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THE DEVELOPMENT OF AN EDUCATIONAL COMPONENT IN A PROGRAM FOR THE TREATMENT OF DRUG ADDICTION

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

Gabriel Thomas Ukott, R.N., B.S., M.A.

**********

The Ohio State University
1975

Reading Committee:
Dr. Ross L. Mooney
Dr. Donald Sanders
Dr. Paul R. Klohr

Approved By

Ross L. Mooney
Adviser
College of Education
DEDICATION

To my late father, Chief and Judge Thomas Akpan Ebok Ukott; to my devoted mother, Jannie Thomas Ukott; to my only brother, Emmanuel Thomas Ukott; to my son, Enoh Gabriel Ukott; to my daughter, Imeh Adiaha Gabriel Ukott; to my entire family (immediate and distant); to Mrs. Della Maddox and her daughter, Mrs. Virginia Swope, of Welch, West Virginia and to Dr. Ross L. Mooney who have all instilled strength and encouragement in my life and endeavors, I dedicate this work.
ACKNOWLEDGEMENT

I am grateful to my adviser, Dr. Ross L. Mooney for his guidance and earnest interest in the preparation of this dissertation. Without his unremitting devotion and unique professional help, this dissertation would not have been completed.

To Dr. Donald Sanders, who has carefully read and evaluated the work, I am grateful. Without his professional experience and perceptiveness, this work would not have evolved to its present stage.

I want to thank Dr. Paul Klohr for his helpful suggestions and encouragement throughout the entire work. Without his catalytic influence, I would not have generated enough strength for the completion of this study.

I want to thank the entire faculty of Educational Development of the Ohio State University for providing a place and support for my graduate study. The faculty's willingness to include a citizen of another country as a member of its professional family is greatly appreciated.

Special appreciation is extended to Mr. Curtis Jewell, the former Executive Director of Uhuru Drug Program, for his patience and understanding, even when the dissertation writing brings conflict with my regular assignments at Uhuru.
I want to thank Mr. Louis Haynes, Mr. Ronald Burke, Mr. Jessie King, Mr. Berndt Mann and the entire family of Uhuru for their advice and ideas—most of which are incorporated in this study. Special thanks is likewise extended to Mr. Rip Burnett, the Director of the Alum Creek Therapeutic Community (Integrity House), Mr. Bob Sweet, the Director of VITA Center, Mr. Karl Dick, the Director of Research and Evaluation of VITA, and Dr. William B. George, the Director of Franklin County Comprehensive Drug Treatment Program for their helpful inputs and suggestions during the data gathering stage of the dissertation.

I want to thank Mr. Memo K. Rogers, the former research assistant of Uhuru and a graduate student in the Ohio State University Department of Journalism, for checking and xeroxing most of the reference materials that are used in this work. I also thank the entire library staff of the Ohio State University (especially the medical school library staff) for their cooperation and friendly assistance in locating all the needed articles.

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Lastly, I thank God and my family spirit of endurance which made it possible for the work to be completed in spite of the problems and frustrations which I encountered during the period. May this be seen as the beginning of my involvement in the creation of a better tomorrow for mankind.
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"Black Education: Content and Direction." Onyx Weekly Newspaper, Vol. IV, No. 12, Columbus, Ohio, March 24-30, 1975, pp. 5-13.


FIELDS OF STUDY

Major Field: Educational Development

Minor Field: Preventive Medicine
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CHAPTER I

INTRODUCTION

Synopsis

Drug abuse has become a significant social problem. Agencies have recently been created to treat drug addiction. The programs have thus far been clinically oriented with an emphasis on medical, psychological and social dimensions. There is need, also, for an educational component. This need has been recognized but, as yet, appropriate educational programs have not been developed. The first problem is the education of staff personnel who can initiate the development of an appropriate educational program.

The author has served on the staff of Uhuru, an agency for the treatment of drug addiction in Columbus, Ohio, in the role both of a planner and evaluator in close working relationship with the educational department. This study presents content and procedures found by the author to be relevant to the development of an educational program for Uhuru. It is offered as potential aid to others who may have similar roles in similar agencies.

Initially, the author needed a basic orientation to the drug abuse and addiction phenomenon in society; he sought understanding in historical, social, cultural, economic, psychological and legal perspectives. This orientation he felt to be essential to an understanding
of the place and work of agencies dealing with treatment of drug addiction. The study summarizes content derived from this exploration.

Secondly, the author interviewed drug addicts who were clients of Uhuru. Since the educational program was to serve these clients, it was necessary to personally know clients as individuals in order to gain perspective on what might be serviceable to them when offered within the context of an educational program. The study presents examples of these interviews, discusses the procedure and the content derived.

Thirdly, the author used a problem checklist to survey the personal problems of two groups of clients: those just entering the program of the agency, and those who had been in treatment in the agency for thirty days or more. This was done to gain perspective on the educational content which would most likely be relevant to the felt needs of clients on entry, and to changes in content, if any, which might be indicated for clients who had been served by the agency over a significant period of time. The study reports on the findings of the survey, their implications, and the utility of the procedure.

Fourthly, the author searched for methods by which an educator could help clients, individually and in groups, move from the level of problem expression toward the level of problem solution. The study reports on promising methods which were discovered.

Lastly, the author summarizes his perspective to date on the development of educational programs as components within the operations of agencies like Uhuru which treat drug addiction.
Continuing, the present chapter provides an introduction to Uhuru and further orientation to the problem being addressed.

An Introduction to Uhuru

Since this study is undertaken in the setting of the Uhuru Drug Treatment Program of Columbus, Ohio, an understanding of Uhuru itself will be essential.

The world "Uhuru" is a Swahili (East African) word meaning freedom. The word is used to stress the drug free philosophy of the program, as well as imparting some cultural identity to the Black addicts who form the majority of the program. The Uhuru Drug Treatment Program, simply stated as Uhuru, is federally funded. Originally funded by the Office of Economic Opportunity (OEO) in Washington, D.C., it is now receiving grant support from the Office of the National Institute on Drug Abuse (NIDA). Its purpose was, and still is, to operationalize a therapeutic community (TC) drug treatment center in Columbus to serve the needs of the economically deprived addicts within Franklin County.

