" crime. There is, however, a relationship between the type of person who becomes a drug-user (abuser) and who has personality difficulties. It is a fact that persons with histories of personal difficulties, deprivations, or deficiencies, loss of control, and impeded judgment, etc., are likely to be drug users. Many heroin users are likely to have a delinquent record prior to their involvement with heroin. To say all drug users are potential criminals would be a fallacy.

Harold Finestone states in Narcotic Addition:

> Reverting now to the relationship between narcotics and criminality, the principal observation to be made is that narcotics use spread to adolescent groups who simultaneously evaluated highly adults who were engaged in a wide variety of criminal activity and adults who were addicted; and these valuations were reflected in both criminal activity and experimentation with narcotics. Thus, both the criminality and experimentation with narcotics stemmed, at least in part, from influences to which the youngsters were exposed, as represented by adult models within the local community. Both criminality and narcotics use came to be prestigful forms of activity. In this sense, it is irrelevant to ask whether the delinquency preceded the addiction or vice versa. Many of those who became addicted and were forced to engage in crime to support the high cost of their addiction would probably have gone on to engage in crime as adolescents regardless of whether or not they had become addicted.[1]

Finestone goes on to say that through his study, those addicts who committed violent crimes against persons and property had usually committed similar offenses prior to addiction. And, the proportion of

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*See Appendix II - Pennsylvania Drug Device and Cosmetic Act of 1972 for prohibited acts and penalties.

[1]Finestone, Harold, Narcotic Addiction, O'Donnel and Ball, editors, pp. 150-151.

offenses coupled with violence committed was indeed a small percentage of the total.

> Addiction, thus, appears to reduce both the inclination to violent crime and the capacity to engage in sophisticated types of crime requiring much planning.[2]

Through information available to date, a cause and effect relationship between drugs and crime has not been established.

DRUG TREATMENT PROGRAMS

Methadone Maintenance

Methadone Maintenance is currently the most prevalent treatment method for narcotic addiction in the United States. A pharmocalogical treatment, it is based on the theory that drug dependence and abuse is a metabolic disorder.

Methadone is a narcotic, and causes physical dependence. However, no "high" results from the oral administration of methadone and the patient becomes tolerant to most side effects of opiates.

From a treatment standpoint, high dosage methadone maintenance offers two advantages: (1) "drug hunger" is satisfied; and (2) since a tolerance to injected heroin results, a relapse to self-administration will not result in a euphoric high. Proponents claim, therefore, that (a) methadone maintenance should stop drug seeking behavior, and (b) it enables clinicians to reshape the patient's behavior in more socially acceptable directions.

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[2] Ibid, pp. 153

*See Appendix III for further definitions of treatment approaches. See Appendix IV for breakdown of number and types of programs in Pennsylvania.

The eventual withdrawal from methadone is necessary for this type of treatment to receive greater community acceptability. Proponents have suggested that the community will have to accept methadone maintenance in the same way that insulin used by diabetics is accepted.

Methadone Maintenance has been found to be more acceptable to the drug population than residential treatment in a therapeutic community or any other treatment approach.

It is not advisable that minors be treated by this method. Since methadone is a narcotic, it is possible to addict the juvenile for life by its administration. There have been no reported instances of death due to uncomplicated withdrawal from opiates. Withdrawal or almost any other treatment modality would be better for adolescents than methadone maintenance.

There are numerous drawbacks to methadone maintenance. Some are the following:

1. Poisoning
2. Death can result from methadone overdose
3. Accidental poisoning of children
4. There is little collected data on chronic human toxicity of methadone.
5. The point of view is sometimes held that nothing more than the administration of methadone is required to deal with the addict. This suggests that the psychological, social, and vocational rehabilitation efforts by other quarters of treatment are, in fact, superfluous. These are all expensive treatments, and, thus, methadone maintenance invites a society with a heavy tax burden to call for an end to these programs. This can result

in methadone programs becoming narcotic distributionships and leaving other important needs for rehabilitation untouched.

6. In relation to the simplistic view of the relationship between drug addiction and crime, the methadone corollary that follows is: if an individual is legally maintained on methadone, he will be protected from withdrawal. Therefore, he will not commit crimes to support his "habit". Is retaining an addict on drugs legally an adequate response to the drug problem?

7. Most of the illegally available heroin is so thoroughly adulterated and the quantity of narcotic drug in illegal preparations so small, that in most cases the users of these preparations do not receive enough of the active ingredient to become physically dependent upon it. Also, the majority of narcotic drug users in the U.S. are not addicts. With these two points in mind, it is easy to see that the administration of methadone to any of these persons will result in addiction in persons who were not previously in this state. Methadone is not a panacea for all narcotics users. By administering methadone in these cases addicts will be made out of non-addicts. Though methadone does not have the euphoric high and other affects of heroin, it should always be remembered that it is a narcotic.

8. It is also possible for a person to be both on methadone and heroin simultaneously. Since the effects of either only lasts a certain number of hours, it would be possible for an addict to receive his dose of methadone at the clinic in the morning and "shoot up" with heroin that night.

9. Some patients have unpleasant side effects while on methadone. Some of these are constipation, drowsiness, sweating, and difficulty sleeping. Most of these will disappear over time.

Methadone maintenance is perhaps a more acceptable treatment modality because it calls for less committment on the part of the patient. The goal of methadone treatment is the total rehabilitation of the patient including the withdrawal from methadone use. Unless it is used in conjunction with other forms of rehabilitation, it will miss some important components necessary for complete readjustment to society.

Narcotic Blocking Drugs -

There are drugs which are non-narcotic which will block the euphoric effects of heroin. Two of these are cyclazorine and naloxine. The principle behind this treatment modality is that if a person no longer receives positive reinforcement from the drug (i.e. a "high"), he will eventually stop using it.

