How To Combat Drug Addiction

WE'VE ALL heard the frightening stories about how drug abuse has spread into even the most unlikely communities, and how dope is making the rounds in every school. No family, or neighborhood is immune from the threat. It's hard not to feel helpless about this nationwide menace that most of us understand hardly at all. What can any one individual do?

National and state programs against drug abuse are beginning to work, but the real need for action is on the local front right now. The fact is, more and more parents and community leaders are learning that they can do something about drugs. Their experience suggests action you can take in your town.

You might start by looking into the problem on your own, but it's wise to get others involved soon—friends and neighbors, or a club you belong to. You can also join existing anti-drug programs if there are some good ones in your town.

Whatever your approach, here are some effective actions to take:

1. **FACE THE PROBLEM.** Despite vast evidence that drug abuse goes on almost everywhere, many people don't want to look in their own backyards. You need hard facts to convince skeptics, that your town is indeed vulnerable—and perhaps in serious trouble.

Because illicit drug traffic is an underground activity, the facts aren't easy to come by. Start by talking with your police department, school and hospital officials, doctors, pharmacists, clergy, local service agencies. You might also set up a survey to send to doctors, school officials, and other people who may be alert to the problem. Get someone who knows about research methods to help you design the survey.

2. **KNOW WHAT YOU'RE TALKING ABOUT.** Learn as much as you can about the different kinds of drug abuse, and what the appeals and dangers are. It's easier to stimulate action when you're up on your facts. You'll also get better answers from the youngsters. Try to understand the drug culture and how young people think today—and be prepared to discuss adult abuse of medicines, alcohol and tobacco.

3. **FIND OUT WHAT YOUR TOWN IS ALREADY DOING.** Before starting any program yourself (or with a club), you should investigate what can be done with existing facilities. You will avoid duplicating efforts, and you may find the right niche for your particular interests. Volunteers are welcome in many operations; often you'll receive special training.

4. **DRAFT FOR FUND-RAISING.** Typically, anti-drug programs start out with private donations and some local government support. Find out what's available in your town.

Existing agencies, both private and public, probably have some money channels open already. Look into how these could be expanded, but tread lightly. There's no issue more sensitive than how money is distributed.

4. **KEEP THE MEDIA INVOLVED.** One splashy TV program or a single open meeting will not stop drug abuse. You must make everyone in town aware of the continuing menace—and keep them up to date on what you're doing. Cooperation from the media is a necessity. Make such publicity the full-time concern of at least one member of your coordinating committee.

5. **GET YOUNGSTERS INVOLVED.** "Peer pressure is a prime mover in drug abuse," according to CODAC's director, Donald Jackson. "When you can get youngsters to influence other youngsters about not using drugs, you've got a fine preventive program going."

When young people can throw their energy and ingenuity into helping other kids, they're using themselves constructively. Among other things, this activity counters the boredom that leads so many youngsters into drugs. Furthermore, the kids know what their friends will and won't listen to; teen-age advisors on any community program can save considerable time and money.

SOME COLD, HARD FACTS ABOUT DRUGS

Maybe sometime soon you might have to talk to some teenagers about drugs. We hope not. But if you have to, this page is intended to give you something to start talking about, in terms they understand. Please get through to them—about the evils of it all.

THE OPIATES

This group of drugs is what people generally refer to when they say "narcotics". Opiates can be used medically as pain killers. Outside medical circles, they can cause pain for the user and society in general.

Proliferation of the use of these drugs—opium, morphine and heroin—has stemmed here largely from Tondo, regarded as the hotbed of local addiction. The Tondo addicts have coined their own words and phrases for the so-called "habit."

Opium

The white powder is extracted from the unripe seeds of the poppy plant. It can be eaten, but generally is smoked in a pipe.

Morphine

A derivative of opium, it is one of the strongest medically used pain killers—and is strongly addictive. Doctors use it to relieve pain and induce sleep. In large doses, it can bring on a coma, and even death.

Heroin

This is the ultimate in a three-stage preparation that begins with opium. Unlike the second stage, morphine, it is banned from medical use because of its higher rate of addiction. It is the most commonly used drug among aUdicts in most parts of the world—through sniffing or injection either under the skin or into a vein.

Related Slang

"Gamot"—the term local addicts use to refer to the three opiates.

Mainline or "saksak"—injecting a drug into a vein.