As a Therapeutic Community, it was patterned after the Synanon model and is, essentially, an environmental therapy involving a family-like living situation where treatment is viewed as an interaction process between the drug user, his community and local community resources, such as the health and welfare agencies, drug treatment

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centers, employer and employment group, etc. The family (especially peer pressure)\(^2\) is utilized as a primary influencing factor in regulating the behavior of the individual.\(^3\)

The treatment process consists of an induction procedure (an orderly and uniform method of accepting an addict into the program), the in-patient residential community program, the out-patient treatment and counseling program, reality therapy for both in-patient and out-patients, the social orientation program, including education and training, client counseling, family counseling, training for physical fitness, job-finding assistance, school placement, activities in the cultural arts (karate, dance, music, drama, painting, arts and crafts, photography, etc.) and the community program.

The residential treatment is completed in three phases: six months (1st phase); four months (2nd phase); and two to four months (3rd phase). By the time a client (patient) reaches the last phase he or she should have met all progress and achievement criteria and should be ready to return to a full productive community life.

The out-patient treatment schedule is slightly longer than the in-patient's by approximately six months because of frequent setbacks and interruptions in the treatment schedule. Both the in-patients and the out-patients are placed on a preferred Treatment Plan which must

\(^2\)Parenthesis is the author's insertion based upon experience.

\(^3\)James P. Reardon, Director of Specialized Treatment Services in the Parole Supervision Section of Adult Parole Authority, "A Program for the Treatment and Supervision of Paroled Drug Addicts," (Unpublished Article, Columbus, Ohio: The Adult Parole Authority, October 25, 1972), p. 7.
be either drug free (abstinence) or methadone support (21 days) leading to detoxification.

The program operates two facilities located on the east side of Columbus. The administrative and community outreach center is located at 765 East Long Street and the residential community at 800 North Nelson Road. The Long Street location is in keeping with the program's desire to serve where high crime rates exist and to partially measure its overall effectiveness by the extent of crime reduction in the neighborhood.

As of January, 1975, the staff consisted of 17 persons, 15 full-time and two part-time: An administrator (called an executive director), a clinical director, a career-development director, an administrative assistant, a finance comptroller, a planning evaluation director, two senior addiction specialists, three addiction specialists, an addiction aide, an education development coordinator, a nurse, a secretary-typist and two part-time workers—a psychologist and a teacher. The author came on the staff as the planning-evaluation director on July 16, 1973, and continues in that function.

In January, 1975, the client load was 310—200 initiating contacts, 15 new admissions, 35 in residential treatment and 60 in outpatient programs.

During a typical week in the winter time, the schedule of activities in the residential center include as main features the following as a sample:

**Weekdays**

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<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>6:00 - 6:45 a.m.</td>
<td>Wake-up and physical development</td>
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<td>7:00 - 8:30 a.m.</td>
<td>Clean-up and breakfast</td>
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8:30 - 9:30 a.m.  Family Planning Meeting
9:30 - 11:59 a.m.  Free time
12:00 - 1:00 p.m.  Lunch
1:00 - 1:30 p.m.  Free time
1:30 - 4:30 p.m.  Recreation outside the facility
4:30 - 5:00 p.m.  Return to facility
5:00 - 7:00 p.m.  Dinner and free time
7:00 - 9:00 p.m.  Encounter group
9:00 - 10:00 p.m.  Informal rap sessions
10:00 - 12:00 midnight  House closes, night duty begins

Activities scheduled for Tuesdays, Wednesdays, Thursdays and Fridays may also include the following:

Tuesdays, Wednesday  1:30 - 4:30 p.m.  Sensitivity Session
Thursday
Tuesday  7:00 - 9:00 p.m.  Hypnosis Group
Thursday  7:00 - 9:00 p.m.  Static Group
Friday  7:00 - 9:00 p.m.  Arts Impact

A typical weekend schedule might look like this:

Saturday
9:00 - 10:00 a.m.  Wake-up/breakfast
10:30 - 12:00 noon  General clean-up of facility
12:00 - 1:30 p.m.  Second/Third phasers group meeting
1:30 - 5:00 p.m.  Recreational activities
5:00 - 7:00 p.m.  Dinner and free time
7:00 - 11:00 p.m.  Recreational activities
11:00 p.m.  House closes
12:00 midnight  Night duty begins

Sunday
10:00 - 11:50 a.m.  Wake-up/breakfast
12:00 - 5:00 p.m.  Shopping, TV, visits, etc.
5:00 - 7:00 p.m.  Dinner and free time
7:00 - 11:00 p.m.  Movies
12:00 midnight  Night duty begins

In the administrative and community outreach center, 765 East Long Street, the typical week includes the following main activities:

Children's Workshops
4:00 - 6:00 p.m.  Childrens' Art  Monday, Wednesday
   (Visual)
4:00 - 5:00 p.m.  Creative Dance with  Tuesday, Thursday
   African Drumming
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<td>5:00 - 6:00 p.m.</td>
<td>Hobbies, Crafts</td>
<td>Tuesday, Thursday</td>
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<tr>
<td>10:00 - 1:00 p.m.</td>
<td>Youth Rendezvous (Weekend talent display)</td>
<td>Saturday</td>
</tr>
<tr>
<td>7:00 - 9:00 p.m.</td>
<td>Photography</td>
<td>Thursday</td>
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<tr>
<td>7:00 - 9:00 p.m.</td>
<td>Karate</td>
<td>Monday through Friday</td>
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A typical Saturday schedule might be:

- **11:00 - 1:30 p.m.** African Drumming & American Jazz
- **3:30 - 5:30 p.m.** African Drumming & American Jazz
- **5:30 - 7:30 p.m.** Adult Creative Dance
- **5:00 - 7:00 p.m.** Hair Braiding
- **7:00 - 12:00 midnight** Dawn Dance and Community Entertainment

The problems of Uhuru, as an organization, are similar to the problems which other drug treatment programs are facing. Uhuru is still seeking ways to structure its treatment units to be responsive to the overall problems of the addict. In many planning sessions the questions have been raised: "What should be the role of education in the rehabilitation of institutional addicts?" "What should be the function of the teacher and what factors should be considered in the planning of educational activities?"