There are, however, drawbacks to both of these drugs. Cyclazocine lasts only 18 hours, has unpleasant side effects and must be administered on an inpatient basis. Though naloxine has none of the unpleasant side effects of cyclazocine, its period of action is so short (only 3 to 4 hours) that it cannot be effective as a treatment modality.

The Therapeutic Community -

The therapeutic community purports to engulf the drug addict within a social matrix of former drug users, thereby making him part of a viable and productive organization. It provides him a role structure and a series of graduated status positions which he has not formerly experienced.

Synanon, Founded by Charles Dederich, was the first residential therapeutic community. Through the structure of the community, it is claimed that the user will be able to surrender his drug crutch and become an effective community member. This idea receives support from studies which indicate a direct relationship between living within an integrated social structure and an absence of emotional and mental strains. However, there is little empirical data for testing this hypothesis. To passionate supporters and members, any evaluation of the community and treatment is seen as an intrusion and an insult.

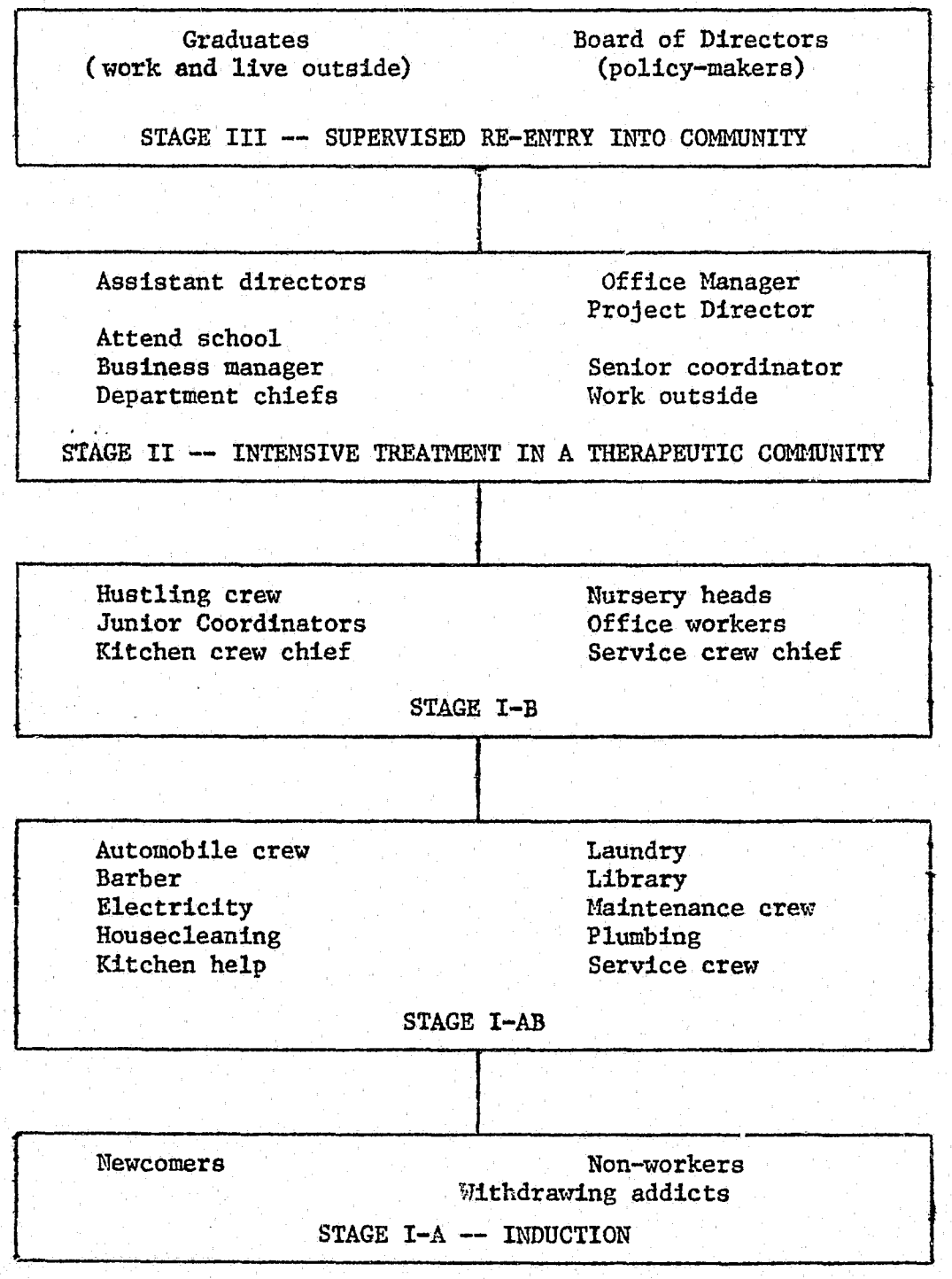
The treatment is divided into three phases: (1) induction; (2) intensive treatment in the therapeutic community, and (3) supervised re-entry into the outside community.

Induction: Prior to acceptance into the community, the potential member must demonstrate his true desire to give up his addicted life style. A traumatic initial interview is conducted by former addicts of the community to determine whether the prospective member is indeed dedicated to change and the goals of the community. This eliminates persons who are not sufficiently motivated. The interview is carried out with the understanding that voluntary residence requires commitment and a high degree of motivation. Acceptance into the community means submission to the value system of the group.