Paraphernalia or "gamit"—the apparatus for drug injection, including a syringe, platter and spoon with which to inject a powdered drug.

Fix or "kasa"—an injection of opiates, usually heroin.

Junkie or "magkakasa"—an opiate addict.

Packet "balot" or "papelito"—amount of drugs being peddled to addicts.

"Cold Turkey"—the method of curing a drug addict by taking him off drugs without a tapering-off period. (Experience here has shown that this method has been only one per cent effective in the country's lone rehabilitation center in Tagaytay, Cavite.) The main problem in discontinuing opiate use is not getting off the stuff but staying off it.

Pusher or "may patinda"—a main source of the drugs. Some Tondo pushers reportedly have elaborate setups, using third parties in peddling their wares.)

High or "sagad"—the state of near unconsciousness experienced by an addict as the result of a mild overdose. (An overdose is the main cause of death among addicts, paralyzing the victim's brain.)

Parents and community leaders can be potent factors in the fight against the drug menace. Their influence in the home and community can bolster existing anti-drug programs.

THE STIMULANTS

These drugs stimulate the body system, prodding its user into excessive activity, excitability, talkativeness, extreme nervousness, irritability and an argumentative disposition. Although not physically addictive like opiates, they can produce a psychological dependence or craving.

Amphetamines

These are the main group of stimulants which can be taken in tablet or capsule form, or by injection into the bloodstream (by "speed freaks"). The most widely used in this country is Benzedrine (bennies). Others classified under this category are Dexedrine ("dex" or "dexies"), Methedrine ("speed") and Biphetamine ("foot-balls").

A major danger from amphetamine use is the overdose, resulting in mental dislocation. (A Manila police report refers to this as "persecution complex — amphetamine style.") A person suffering this usually loses contact with reality. Complete cure is not assured by the withdrawal of a victim.

Cocaine

This stimulant, in powdered form or liquified for "mainlining," is derived from the leaves of the coca plant. While not necessarily addictive, it does produce a strong psychological craving.

Related Slang

Crashing or "basag"—withdrawal from amphetamines, marked by a sudden fit of depression.

PSYCHEDELICS OR HALLUCINOGENS

These are drugs which create hallucinations or other mind-altering experiences. Manila police criminal blotters have recorded accidents or rape cases in which those involved allegedly had taken such drugs.

LSD (Lysergic Acid Diethylamide)

The most potent hallucinogenic drug, it comes in the form of powder in a capsule, small white pills or a colorless, tasteless liquid. A pill no larger than the point of a pin can launch its user into mind-staggering experiences, marked by dislocation in time and space, eeriness, fear, panic and even psychosis. It is also referred to as "acid," "cubes," "Pearly Gates" or "heavenly blue."

DMT (Dimethyltryptamine)

A powerful psychedelic, it produces effects similar to those of LSD, when taken in large doses. It comes in powdered or liquid form, and is usually injected into the vein or smoked along with marijuana or in cigarets. Its effects last generally an hour or two.

Psilocybin

This psychedelic comes from a mushroom and is less potent than LSD. It is supplied in crystal, powder or liquid form. Its effects last from two to six hours.

Mescaline

Derived from the peyote cactus, this drug is the most recent in the hallucinogenic field in this country. Though milder than LSD, its effects are the same—vivid visual impressions that can last from 10 to 12 hours.

Peyote

Also from the peyote cactus, this is a less concentrated form of mescaline.

STP or DOM

This is a synthetic chemical related to mescaline and amphetamines and is reported to be mind-distorting but less so than LSD. It has not yet found a market here, but the National Bureau of Investigation has been alerted about its eventual entry.

Marijuana

Derived from the crushed and chopped leaves and flowers of the Indian hemp plant, Cannabis Sativa, it is either smoked in a cigaret or in a pipe. It causes a giddy feeling and moodiness. Though found not to be physically habit-forming, it nonetheless can serve as a springboard to the "harder stuff." (Also known as "pot," "tea," "grass," "Mary Jane," "loco weed," "flower," "straw" and "vipers weed.")

Hashish

More powerful than marijuana, this drug also comes from the flowering top of the Indian hemp plant, and can be taken either orally or as a smoke. It is also referred to as "hash.")

Related Slang

Acid head or tripper—a frequent LSD user.

Barrels—a package of LSD tablets of not less than six.