In regard to these questions, the author has made some surveys into current practices of education in drug treatment programs in order to offer some suggestions on the development of a drug abuse educational component for Uhuru. In Chapter II, an analysis of educational functions in institutions similar to Uhuru has been made. These programs tend to equate education with the placement of clients in schools or with vocational institutions, having to acquire necessary skills for economic survival. Otherwise, education, if offered at all, tends to be seen as a peripheral activity that takes place outside the unit.
(e.g., adult education classes). A similar restricted conception of education has thus far characterized Uhuru. It is dissatisfaction with the outcome that has motivated this study. The education unit has been alienated from the clinical component, the baffled educator being frequently frustrated not only by this alienation, but also by the lack of guidelines on how to build an educational program on new and different lines.

Despite the apparent failure of drug treatment programs to develop strong and integrative educational components to date, the leaders in the development of therapeutic treatment communities continue to give their support to the proposition that education could and should be a constructive force in developing alternatives to the addiction cycle.  

Orientation to the Problem and the Report

In varying degrees, drug abuse and addiction problems are universal in all cultures and in all social classes. Once regarded as

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a ghetto problem, drug abuse and addiction have now changed their patterns, becoming ubiquitous and including many social strata.

While research on the source determinants of drug abuse is still incomplete, available evidence is descriptive of drug abuse as a manifest symptom of some underlying human problems. For many people drugs can become a supportive crutch for human external and internal stresses. Indeed, the author's internship at the Uhuru Drug Program has exposed him not only to the external political and economic crises, but also to the internal emotional, psychological and spiritual trauma with which most addicts struggle.

The addicts themselves have a lot to teach and the non-addicts have equally a lot to learn. Contrary to the common general description of an addict as a non-responsible, immature and unintelligent individual, the author's experience at Uhuru has found the addict to be an alert, witty, sometimes brilliant individual who has learned to survive by presenting "false fronts." The addict seems to be generally described as an ignorant, intellectually undeveloped individual on the basis of his facade. Yet, behind his facade lies a wealth of knowledge and abilities which he has informally acquired in the street.

Whatever the public attitude and perception of an addict may be, the problems of the addict will continue to accumulate unless he

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is given a sincere public hearing and understanding. Description of 
an addict as either a patient in need of support and sympathy or as a 
criminal in need of arraignment and punishment would not alleviate and 
has not yet reduced the problem of addiction. Instead, the problem 
is increasing, the drug population is expanding and there is a shift 
in pattern of abuse from mono to poly drug abuse.

Credit should, however, be given to such bodies and programs 
as the National Institute on Drug Abuse (NIDA), the Methadone 
Maintenance programs, The Therapeutic Community (TC) Drug Treatment 
Centers, the Hotline Centers, the Crisis Intervention Centers, the 
Correctional and the Halfway Houses, etc.—all of which have honestly 
and sympathetically responded to the problem of drug abuse and addiction. Marked success has been achieved in varying degrees by all of 
these programs; yet a lot more remains to be achieved. Some treatment 
modalities need to be more emphasized in order to produce greater success.

This study undertakes to develop an educational component as 
one of the modalities for a program of treatment. While public educa-
tion on drug abuse is relevant and desirable, a special type of educa-
tion needs to be offered for addicts admitted to drug treatment centers. 
Thus far in such centers, educational programs have been little de-

of the American Experiment in Drug Control (Chicago: The University 

10"More to Drug Issue than Heroin Abuse," The Journal of the 
Addiction Research Foundation, May 1, 1974, p. 6.
veloped or not at all. The emphasis thus far has understandably been medical, psychological and social.

With a treatment span typically running beyond a year, there is time for an educational program to have an effect. There is also a client need for a more structured learning operation than the clinical and "family-living" emphases, in themselves, provide. One would hope that an educational program, pursued as such by the clients, would make obvious to them and others how successfully treated addicts might then become agents for the development of better educational programs, not only in the clinics, but more generally, in the drug-risk populations of the community and schools where preventive programs are needed. Drug addicts who are successful cases of treatment are invaluable sources for the teaching both of addicts and non-addicts.

The problem, at present, is that one who takes a role as educator on the staff of a center for treatment of drug addiction has no place to get preparation for his role in advance of his taking the position; he has to educate himself. This study presents some of what the author has learned from his efforts to thus educate himself during his first year on the staff of Uhuru in Columbus, Ohio.

His greatest needs have turned out to be four:

Although there is a group of eight national training centers for people interested in drug abuse prevention careers, the curriculum of these centers is academic in nature--offering little or no suggestion on an alternative to the present drug abuse educational program (See Newton Stark, "NIMH Chief of Education Discusses Training in the Drug Abuse Field," Drug Program Review, Vol. 2, No. 3, undated, pp. 18-25).
(1) To orient himself to the social context in which drug abuse, addiction, and treatment have grown in contemporary society.

(2) As a non-addict and "staff professional," to find a way to relate to individual addicts as persons for whom educational programs might become relevant and meaningful.

(3) To find a way, more rapidly and generally, to get from clients information concerning problems they accept themselves as having and in terms of which educational programs might be created with sufficient pertinence to hold their continuing interest.

(4) To find procedures that can help clients make progress in meeting their problems and in overcoming addiction.

These needs have led to four procedures:

(1) Reading in the professional literature and discussing with staff members of Uhuru and similar agencies to glean information pertinent to understanding drug abuse and addiction, and the work of agencies serving clients of addiction.

(2) Interviewing of a sampling of clients.

(3) Using a checklist to survey the personal problems of two groups of clients—one of persons who had been enrolled in the program for one to three days, and the other of persons who had been enrolled in the program for thirty days or more.

(4) Searching the literature for realistic and creative ways of helping clients solve their personal problems.