Intensive Treatment in the Therapeutic Community: After entry into the community, the addict immediately undergoes supervised withdrawal without the aid of opiate substitution. This is part of the process of reorienting the addict away from drug use for symptom relief. The resident begins his stay by being assigned to the lowest level of the community's hierarchial work structure. The member then must work his

SYNANON, JUNE 1962*

Division of Labor and Stratification System



*This table can be found in Narcotic Addiction, O'Donnell and Ball, editors, pg. 224.

way up through the hierarchy, primarily on the basis of his personal growth and ability to accept and carry out responsibility. If the member reverts back to a poor attitude, he will be demoted back to the bottom rung of the work ladder. Discipline and negative reinforcement are important tools in stimulating growth and change. Positive reinforcement is also utilized. Group sessions are held on a daily basis where confrontation methods are used.

Supervised Re-entry into the Community: The length of a person's stay in the community can range from twelve months to two years. As he progresses through the hierarchy, he begins to move into the re-entry phase. He does this by first working out of the community and living in. Later he moves out but will retain loose ties with the community.

Therapeutic Tools that Constitute This Treatment Approach

1. There is a paternalistic family structure in which conditional love is offered.
2. There is an initial screening process and intake procedure followed by "cold turkey" detoxification.
3. During the indoctrination process, it is conveyed to the patient that no antisocial behavior will be tolerated. Any form of verbal behavior is encouraged.
4. The principles of status and mobility are most important (i.e. the patient works for positions as prescribed by behavior through status stages).
5. Seminars where no solution is right or wrong are held on philosophical topics.
6. The ritual called the "hair cut" is used. This is applied to an individual when he displays a negative attitude. In the

"hair cut", he is confronted by other members concerning his behavior. During this, he is not allowed to respond or react verbally.

7. The work situation is such that the participant of each member is essential for the continuance of the program.
8. Group therapy sessions are held which encourage open participation.

For those who remain in the group and complete the program, the success rate is high. However, the actual number of persons who complete the program is small.

Drawbacks to the Therapeutic Community Approach

1. Many addicts have admitted having difficulty leaving the therapeutic community and returning to the outside world. This results in the community developing into a sub-culture.
2. Career choices and orientation for those ex-addicts who leave the community are very limited. In some cases, the only role available is that of being an ex-addict group leader for another community or rehabilitation program.
3. The data available suggests that this type of treatment is only acceptable to a small number of addicts. The intense verbal attacks and confrontation tactics are often not good tactics for the treatment of adolescents. It also has limited appeal to older addicts. This can be attributed to its severe treatment approach and modified Calvinistic work ethic. Anyone choosing this treatment must be truly committed to giving up his addicted way of life. If not, the likelihood of his completing the program is small.

Religously Based Programs

These programs are often exhortive in nature. Run largely by the Fundamentalist and Black Muslim faiths, they are often effective. However, there is no specific data available to give an accurate measure of their effectiveness.

The general approach employed is exhorting the individual to give up drugs and his "sinful" way of life while aspiring toward moral conversion with the help of the group.

Non-residential Community

These communities are aimed at the non-addicted drug population. Though they often employ similar techniques as a therapeutic community, their clients do not live at the facility. These clients are still capable of relatively normal functioning within the society. They still go to school or work. They continue with their normal daily routine except to incorporate into it several hours a day at the community.

Multimodality Programs

This type of program allows for total flexibility of treatment modality under a single roof. A wide variety of treatment alternatives are available including methadone maintenance, out-patient, crisis intervention, counseling, etc.

Individual and Group Psychotherapy

This is based on the theory that persons who have drug problems have a particular constellation of personality characteristics that are summed up as an "addictive personality." It is claimed that only these people will become dependent on drugs. On this basis, the only way to

deal with these people is through personality modification.

Method of Treatment: Personality modification can be achieved through counseling and discussions either by trained professionals or in a group setting with persons who have similar problems. These people are perceived as being able to contribute understanding to the problem. Once the underlying problem at the basis of addiction is conquered, then the patient's need for drugs will disappear.

This treatment approach has several obvious loopholes:

1. A group or individual session of only a few hours a week cannot get to the root of the problem.
2. It has not been proven that there actually is such a thing as an addictive personality.
3. The addict is not given anything (an ongoing program) to ease the transition to a non-addictive state. This type of program would be more successful if used in conjunction with another treatment modality (methadone maintenance, therapeutic community, etc.).

NON-NARCOTIC DRUG ABUSE

Determining the extent of non-narcotic drug abuse is difficult because not only is there an illicit market of non-narcotic drugs, there is also an indeterminable population of abusers who are maintained by private physicians. This is not to say that private physicians are knowingly maintaining these chronic drug abusers. However, this can occur through negligence.

A part of primary prevention should be aimed at physician education so that a patient's actual use of drugs can be monitored. Also, unlimited

refills of prescriptions should not be allowed. The physician should be alert to a patient's repeated request for more medication. Patients who exceed their prescribed dosage are often looking for intoxication rather than simple symptom relief.

The value of sedative drugs as therapeutic in helping the patient learn to cope with anxiety has not been clearly determined. Something learned under a drug-induced state is not necessarily transferable to a nondrugged state. A sedative can be effective in reducing anxiety but this treatment should perhaps be coupled with psychotherapy to produce an actual increase in coping skills. It should be noted that much more clinical research is necessary before the interaction of psychotherapy and sedatives can be determined.

There is a tremendous non-narcotic illicit drug market in the U.S. There is substantial evidence to say that a new drug-abuse problem is arising and that the characteristics and complications of this type of drug abuse does not correspond to patterns exhibited by narcotics users. Thus, traditional approaches used with narcotic addicts are not applicable to this type of drug abuse.

The following is an overview of general characteristics of non-narcotic drug abusers and treatment programs.