Flashback—a risk taken by LSD users in which they undergo the same experiences as when they took the drug months before. Other risks:

possible brain damage and chromosome breakage.

Drops—LSD taken orally, usually dissolved in water and placed on a sugar cube.

Reefers—marijuana cigarets also called "joints" and "sticks." "Roach" is the butt end of a "joint."

DEPRESSANTS

This category of drugs depresses the functions of the brain. Some addicts use depressants with stimulants to achieve a "see-saw" effect. When combined with alcohol, the results can be fatal. Prolonged use could lead to impaired judgment and sluggish thought. Its most common effects are slow movement, slurred speech, dilated pupils of the eyes and symptoms similar to those of alcohol intoxication.

Barbiturates

These drugs—taken in tablet or capsule form—are called "sedatives-medicines" and are aimed at causing sleepiness. They are highly addictive, and repeated use results in physical withdrawal. The most popular here are Seconal, Mandrax, Nembutal, Amutal, Luminal or Tuinal.

Related Slang

Seconal—"red devils," "pula" (red), "bala" (bullet) and "balatong" (mongo beans).

Mandrax — "Mx," "Blue Max," "Puti" white), "M" and "bala."

The Moral and Theological Aspects of Family Planning

Morality means responsibility. When we deal with responsibility in conception control, two problems confront us which are distinct but not unrelated. They are the problems of the (1) Development of Family Life, and (2) the Control of Population. I shall deal with these two problems separately. These two are not mutually exclusive; in attending to one, the other is not necessarily neglected. And yet not any solution of one, e.g. Population Control, will automatically guarantee the authentic solution of the other, Development of Family Life. Of the two, the more fundamental is the problem of the authentic development of Family Life. In the final analysis, the basic problem confronting us is the problem of development; and the crucial target of development is not material resources, but the spiritual quality of our human resources.

Let us then examine the problem of responsibility in the development of family life particularly in the exercise of parenthood.

Areas of Responsibility

The area of our responsibility, in general, expands as the area over which we exercise conscious control, expands. Thus in the area of parenthood, responsibility was exercised, in our long history, only after new life came to birth. Man had no control over the process of gestation of life in the womb; much less, over the moment of its conception. It is only in fairly recent times that this responsibility was extended to pre-natal care with the advances in medical science. And in our own days, when the time and frequency of conception have finally come into our power, these two now become matters for responsible deliberation The day may not be too far off when the determination of even the sex of some future child will be added to matters of parental responsibility.

Responsibility Over Conception Control

Responsibility over the control of conception is peculiarly critical in our times because of the changed conditions in our life. New demands of a medical, economic, social, eugenic and cultural character have been created, and they have imposed themselves as needs for human life in the societies of today. Responsibility dictates that parents take these into their reckonings, if the children they are to raise are not to become socially handicapped in their world. I need not dwell on this; it has been sufficiently treated. I just want to note that the newness of this responsibility over conception control is catching many parents by surprise, and has consequently found them unprepared. It will be our task to prepare them for this.

There are two qualities that the exercise of this responsibility calls for: 1) a personal, and 2) flexible exercise.

No Imposed Decisions

Responsibility can not be exercised by any other than the person upon whom that responsibility rests; it can not be imposed by another. Thus, in decisions involving the exercise of parenthood, the responsibility for such decisions must rest with the parents or parents-to-be themselves. And that, jointly. No other person or institution can substitute for them —not their own parents, nor public authority, nor their pastor. To opt for a limitation or expansion of the size of their family belongs exclusively to the couple, as an exercise of an inalienable right. This principle is upheld by both Vatican II and the United Nations. The role of interested agencies is to help couples to develop as to be able by themselves to arrive at responsible decisions in this matter. Our role is essentially educational. This is why the primary orientation of our Program is towards Education, a formation in Responsibility.

No Irreversible Measures

No decision that parents make can truly be responsible, if made irrevocably, once and for all. For the decision affecting the exercise of parenthood is conditioned by the human situation; and since human situations are ever changing, decisions must be open to revisions necessary to meet the changes.

Can we say that a couple is truly responsive to their vocation to marriage when from the very beginning of their married life, they have already determined for the entirety of that life what the number of their children is to be? Marriage is a vocation to a love whose creativity is an ever present challenge. What that challenge calls for, can be responsibly determined only from moment to moment; it is conditioned by variables: the medical condition of spouses or of the children, their fi-