The results of these four procedures are presented under four chapter headings: Chapter II—Social Dimensions of the Drug Abuse and Treatment Problem; Chapter III—Interviews with Clients; Chapter IV—the Survey of Personal Problems of Clients; Chapter V—Suggested Steps in Follow-up. In the closing chapter (Chapter VI), an overview, conclusions and recommendations are offered for developers of educational programs in agencies for treatment of drug addiction. These recommenda-
tions are guidelines for the development of a client-centered drug abuse educational program.

Focus and Limits of the Study

The content derived from the interviews and the survey of personal problems of clients in Uhuru is not presumed to be generalizable to the clientele of other agencies similarly engaged in therapeutic drug treatment. Should comparable interviews and surveys later be done in similar agencies, it may turn out that the content-findings from the present study and population are very much, or very little, in line with what is found elsewhere. The present study is not designed to test the degree of congruence between the Uhuru and other populations, and we do not know the answer to the generalizability of findings concerning clients.

This is not seen, however, as a major handicap to the present study since the purpose here is primarily to try activities and instruments which might be found to be valuable by educational developers in their efforts to do what the author is trying to do, i.e., to initiate procedures which may give a local agency good information on which to base educational activities that personally fit to the concerns of specific clients in specific settings.

At this stage of educational development in this area, it is procedures that most need attention and testing. The lack of generalizability of the content derived from the interviews and surveys is, therefore, not seen as a major limitation. The content is used, not as though it were tested fact, but as a source for hypotheses to guide further inquiry, either by the author in his work at Uhuru or by others who take the role of educational developers in similar settings.
CHAPTER II

SOCIAL DIMENSIONS OF THE DRUG ABUSE
AND TREATMENT PROBLEM

While specific information about individual clients is necessary to a good educational program, general information about the social phenomenon of drug abuse and treatment is also essential in the orientation of the educational developer. This chapter is given to a summary of information which the author found to be important in his understanding of the underlying conditions within which individual clients get caught, against which they need to successfully struggle if their rehabilitative program is to be successful, and in the setting of which rehabilitation agencies are required to operate.

The summary information is presented under three headings: the first, on "The Scope of Drug Abuse and Addiction," is to gain a perspective on the nature and proportions of the problem; the second, on "The Role of Education in Programs of Agencies Treating Drug Addiction," is to gain a perspective on the place of education in rehabilitative work to date; and the third, on "Basic Principles and Related Information," is to gain a perspective on what the author has learned, to date, concerning the effect of a wide range of conditions having an impact on drug addiction and treatment.
The Scope of Drug Abuse and Addiction

The scope of addiction and drug abuse is international and accelerating.¹ In England, the number of young narcotic addicts is increasing.² In Sweden, the increase in intravenous abuse of central stimulants has been reported as having become "intolerable."³ Reports from Africa and other developing nations also indicate drug abuse problems.⁴ ⁵ Drug abuse has also reached Russia, where addiction has usually been regarded as non-existent.⁶

Gary Rusk, in his Worthington (Ohio) High School survey, had reported on increased use of marijuana and hallucinogens among high school seniors.⁷ In Mansfield, Ohio there are statistical reports of


A two-fold increase in drug abuse.\textsuperscript{8} A 1970 issue of \textit{Newsweek} reported that 30-35 percent of all United States secondary school students use drugs,\textsuperscript{9} and Richard Earle, President of the National Co-Ordinating Council on Drug Education, stated that,

\begin{quote}
Just about every child in America is going to have at least one friend who is experimenting on drugs.\textsuperscript{10}
\end{quote}

Addiction and drug abuse have complex associated factors and just as these associated factors are complex, so are the effects of drugs on the victims. Apart from the psycho-physical dependence effects,\textsuperscript{11, 12} such reported effects as brain syndrome (mental disorder associated with organic impairment of the brain, classified as acute brain syndrome if the disorder is reversible, chronic brain syndrome if it is not) and marked distortion of perception are also present.\textsuperscript{13} Other effects include an impairment of judgment, diminished

\begin{itemize}
\item \textsuperscript{8} \textit{News Journal}, January 22, 1971, p. 1.
\end{itemize}
attention and concentration span, broken chromosomes, chronic memory loss and the development of female-like breasts in men. Compounded with the above problems are homicides, as indicated by the Detroit Study where 10 percent of all homicides were drug related.

Medically, several types of respiratory diseases such as tuberculosis, have a greater incidence among heroin users; hematogenous osteomyelitis (blood inflammation of bones) is also rising among the intravenous drug abusers. Pulmonary edema (swelling of the lung), as a complication of drug abuse, has been reported, along with the methadone maintenance associated condition of chronic hypercapnia (excessive carbon dioxide in blood). Increase in narcotic addiction within teenage and adult populations is bringing a corresponding inci-

dence of neonatal effects from the maternal narcotic addiction.\textsuperscript{20} Such neonatal effects include convulsions, inanition (starvation), fluid and electrolyte imbalance and death.\textsuperscript{21} Another biological effect is the septic arthritis of the sternoclavicular sternochondrial articulations which may be common in heroin users.\textsuperscript{22} The preceding statistics attest to the severity of drug abuse problems and call for a concerned action for the treatment rehabilitation of addicts.

Apparently aware of the above problem, President Nixon, in March, 1970, expressed his concern over addiction and created the National Action Committee to deal with addiction and the drug abuse crisis.\textsuperscript{23} This, along with earlier recognition of this problem, had led to the establishment of two federal narcotic treatment facilities at Lexington, Kentucky and Fort Worth, Texas,\textsuperscript{24, 25} respectively. Since then, many other drug treatment programs have proliferated and

\begin{itemize}
\item \textsuperscript{21}Ibid., p. 169.
\end{itemize}
have taken such diverse forms as the Medical-Psychiatric approach, the Communal approach, the Community-Based approach, the Chemotherapy approach, the Rational Authority approach, the Punitive approach. Uhuru is an example of the Community-Based approach.