Barbiturate Abuse

Barbiturate abuse is not particular to any single group or social class. Barbiturates are often used by alcoholics to increase the effects of alcohol. The abuser of this drug uses it not for its sedative effect but for intoxification. Barbiturates can cause neurological damage and mental deterioration after continued abuse over a long period of time.

A physical dependence can occur if the drug is abused regularly. An overdose can cause death. This is a common tactic in suicide attempts.

Barbiturate Abusers: Barbiturate abusers can be classed generally into three types:

1. There are those who abuse barbiturates solely for the sedative-hypnotic effects in order to deal with emotional distress. In doing so, they remain constantly in a highly sedated state.
2. There are people who use barbiturates to obtain exhilaration effects. Many of these people have found when using barbiturates for therapeutic purposes that when sufficient tolerance develops, the drug will stimulate rather than depress.
3. There are persons who while in the course of abusing other drugs will use barbiturates to alter their effects. Examples of this would be: (1) using barbiturates to counteract amphetamines; or (2) substitute a barbiturate for an opiate when none is available. This can lead to a cyclical pattern of abuse.

Treatment: Barbiturate abusers are more likely to have competitive skills (jobs, education, status, intact families, etc.) than narcotic abusers. They are often deficient in their ability to adapt to new situations. A goal of treatment is to aid the patient to achieve a higher degree of coping skills and to learn to bear and express these stresses in a non-intoxicated state. Individual or group counseling is sometimes seen to be effective in the sharpening of coping skills. The particular situation of the patient is important for determining which would be effective.

Unlike opiate withdrawal, withdrawal from barbiturates can result in death. Because of this, the initial phase of treatment should be done

only on an inpatient basis. In treating barbiturate withdrawal, short-acting barbiturates are used in decreasing doses to ease withdrawal. The dosage is reduced on a daily basis to finally arrive at a drug-free state. It appears necessary to keep the patient in a slightly intoxicated state in order to ward off convulsions which are associated with a higher mortality rate. Also during initial phases of treatment, suicide prevention procedures should be implemented.

There is no "drug-hunger blocking" medication effective against barbiturates, as methadone is to heroin. Because of this there are problems in treating a person who has chronic relapses.

In most cases, barbiturate abusers have not been involved in either criminal or illicit drug subcultures, and should, therefore, not be treated in close proximity with narcotic addicts. There are, of course, those who are concurrent abusers of other drugs as well as barbiturates. These people may have been involved in multiple convictions and there is little danger of contamination of treating these people along with narcotic addicts.

In general psychotherapy in some form after withdrawal, aimed at the underlying problems is the only viable form of treatment at this time.

Amphetamine Abuse

Amphetamine Abusers: Amphetamine abusers can usually be characterized as two types: adaptive abusers and escapist abusers. The adaptive abuser usually uses amphetamines to enhance his functioning in conventional social activities. This is in contrast to the escapist abuser who uses drugs to avoid interactions. These two types of abusers can be further characterized in contrasting ways.

With the adaptive abuser, the initial abuse in usually accidental medicine abuse and he continues to use the medicine rationalization. The start of his abuse occurs after reaching adulthood and after attainment of most of his individual roles. He receives a nonaggressive reaction to amphetamines and uses oral drugs which he gets legally. His abuse is regular and not for the purpose of achieving mood exhilaration.

The escapist abuser, on the other hand, begins his use of amphetamines with a predefined euphoric effect. He continues to use amphetamines to attain this euphoric state. Most escapist amphetamine abusers are younger than the adaptive abuser and, therefore, have neither attained adulthood nor his concept of his individual and social roles. He receives an aggressive reaction to amphetamines and often takes them intravenously. His drugs come from illegal sources. His use-pattern is cyclical and for the specific purpose of attaining a euphoric effect.

The adaptive abuser and escapist abuser are similar in that both have usually experimented widely with other drugs. An example of the adaptive abuser is the obese housewife who is prescribed diet pills and perpetuates a cycle of mood and weight change. She eats too much and becomes depressed, then takes diet pills to relieve her depression. The "speed freak" is an example of the escapist abuser. He is usually a youth who has experimented widely with hallucenogenic drugs and begins to use amphetamines for their exhilerating effect.

Treatment: The treatment of amphetamine abusers consists of three phases: (1) initial physiological detoxification; (2) initial abstinent phase; and (3) the long-term aftercare phase.

While amphetamine withdrawal is not life threatening, the initial physiological detoxification should be done on an inpatient basis. The

physical exhaustion and emotional depression associated with amphetamine withdrawal, which may require medication makes hospitalization necessary. There are often medical problems which are concurrent with amphetamine abuse (such as hepatitis from unsterile intravenous usage, and malnutrition), which may require attention. Treatment in this phase is essentially the same for both escapist and adaptive abusers. Both types will suffer from sleepiness, social withdrawal, severe suicidal ideas, and neurasthenia during this phase.

The second phase of treatment, the initial abstinence, should be conducted when the patient is ambulatory. During this phase, the patient suffers from depression, fatigue, apathy, and lack of initiative. He often is considerably guilt ridden. Because of this, intensive supportive counseling has been found to be beneficial. It is aimed at alleviation of neurotic-like reactions to normal interpersonal relations and social activities.

The aftercare treatment phase is a continuation of this counseling but less frequently and in group sessions. Reality therapy is effective during this phase except when a crisis signals that a relapse may occur. In that case, supportive counseling should again be used.

It has been stated that the adaptive abuser should not be treated in conjunction with the escapist abuser. This is because the adaptive abuser sees himself as taking medicine and the escapist abuser has a closer relationship with the narcotic addict. Both have been involved with the illicit drug market and subculture and perhaps their only difference will be in their drug or preference.

While there is an "amphetamine blocking" drug, phenothiazenes, its use in prevention of chronic relapsing behavior has not been determined.