Role of Education in Programs of Agencies Treating Drug Addiction

Traditionally, the term "drug abuse education" has referred either to programs used in schools and colleges to inform students of the effects of drugs or to programs used by treatment centers to inform the general public of the drug abuse problem. A considerable literature is available in description and evaluation of these programs.

27Key articles from this literature up to 1975 follow:


Our concern, however, is not with the programs for schools or the general public, but with educational programs within agencies for the treatment of drug addiction designed as part of their overall program for helping addicts. Our attention, therefore, turns to programs in these agencies.

A review of the Family Self Help Program28 at Talmadge, California affords an example of one treatment program. Typical activities include screenings, weekend marathons, regular weekday meetings and other spontaneous events.29 Education is not mentioned.


29 Ibid., p. 337.
and no teacher is included among the staff. In addition to the activities above, members (addicts) were given additional commitments to shave their heads, take daily showers and learn to read and write. Reading and writing form the major elements of the Self Help Drug Educational Program. Educators will agree that although literacy is important, it is a limited aim.

An examination of the California Rehabilitation Center drug programs reveals certain strengths as well as weaknesses. Although the California Rehabilitation Drug Program has broadened its program beyond the usual traditional counseling services to include trades such as upholstering, laundry, dry cleaning, baking, general shop building maintenance, landscape gardening, cooking and hospital aides, its goal of education is largely to place residents in elementary and high schools.

Still, the agency has recognized the need for the broadening of its educational base, and has responded to the need by the introduction of physical training, leisure time education and the teaching of desirable work habits. With proper planning and development of guidelines, its educational services should also begin to address the social, emotional and the psychological needs of its clients.

30Ibid., p. 338.


32Ibid., p. 496
A study of other programs such as the New York's Bayview Rehabilitation Center, the Phoenix House at Hart Island, New York, and the Synanon, reveals few or no education programs. Their main treatment emphasis, especially the Phoenix House, is on encounters, marathons and general meetings. Synanon, in Santa Clara, California, is the first Therapeutic Community of ex-addicts. Since its founding, many other therapeutic communities are characterized by residential living under strict supervision and harsh discipline. The essentials of treatment are progressive work mobility from menial to an elevated work status within the facility, a special kind of group therapy where confrontation, verbal abuse and intense emotional interaction take place. The significance of education is either not recognized or so taken for granted that it is not mentioned among the experiences received by the addicts. Such an oversight would hardly be accidental if institutional drug education has received serious consideration within the total treatment process. A strong institutional drug education structure is seriously needed in drug treatment centers to provide in-house educational experience to augment the usual counseling provided to patients or clients who want to go to school for


34Ibid., p. 34.


36Ibid., p. 44.
high school equivalency diplomas.

Dr. Edward A. Wolfson, an Associate Professor of Public Health and Preventive Medicine and the Director of the Division of Drug Abuse in the New Jersey College of Medicine and Dentistry, Newark, has stressed the value of drug treatment services in teaching adaptive and coping techniques, in providing an "honest" environment and by offering a drug free social and educational environment where the drug abuser may learn from the examples of others who have "made it." While an educational environment is needed for addicts, that environment cannot, and will not automatically become educational unless features, planning, concepts, strategies and philosophies that are fully educational are purposefully introduced. This clearly dictates a need for determinants of drug abuse education curriculum.

In the author's initial needs assessment study, for example, two states were contacted over the telephone for some information about the kind of institutional drug education offered in those states. One of the state drug education directors frankly admitted the absence of any education in drug treatment centers, saying that the state's program was directed not to helping addicts, but to informing the public and on their request. The other director spoke along the same line, adding that the neglect was dictated by inadequate funding.

Also, at the Washington, D.C., National Conference on Drug Abuse (February 11-13, 1974), a director of a major drug treatment program in the nation, on being questioned, told the author that all his drug educational programs were covered in group therapies, marathons, encounter groups, and in counseling where clients learn of
their mistakes and profit by the feedback generated in the group. Asked what his education curriculum was composed of, the director answered negatively on the ground that "these people-problems are always changing along with group emphasis." The changing patterns and problems of drug abuse are, however, no excuse for lack of institutional drug educational content. In essence, only a well-planned educational program that is solidly pegged on researchable ingredients (as curriculum determinants) can bring about systematic improvement. A generally low educational priority—if it may be so termed—is not just accidental. Its thrust and direction are often dictated by most of the State and Federal funding policies which tend to favor the medically-oriented treatment modality 37 (methadone maintenance programs), where little or no internal educational program is emphasized. 38

Although education has been largely emphasized in The Therapeutic Community Drug Treatment Centers, experience has frequently revealed conflicts between the educational and the clinical components of the therapeutic communities. At Uhuru, for example, the teacher is in constant disagreement with the clinical staff whose education concept is at variance with the concept and teaching behaviors of the education specialist. This is because of the inability of the program to develop a therapeutic framework within which


education can form a part. Another reason is the inability of Uhuru to decide on the kinds of learning experiences (curriculum content) to which the addicts should be exposed, and this problem is not unique to Uhuru.

Basic Principles and Related Information

To function as a developer of an educational program in agencies treating drug addiction, one needs not only an orientation to the extent of the drug addiction problem (as reviewed in the first section of this Chapter), and an orientation to the operational status of education in the agencies treating drug addiction (as reviewed in the second section of this Chapter), but also an orientation to a cognitive framework within which to structure educational development. The last is the function of this section, which presents a series of statements of principle, each statement followed by a brief discussion.

1. We need first to realize that certain needs are basic to all people.

The Educational Policies Commission of the National Education Association of 1938 stated the needs of persons in the American democracy as being those of,

1. Self realization
2. Economic efficiency
1. Human relationship
2. Civic responsibility

The above four needs are generally regarded in America as significant areas of growth by which good citizenship is largely evaluated. In addition to the above four areas of needs, Maslow has ranked organismically-based needs in terms of:

1. Physiological needs
2. Safety needs
3. Love and belongingness needs
4. Self-esteem needs
5. Self-actualization needs

Combining Maslow's needs with the Commission's four areas of educational needs, the following provides a useful listing here:

1. Physiological needs
2. Safety needs
3. Human relations, or love and belongingness needs
4. Self-esteem, or adequacy and confidence needs
5. Economic efficiency needs
6. Self-actualization, or potentiality actualization needs
7. Civic responsibility, or socio-political needs

Although the above needs are not complete, it is the author's belief that human existence is generally affected and influenced by the physiological needs (needs to be healthy), the need to be safe, the need to be loved and belong to a group, the need to feel adequate and confident, the need to survive economically through exchange of labor and services, the need to develop and excel in some innate or acquired ability, and the need to be responsive and be contributing


to the social-political system in which an individual finds a niche.

2. Drug addicts have developed a sub-culture through which they seek to meet their basic needs. This sub-culture has a history of its own.

The primary motivational and supporting system of the addicts is the addicts' sub-culture—their immediate environment. This sub-culture originated with the opium addicts of the late nineteenth century as a non-criminal sub-culture where smokers from all walks of life gathered regularly. Although some criminals frequented these groups, largely concentrated in centers of Chinese life, they were mainly composed of people from the dominant culture and did not become predominantly criminal until after 1914, when the Harrison Act outlawed the drugs as well as the addicts. Today, the culture is a tightly organized sub-culture, supplied with drugs from the underworld and at the same time exploited by other criminal sub-cultures which prey on the addict.

The addicts' sub-culture is generally believed today to be made up almost exclusively of ghetto dwellers. This belief, unfortunately, tends to obscure the needs and problems of the middle-class members who are also a part of the addict's sub-culture and have been such for some time. At the turn of the nineteenth century, for example, opium was much consumed by the upper-class persons, by


43Ibid., p. 264.
eminent statesmen, by high clergy and by the literati.\textsuperscript{44} Records have also indicated a steady accumulation of narcotic users and addicts in the nation among the intellectuals in the period during and after the nineteenth century. Opium prepared in the form of a "home remedy" was also consumed among the upper-class men and women in the form of "Winslow Soothing Syrup," "Godfrey's Cordial," "McMunn's Elixir of Opium," "Dover's Powder," Ayer's Cherry," "Pectoral" and so on.

While the nineteenth century addict's sub-culture was largely characterized by morphine usage, the present day (twentieth century) addict's sub-culture is largely heroin-oriented due to the synthetic preparation of heroin in Germany by Dresser in 1898. Heroin, in its synthetic form, was heralded both in Europe and in Germany as the most useful non-addictive analgesic and as a choice treatment drug for opium.

In the States, the widespread use of heroin was seemingly encouraged by two important historical factors:

(1) the use of hypodermic needles for the administration of heroin to the soldiers of the American Civil War (1861-1865), and

(2) the use and introduction of heroin by the returning veterans of the Second World War (1939-1945).

It was obvious that the value of heroin as a pain and frustration relieving drug was well recognized by many, including the so-called poor who had fought in both wars and had also received heroin for

their pain and anxiety relief. When, therefore, in the midst of the widespread abuse and danger of heroin, the Harrison Narcotic Act of 1914 introduced a controlling factor to the production and distribution of opium and its derivatives, the overall effect of that Act (like the Volstead Act, which prohibited the sale of alcohol) was an illegal trafficking and sale of narcotics. The harsh penalty and difficulty in obtaining both heroin and opium forced people to illegally channel the drugs into and through crime-permissive areas where police interference was virtually minimal. The urban Black communities became the logical places for the sale of narcotics (e.g., Harlem in New York, the Watts and Philadelphia Black areas).

3. The seat of the sub-culture lies in urban poverty areas, but all levels of society are represented; social ills feed the sub-culture its new recruits.

In the Black urban areas which abound with poverty, crime, unemployment, broken homes, pimping, etc., narcotic abuse and addiction have increased more significantly than in other areas to provide coping mechanisms for the frustrations that have resulted from the Black economic, educational and status deprivations. In this perspective, it is usually convenient to picture the drug sub-culture as widely scattered ghetto areas inhabited by the economically and the socially deprived elements of the American Society. This picture should not, however, obscure the presence, in this sub-culture, of


the middle and upper-middle class members whose problems of loneliness, over-protection, lack of love, boredom, overt rebelliousness against authority, etc., are also associated with their drug taking behavior.

The drug sub-culture has become an underground world; it has assumed a secret character; it has developed its own particular language and lifestyle, and it is constantly socializing its members into unique norms and expectations of the sub-group. The sub-culture admits individuals from all social classes and performs a primary protective and motivational function.

The sub-culture is fed by new recruits wherever, in the larger society, there is oppression, alienation from self, injustice, injured mental health, loss of religious faith, hypocrisy, etc. The sub-culture will persist as long as such condi-


51Ardis Whitman, "We Need New Ways to Pray," Reader's Digest, December, 1969, pp. 77-80.

tions exist in society. Ultimately, agencies working to treat drug addiction come face-to-face with these conditions.

4. Because individual addicts vary in the background from which they come, and because each has his own particular pattern of causes leading him into addiction, programs which are successful in aiding addicts will need to be sensitively oriented to each individual's pattern of need and response.

The addicts' sub-culture is one inhabited by a heterogenous group of individuals who represent many socio-economic strata, with the majority of the addicts coming from the lower economic base. Usually, the members of the sub-culture are "visible" drug users who are regarded by the community as being of relative unimportance—individuals whose present and future fate are not of immediate interest to the public. Using Einsteins' and Quinones' words, the sub-culture "is a pariah, pushed aside and largely ignored by the larger society."