The treatment of relapsing behavior is an enigma because of the wide variety of reasons that people abuse amphetamines.

Hallucinogenic Drug Abuse

Though there are a number of hallucinogenic drugs, this discussion will be directed toward LSD, since most of the knowledge accumulated to date has been LSD related. The abuse of hallucinogenic drugs has been a recent phenomenon arising primarily out of the counter-culture movement by the 1960's. Physical dependence is not associated with this drug and any psychological dependence resulting from usage is different from that of other drugs. Adverse psychological reactions or "bad trips" do occur and treatment has been primarily related to these.

The acute reactions to LSD are two types: (1) Psychotoxic reactions and (2) panic reactions. Confusion and/or acute paranoia, feeling of omnipotence and invulnerability characterize psychotoxic reactions. In some cases the individual will expose himself to dangers resulting from his feeling in invulnerability which can cause injury and in some cases death. Whereas psychotoxic reactions occur as a direct result of the drug itself, panic reactions occur as secondary responses to the drug-induced symptoms. The setting, personality, age, and preparation of the individual for the experience are all important in determining the course of the panic.

Treatment for adverse reactions to hallucinogenic drugs is primarily in the form of reassurance and "talking the patient down." Minor tranquilizers are sometimes employed but since the content of the drug on the illicit market cannot be determined, administration is not always advisable. Also the individual may have taken a combination of drugs.

The Free Clinic was developed in many communities to meet these counseling needs. Also "crisis" telephone numbers where the individual on the "bad trip" can call for counseling have come into being. Psychological support during initial treatment has been seen to be most effective. The initial treatment phase is short, lasting only from 12 to 72 hours. Sympathetic supportive counseling also seems to be most effective during post detoxification treatment.

Recurrent reactions known as flash backs, which can spontaneously occur, are more common during the first year after administration of LSD than thereafter. Treatment of flashbacks by supportive counseling has not been effective. Prolonged reactions from LSD, after the period of acute intoxication, include chronic anxiety states and psychoses. Traditional psychotherapy has not been entirely effective especially in cases where the individual is a member of the counterculture. Those who are still living at home and involved in school, have good chances that traditional psychotherapy will be successful.

Claims that hallucinogenic drugs can cause chromosomal abnormalities have not been substantiated to date. There is question as to whether the use of LSD and other hallucinogenes taken during pregnancy can cause birth defects.

Someone who purposely takes hallucinogenes cannot be classified as an adaptive drug abuser. Even the individual who takes LSD without experiencing acute adverse reactions would benefit from some mental health care in order to place the psychedelic experience in proper perspective.

SUMMARY

The above has provided an overview into the various types of drugs and drug treatment programs. It should be noted that all the implications and relationships in drug usage have not been determined to date. There are still many questions in the drug picture. Conclusive evidence about the relationship of drugs to crime has not been found, nor is there any panacea or sure cure for drug problems. The drug problem is one that has been with us for scores of years and will continue to be in all likelihood for scores more. The bright side of the problem is that more research and constructive action in both the cure and prevention is being done.

In addition to the specialized drug treatment facilities in the Commonwealth, the Pennsylvania mental health/mental retardation clinics provide statewide coverage which provide treatment to drug users.

It is the responsibility of the probation and parole officer, as a referrer of services, to aid his clients in finding that program which will be most successful. In doing this, he should remember that it is a decision that should be made with that particular individual in mind.

BIBLIOGRAPHY

Blum, Richard, Society and Drugs, Jossey-Bass, Inc., Pub. 1970.

Chambers, Brill, and Incardi, "Toward Understanding; and Managing Non-Narcotic Drug Abusers", Drug Abuse in Pennsylvania, The Governors Council on Drugs, December, 1970.

____ The Master Plan for Prevention, Treatment, and Control of Drug and Alcohol Abuse, Governor's Council on Drug and Alcohol Abuse, 1973.

Glaser, Frederick B., "Drug Addiction and Crime: Is Methadone Maintenance Preferable to Withdrawal?" International Journal of Offender Therapy and Comparative Criminology.

Harns, Robert T., Drug Dependence, University of Texas Press, 1970.

Lindesmith, Alfred R., The Addict and the Law. Vintage Books, 1965.

King. Joan, The Probation and Aftercare Service, Butterworths, 1969.

Meyer, Roger, Guide to Drug Rehabilitation, Beacon Press, 1972.

National Director of Drug Abuse Treatment Programs, 1972, National Clearinghouse for Drug Abuse Information.

Weinswig, Melvin, Drug Abuse: A Course for Educators. 1968.

Yablonsky, Lewis, Synanon, The Tunnel Back. The Macmillan Co., 1965.

FILMS

* BEYOND LSD #31266 25 min. 1968 (FA)

Concerns the communication gap between two generations: teenagers and young adults, and the generation of those over thirty -- the "establishment." Use of LSD and other drugs indicated as only one of the symptoms of the communication gap. Show parents seeking help in trying to understand how to relate to their teenagers. J. Thomas Ungerleider, M.D., of the Neuropsychiatric Institute at U.C.L.A. discusses young people and drugs.

* THE CRIMINAL MAN #9: TEA HORSE, AND CRIME. 31357 30 min. sh-c-a. $6.10 1965. (NET)

Discusses the basic narcotic drugs and their relationship to crime, pointing out that crime committed by the drug addict is a secondary affect. Includes a filmed sequence showing an addict undergoing withdrawal and receiving a shot that assuages him.

* HOUSE ON THE BEACH #60079 60 min.

Development in the rehabilitation of drug addicts at the communal center at Synanon (Santa Monica, California), which emphasizes self-help among volunteer addicts working and living together.