Another noteworthy aspect of the drug sub-culture is its high crime rate and the social needs-fulfillment which the system offers to the young. As a supporting and motivational system, the drug sub-culture offers some attractions for the marginal, ego demeaning


elements of the society. It teems with people who are poor, people with weak family relationships, people who have left school prematurely, people with lack of vocational training and an unstable job history and people who have moved into the quasi-legal and illegal occupations, such as the dance hostess and the prostitute.56

The addict's sub-culture is a system voluntarily formed by many age groups, with the age range of 19-30 years becoming the majority.57 The abuse of drugs is now spreading to younger children.58 Within the younger age group are the junior high and the upper elementary school populations which, according to experts, are the age groups most susceptible to drug abuse. Although the Blacks and other minority members are overly represented within the drug sub-culture, the percentage of Whites is increasing. Within the adult group, alcohol, tranquilizers, diet pills and over-the-counter drugs are abused, and while the adult population representation is presently limited, advertisement of drugs in the media likely push the adult population more and more into the drug sub-culture.59

58Ibid., p. B52.
The addict's entry to the system of the drug culture is dictated by levels of needs and problems; socio-economic and educational backgrounds are also differentially represented within the drug culture. The degree of family cohesiveness, racial origin, religious commitment and tolerance levels are variables which help in dictating the present trends and patterns of drug abuse. A program of drug abuse education would need to take such variables into account in planning individual and group curricula; otherwise, the individual client would not be able to see the relevance of the program for his problems and background.

5. The drug sub-culture gains its attractiveness from its capacity, for a time, to meet certain important and basic human needs; in due course, addicts learn that the sub-culture cannot meet those needs over an extended period of time; they may then want to enter the mainstream culture, but, unless their basic needs are met within that mainstream, they will be drawn again toward the drug sub-culture.

In spite of the harsh penalties that accompany narcotic abuse and of the hard conditions that are inherent within the sub-culture itself, many people still find pleasure and attraction to which they respond. Interviews with many addicts reveal an existence within their culture of a sincere concern and acceptance which they report to be lacking in the "square" society. The communal existence, the protection accorded to members, the sense of common purpose that draws people together, the love that is being generated among the members, the absence of racial discrimination, the strong interpersonal ties that are derived from membership, the temporary relief from the pressures of industrial living, the feeling of euphoria derived from drug
taking and the quick economic reward that results from illegal drug trafficking, have all been reported to be goals of the drug sub-culture's members. Yet, in the midst of these seeming charms are diseases, a feeling of guilt for crimes committed, murdering for cheating, starvation from insufficient purchasing abilities, sleeplessness from long hours of hustling, venereal diseases from promiscuous living and a chronic fear of the agents of the law and critics in the community. Psychologically, many addicts have a feeling of failure and of low esteem for themselves. They also become poor risks as they return to the community. After a careful reflection on the life spent within the drug sub-culture, many addicts--on interview--have frankly stated that life within the drug sub-culture "is an existence without meaning," "a mission without a compass," "an accomplishment without honor," and a "happiness that is not enduring."

Drugs, they say, are the answer when other supporting backbones and beliefs have fallen. The sub-culture itself will perpetuate itself, they predict, because of:

(1) the economic factor (profit involved in the illegal trade).

(2) the existence of glaring injustices.

(3) the conflicting and discriminatory system of rewards and punishments.

(4) the rapid changes in societal values.

(5) the failure of religious insitutions to satisfy human needs and spiritual hunger.

(6) the increasingly agonizing dehumanization produced by the industrial order.
6. Conditions pertaining to health in the drug sub-culture are particularly bad; an understanding and discipline with respect to health is a clear necessity in the rehabilitation of the majority of cases.

The health aspect of the drug sub-culture warrants observation and analysis. The dynamics of the drug sub-culture, the economic factors that are needed to sustain the drug system and the forces which drive people into the drug sub-culture have all combined to produce a population with a high incidence of "physical illness, accidents and death." This point is supported by O'Donnell's discussion that addiction and drug use are found in slum districts characterized by poverty, high mobility, high crimes, and high disease rates... Complications of addiction include thrombophlebitis (venous thrombi in the presence of inflammation in the vessel walls), septicemia (general blood poisoning), introduced by septic intravenous injection of drugs (mainlining), multiple tattoos, vein tracks and abscesses. Vein tracks are marks of repeated needle injections in the antecubital fossa of the forearms, while multiple abscesses and scar tissues are frequently common sources of lymphedema (swelling


of the lymph nodes), cellulitis (inflammation of the cells) and sometimes vascular insufficiency. Also, the addict's social sharing of injection equipment is apt to increase the likelihood of infectious hepatitis and the obvious lack of an aseptic precaution in the preparation and administration of the drug itself is equally likely to increase the probability of physical illness.

In many cases, it is breakdown of health that brings the addict to his resolution to find another and better way of life; it is obvious that sound health practices, based on sound understanding, need to be a common and major goal for rehabilitation programs.

7. Society has created laws and regulations to cope with drug abuse; these have a direct effect on the addict's sub-culture and on the choices available to individual addicts; these laws and their effect need to be known.

A proper understanding of the drug problems requires both the examination and the description of the laws to control the use of drugs and the many assumptions basic to these laws. To reduce laws into a single section is not simple because of their complexity and the many levels at which the laws are enacted. At one level, for example, is the Federal Government, at another are the fifty states, and still at another are the regulatory statements by bodies such as the Food and Drug Administration, the Federal Bureau of Narcotics, the American Bar Association, the Pharmaceutical Association, the American Medical Association and a host of other local drug ordinances.

63Ibid., p. 663.
Every drug institution, every school system and every interested person should try to familiarize itself or himself with its or his state narcotic laws. An understanding of the state narcotic laws would, in fact, be very educational and helpful, not only in an intelligent discussion of drug abuse problems, but also in drug treatment institutions where the addicts' understanding of the many aspects of the laws could help their future rational thinking and positive decision-making about drug sale and consumption. On one occasion, for example, an addict who was arrested, charged, sentenced and probated to Uhuru for a possession of one marijuana joint, confessed her ignorance prior to her arrest of the marijuana possession law. She had thought of marijuana smoking as a permissive offense and on the basis of that ignorance had, unfortunately, established a criminal record which might stand as a limitation against her progress in life. There are other aspects and ramifications of narcotic laws which are either unclear or unknown and whose knowledge and apprehension would not only prove beneficial to the institutional addicts, but also to the parent, to the school teacher, to the counselor and to the individual informed citizen. Subsequent paragraphs contain a brief discussion of the narcotic laws and regulations.