* DRUGS: FACTS EVERYONE NEEDS TO KNOW (FIORF) 1970 29 min. color #31600. $10.80 sh-c-a.

Factual approach to categories and properties of major drugs, including depressants, stimulants, psychedelics, and other mind-affecting drugs. Dr. S.J. Feinglass, California State College, Hayward, replies to questions from adult audience. Needs fulfilled by drugs, factors influencing use, realistic alternatives.

* DRUGS IN THE TENDERLOIN #50187 52 min.

Drug users, some of them homosexuals, who live in San Francisco's Tenderloin district, are interviewed as to their methods of obtaining drugs, their reasons for using them, and their ambitions for moving back into the "square" world. Mark Forrester, a staff member of the local poverty program, describes the rational excuses with which these inhabitants defend themselves. He comments on ways these young people are motivated to change. The interviews alternate with candid scenes taken in the Tenderloin District.

* LSD: INSIGHT OR INSANITY #20702 18 min.

LSD -- lysergic acid diethylamide -- is a relatively new drug. Although people in many cultures for many centuries have used hallucinogenic chemicals to change their thoughts, LSD is by far the most potent and dangerous of these. LSD distorts perception and judgement. Many bizarre and even fatal accidents have resulted. It is not known how LSD works in the brain, or what the long-term effect may be. Also the black market of LSD is of unknown strength and often contains many impurities which may be most harmful. (Bailey)

* SPEEDSCENE: THE PROBLEM OF AMPHETAMINE ABUSE. (BFA) 1970 17 min. color #21290. $6.60. jh-sh-a.

Psychological dependency on these drugs frequently leads to use of addictive forms such as heroin. Repeated high dosage injection of "speed" may lead to hepatitis, malnutrition, as well as rendering the habitual user unable to cope with his environment. Evidence offered against use of amphetamines in any form for other than medical reasons.

* OR DIE #20891 18 min.

Representative activities of Synanon, a social movement run by former drug addicts, includes sequence on the Game, a form of group therapy. The members of the Game group strip away any lies and excuses used by any participant to rationalize his behavior. Sense of community life and social action are shown to redirect self-destructive energies toward positive goals.

* THE SEEKERS #31423 30 min.

In frank conversation with students, former drug users who have joined to form Encounter delve into the reasons they began to use marijuana, pills, and LSD. They tell sordid personal experiences while on drugs with police arrests, serious health problems, near fatal accidents, and their feelings about themselves. Danger to self, an unborn child and even to future generations through permanent genetic damage explained.

THE CIRCLE 1967 $25 in 2 parts, 57 min. black/white 16 mm sound
Request film from: McGraw-Hill Films, Highstown, N.J. 08520

This film portrays the rehabilitation process of drug addicts at Daytop Village by focusing on one individual, Don, from his first day at Daytop to the time when he is ready to leave. Don gradually adjusts to Daytop's communal work and living patterns, but resists the attempts to other residents to force reactions from him in verbal encounter sessions. Various experiences with other addicts and the Daytop techniques, which concentrates on self-help for addicts through group therapy, bring Don to a point where he is better prepared to face society outside of Daytop's confines, without the aid of drugs. This film deletes profanity from the encounter sessions.

SPEEDSCENE: THE PROBLEM OF AMPHETAMINE ABUSE 1969 17 min. color 16mm sound Request this film from BFA Educational Media, 2211 Michigan Avenue, Santa Monica, California 90404. $15.00

Interviews with speed users interspersed with statements from medical authorities present evidence against the use of amphetamines except for medical purposes. The physical dangers of hepatitis, malnutrition and death are discussed. Psychological problems, which often are part of the life style of the speed culture, and the user's inability to deal with his environment are also discussed.

*FILMS available from Audio-Visual Services. The Pennsylvania State University, Six Willard Building, University Park, Pennsylvania 16802. (Phone #814-865-6315). Prices are subject to change. (It should be noted that some of these films may show an exaggeration of the drug picture, therefore, they should be viewed objectively and with a factual knowledge of the drug abuse problem.)

APPENDIX I

THE VAST DRUG STORE

Marijuana

What they are:

Marijuana is the dried flowering tops and leaves of the cannabis weeds, commonly called hemp. It looks like fine, green tobacco and smells like alfalfa. It usually is smoked, but can be baked into cookies, fudge or mixed with honey for drinking.

Slang Names:

Joints, sticks, reefers, pot, hay, Mary Jane, Acapulco gold and Laotian green (in South Vietnam).

Main Effects:

Feelings of perceptiveness and relaxed pleasure often accompany small doses. Erratic behavior, loss of memory and distortion of time, space, color and sounds follow excessive doses.

Possible Dangers:

The risk depends on the personality of the user, strength of the drug, which varies depending on source, and pattern of use. Distortion of space and time make the user accident-prone. Not physically addictive.

Hallucinogens

What they are:

LSD, mescaline and psilocybin occur in a natural state, but are also illegally manufactured. Other chemicals being made include dimethyltryptamine, diethyltryptamine, tetrahydrocannabinol, phenylcyclohexylpiperidine and dimethoxymethylphenethylamine.

Slang Names:

Acid (for LSD), DET, DMT, THC, DOM, PCP (or "Peace pills") and STP (Serenity, tranquility and peace).

Main Effects:

All produce varying degrees of illusions, delusions and hallucinations. They can lead to severe mental changes like those found in psychotics, and to depression and sometimes suicide.

Possible Dangers:

Permanent brain damage is suspected by some investigators but it is unproved. Any can trigger psychotic episodes which may recur months later. Some preliminary studies suggest that LSD can break chromosomes -- a potential for birth defects, but this also is unproved and controversial. Not physically addictive.

Amphetamines

What they are:

Amphetamines and methamphetamines are legally made and prescribed to curb appetites, relieve minor depression and increase energy. They are central nervous system stimulants. Some Methedrine is manufactured illegally.

Slang Names:

Ups, pep pills, bennies, capilots, footballs, hearts and for methedrine, Meth and speed.

Main Effects:

Normal doses produce an increased alertness but very heavy use, particularly if injected, tends to produce vast overconfidence, hallucinations, aggressive acts and psychotic feelings of persecution.

Possible Dangers:

High blood pressure, irregular heart rhythms and heart attacks can result, as well as violent behavior. High tolerance is rapid but there is no true physical addiction.

Barbiturates

What they are:

Barbiturates are sedatives prescribed to induce sleep and for their calming effect. Both psychological and physical dependence can develop with heavy use, particularly when abusers inject the chemicals intravenously.

Slang Names:

Red birds, yellow jackets, downs or downers, blue heavens and goofballs.

Main Effects:

Small amounts make the user relaxed and often sociable and good-humored. Belligerence and depression are frequent with major use, often similar to drunkenness.

Possible Dangers:

Sedation, coma or death from respiratory failure can follow intentional or accidental overdoses. The user forgets how much he has taken. Alcohol and barbiturates together are deadly. Physically addictive. Withdrawal symptoms are often severe, depending on dose. Withdrawal requires medical supervision.

Cocaine

What they are:

Cocaine is extracted from the leaves of the coca bush and is a white, odorless, fluffy powder looking somewhat like crystalline snow. It is eaten, sniffed, or injected, often with heroin.

Slang Names:

Coke, leaf and snow. Speedballs when mixed with heroin.

Main Effects:

Oral use can cut fatigue and produce some exhilaration. Intravenously, it can induce overconfidence, hallucinations and paranoid tendencies.

Possible Dangers:

Convulsions and death can occur from overdoses but are not common. Paranoiac activity is common, however. Not physically addictive.

Heroin Morphine
(Opiates)

What they are:

Morphine is derived from opium, and heroin is produced from morphine. Both are usually seen as a white, snowy powder which can be taken several ways but are usually injected. Narcotic addiction usually refers to these two drugs.

Slang Names:

"M" and dreamer for morphine. "H", snow, junk, horse and nod for heroin, smack when mixed with marijuana.

Main Effects:

The two are generally sedative or calming and are effective pain killers. They slow pulse and respiration. Heroin is faster and shorter acting.

Possible Dangers:

Users are prone to respiratory failure until tolerance develops. Overdose deaths are fairly common because the drug compounds can contain more pure heroin than the user expects or is able to tolerate. Physically addictive. Withdrawal symptoms no worse than the flu but increased sensitivity to pain following drug usage may make addict think it's worse.

APPENDIX III

Definitions of 14 Drug Treatment Modalities*

Primary Prevention - any specific biological, social or psychological intervention that reduces the incidence and prevalence of drug and alcohol abuse and/or addiction in the population at large.

In addition, Primary Prevention Programs are aimed at the non-user of drugs and/or alcohol, and include such attempts as community prevention programs, community education and social action programs. Primary Prevention programs are directed towards the ecology supporting addictions abuse.

Secondary Prevention - programs that are aimed at the early user of drugs and/or alcohol. These programs intervene before abuse becomes a chronic pattern of behavior.

Crisis Intervention - an intensive usually short-term service to an alcohol or drug abuser, either within or outside a hospital setting, which is designed to either shorten or obviate impatient hospitalization stays. Their care may consist of diagnosis, evaluation, medical treatment, therapy or referral to an appropriate facility.

Hotlines - consists of a 24 hour telephone answering service manned by persons capable of convering, advising, listening, making appropriate referrals and, in general, meeting the challange of callers with varying types of problems they wish to discuss. Hotline telephone numbers usually are well-publicized and may be designed for specific purposes, i.e. suicide prevention, alcohol and drug abusers, medical and/or social problems, etc.

Rap Sessions - are services designed to allow alcohol and drug abusers, or any persons affected as a result of alcohol or drug abuse, to discuss at length the problems arising from such abuse. The sessions generally are

conducted on a group participation basis, although one-to-one sessions are not unusual. Peer groups are considered a most valuable asset so that free exchange, and confrontations, may contribute to the interaction.

Counseling - services for alcohol and drug abusers are delivered to help develop a policy or plan of action or behavior to assist that person in diminishing or discontinuing completely the use of alcohol or drugs. Such counseling may be delivered by other alcohol or drug abusers, social workers, therapists, or person or group who may be in a position to influence that behavior.

Referral - is the service designed to send or direct the alcohol or drug abuser to the most appropriate service or facility to assist him in receiving the care or treatment he may need.

Tertiary Prevention - programs that are the acute phase of treatment and aimed at the rehabilitation of chronic and/or dysfunctional users.

Partial Hospitalization - means evaluation, care, treatment, and/or rehabilitation rendered to a person diagnosed as suffering from alcohol or drug abuse, and admitted or committed to a facility for some portion of one or more 24 hour periods.

Day Care - is treatment facilities which are a portion of partial hospitalization services which do not contain overnight accommodations.

Outpatient - services means diagnosis, evaluation, classification, counseling care, treatment and/or rehabilitation rendered to a person suffering from alcohol or drug abuse at a facility to which they have not been admitted or committed.

Inpatient - means diagnosis, evaluation, classification, counseling care, treatment, and/or rehabilitation to a facility to which they have been admitted or committed for a continuous period of 24 hours or longer.

Emergency - means immediate diagnosis, evaluation, classification, care, treatment, and/or referral to an appropriate facility to persons apparently

suffering from alcohol or drug abuse at any location, including home, hospitals, etc., in which such services can be rendered.

Residential - means classification, care, treatment, and/or rehabilitation in a sheltered environment in a facility designed as a home-like living arrangement after a person has been diagnosed as suffering from alcohol or drug abuse. Such living arrangements ordinarily would cover a period of more than one week.

Therapy - means any one of a variety of remedial treatments to persons suffering from alcohol or drug abuse, such as analytical, physical, recreational, social, vocational, etc., designed to bring about a control of the alcohol or drug abuse and usually to afford a social readjustment.

Aftercare - means any procedure, therapy, treatment, and/or rehabilitation delivered to a person as a follow-up to service delivered when such person was committed or admitted to an appropriate facility for the alcohol or drug abuser. The services may be delivered in any appropriate setting.

*From the Master Plan for the Prevention, Treatment and Control of Drug and Alcohol Abuse, Governor's Council on Drug and Alcohol Abuse, Pennsylvania, 1973.

APPENDIX IV

THE TREATMENT OF DRUG ABUSE IN PENNSYLVANIA

MODALITY	NUMBER OF PROGRAMS	PERCENTAGE OF PATIENTS
Methadone Maintenance	17	50.5
Individual Counselling	19	16.3
Residential Therapeutic Community	13	11.2
Group Therapy	6	6.5
Non-Residential Therapeutic Community	8	4.8
Multi-Modality	1	4.2
Religious Therapeutic Community	7	3.1
Rap Houses	3	2.6
Detoxification	2	0.6
Social Action	1	0.3
	77	100.0

Note: These data were gathered by survey between May, 1971 and May, 1972. They pertain only to stated drug abuse treatment programs dealing with ten or more individuals. Since May, 1972, new programs have opened and some programs in the original survey have closed.

To obtain a complete descriptive list of drug treatment facilities, a copy of A Directory to Pennsylvania Drug Abuse Treatment Facilities may be requested from:

Bureau of Policy Planning and Information
James W. Quest, Director
Governor's Council on Drug and Alcohol Abuse
Harrisburg, Pennsylvania

TABLE 1

	SUMMARY OF EXISTING SERVICES*														
		SECONDARY PREVENTION						TERTIARY PREVENTION							
	PRIMARY PREVENTION	RAP SESSIONS	HOTLINE	CRISIS INTERVENTION	REFERRALS	COUNSELING	EMERGENCY	OUTPATIENT	INPATIENT	RESIDENTIAL	PARTIAL HOSPITALIZATION	DAY CARE	THERAPY	AFTERCARE	OTHER
SOUTHEASTERN REGION (5 units)															
1. Bucks County	X	X	X	X	X	X		X	X	X			X		
2. Chester County	X	X	X	X	X	X	X	X	X	X			X	X	
3. Delaware County	X		X	X	X	X		X	X	X			X		
4. Montgomery County	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
5. Philadelphia	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
NORTHEASTERN REGION (8 units)															
6. Berks County	X	X	X	X	X	X		X		X			X		
7. Bradford-Tioga-Sullivan						X	X		X		X	X	X		
8. Carbon-Monroe-Pike	X		X		X	X			X		X				
9. Lackawanna-Susquehanna-Wayne	X	X					X	X	X	X					
10. Lehigh County	X	X	X	X	X	X		D	A	D					
11. Luzerne-Wyoming	X		X	X	X	X	X	X	X				X		
12. Northampton County	D		X	D	X	A			X	A		D			
13. Schuylkill County	X		X		X	X		X	D	X			X	X	
CENTRAL REGION (14 Units)															
14. Cumberland-Perry	X		X		X			X		X	X	X	X		
4. Dauphin County	X		X		X	X		X					X		
5. Franklin-Fulton								X					X		
17. Lancaster County	X		X	X	X	X		X	X	X			X		
18. Lebanon County	X		X	X	X			X	X						
19. York-Adams	X			D	X	X	A	X	X	A			X		
20. Blair County	A				A		A	A	A				A		
21. Cambria County	X		X	X	X	X		X	X	X	X				
22. Centre County	X			X	X			X	X		X				
23. Columbia-Montour-Snyder-Union	X		X		X	X		A		X			A		
24. Huntingdon-Mifflin-Juniata	X		X		X	X	X		X				X		
25. Lycoming-Clinton	X		X	X	X	X	X	X	X	X	X		X		X
26. Northumberland County										X	X		X		
27. Somerset-Bedford	X	X	X	X	X	X		X		X	X	X	X		
WESTERN REGION (14 Units)															
28. Allegheny County	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
29. Armstrong-Indiana	X		X	X	X			X							
30. Beaver County	X	D	D	D	X	X		A	X			X	X		X
31. Butler County	X	X			X	X	X	X	X	A			X		X
32. Fayette County	X		X			X		X	X				X		
33. Washington-Greene	X		X		X	X	X		X	X			X		
34. Westmoreland County	X	X	X	X	X	X	A						X	X	
35. Camerson-Elk-McKean-Potter	X			X	X	X	X			X					
36. Clarion-Forest-Venango-Warren	X		X	X	X	X	X		X	X			X		X
37. Clearfield-Jefferson	X		X	X	X				X				X		
38. Crawford County	X		X	X		X	X	X	X	X					
39. Erie County			D	D	D	D	A	D	X	A			X	A	
40. Lawrence County	D				X	X							X	A	
41. Mercer County	X		X	X		X	X		X	X			X		

Indicator Key — X - Both Alcohol and Drug Programs
A - Alcohol Programs Only
D - Drug Programs Only

*Reprint from The Master Plan for the Prevention, Treatment, and Control of Drug and Alcohol Abuse, Governor's Council on Drug and Alcohol Abuse, 1973.

END

7 Abbildungen