Historically, it appears as if the United States had acted in good faith, internationally, to control the manufacture and distribution of opium. Under the Hague Conference of 1912, the United States collaborated with other European nations to reach an almost universal agreement that opium trade and production be limited to medical and
scientific use. The Hague Conference was, therefore, an attempt to institutionalize the medication and utilization of opium within the medical system, and was also an appeal to the international bodies to curb unrestricted commerce in opium. In recognition and acceptance of the Hague Treaty, the United States introduced the Harrison Act in 1914 to control domestic production, sale and transfer of opium and coca products. In addition, the Harrison Act was also a response to the United States' awareness of the inadequacy of state laws to deal effectively with the then rising international problems of opium.

Since the Harrison Act was still unable to produce anticipated domestic drug control, due to the existence of multiple, divergent state laws, the American Bar Association enacted the Uniform Drug Act in 1932. The Uniform Act defined the domain of dangerous drugs, included marijuana under narcotics and brought uniformity among many states. Also, the Uniform Act typically made possession of a narcotic drug, in whatever quantity, punishable by two to fifteen

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67Ostrow, The Use and Misuse of Drugs, p. 69.
years in state prison, plus a fine. On a second offense the sentence is five to twenty years for mere possession. What is more oppressive about the second offender provision is the stipulation, in almost every state, that on a second offense the sentencing judge cannot suspend the sentence (which can be done in first offenses) and send the defendant to a special drug rehabilitation agency.

Another aspect of the Uniform Act is its inclusion of marijuana under narcotics—a possible fifteen years imprisonment for a possession of one marijuana joint (one marijuana cigarette). Sales of narcotics receives heavier punishment than possession and is so defined as not to require an actual commercial transaction; merely giving a narcotic drug to another constitutes a sale. The inclusion of marijuana under narcotics has aroused powerful criticism and controversy; recently (1973) a lawsuit under the title of Norml V. Wilson was instituted in Washington, D.C. in an effort to declare that the federal and local marijuana laws are unconstitutional because they violate the right of privacy and other guarantees of the U.S. Constitution. It also attempts to prohibit the police from arresting persons for private possession and use of marijuana. The District of Columbia was chosen as the jurisdiction in which to file the suit.


69 Ibid., p. 61.

because of the dramatic increase in the number of local marijuana arrests. The suit, however, is still pending and when decided, its decision would certainly have an important effect on other local and state narcotic laws.

The principal Federal Laws regulating narcotics are:

1. Harrison Act, passed 1914.
2. Narcotic Drug Import and Export Act, passed in 1912, now included in the Internal Revenue Code.
3. Narcotic Hospital Law, passed in 1929, providing treatment facilities for persons addicted to drugs controlled by narcotic laws.
4. Narcotic Information Act, passed in 1930.
7. Opium Poppy Control Act, passed in 1942.

A brief discussion of the principal Federal Laws, especially those not previously discussed, is given at Appendix A, and included on pages 41, 42 and 43 are quick review tables containing the drug laws of the State of Ohio (Tables 1, 2, and 3).\(^\text{71}\)

The above narrative, the section at Appendix A, and Tables on narcotic laws make clear that laws and regulations exist for the

\(^{71}\)The drug laws in these tables represent those frequently violated in Ohio. Further information concerning such laws can be obtained from the Ohio Board of Pharmacy or the Ohio Bureau of Drug Abuse, 2929 Kenney Road, Columbus, Ohio.
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<td>10</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(B)</td>
<td>2nd</td>
<td>25</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(C)</td>
<td>1st</td>
<td>10</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>(D)</td>
<td>2nd</td>
<td>25</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3rd &amp;</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3719.20</td>
<td>(E,F,G)</td>
<td>1st</td>
<td>10</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employ, induce, or use a</td>
<td>2nd</td>
<td>25</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>minor to unlawfully</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>transport, carry, dispense</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>produce, or manufacture a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a narcotic drug; induce</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>or attempt to induce</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>person to unlawfully use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>or administer a narcotic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>drug.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3719.17</td>
<td>Illegal Prescription;</td>
<td>1st</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>make or utter any false</td>
<td>2nd</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or forged prescription or</td>
<td>3rd &amp;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>official written order.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3719.2</td>
<td>Illegal possession of</td>
<td>1st</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>instruments for administer</td>
<td>2nd</td>
<td>1</td>
<td>5</td>
<td>500.00</td>
</tr>
<tr>
<td></td>
<td>ing drugs (habit forming).</td>
<td></td>
<td></td>
<td></td>
<td>1,000.00</td>
</tr>
</tbody>
</table>
TABLE 2

<table>
<thead>
<tr>
<th>OHIO LAWS - AMPHETAMINES AND/OR BARBITURATES</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Minimum Fines</th>
<th>Maximum Fines</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION 3719.24 (A)</td>
<td>1st offense</td>
<td>1</td>
<td>5</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>No person shall deliver, sell, give away any</td>
<td>2nd offense</td>
<td>2</td>
<td>20</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>amphetamines or barbiturates unless a pharma­</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cist, with a prescription.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SECTION 3719.24 (B)</td>
<td>1st offense</td>
<td>1</td>
<td>5</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>No person shall possess an amphetamine or</td>
<td>2nd offense</td>
<td>2</td>
<td>20</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>barbiturate unless obtained by prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SECTION 3719.24 (H)</td>
<td>1st offense</td>
<td>1</td>
<td>5</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>No person shall obtain or attempt to obtain</td>
<td>2nd offense</td>
<td>2</td>
<td>20</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>a barbiturate or amphetamine by deceit, fraud,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>etc. Exceptions: Practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carriers, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records must be kept and the State Board of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy will inspect records.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OHIO LAWS - HARMFUL INTOXICANT

<table>
<thead>
<tr>
<th>OHIO LAWS - HARMFUL INTOXICANT</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Minimum Fines</th>
<th>Maximum Fines</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION 3719.25 (A)</td>
<td>1st offense</td>
<td>1</td>
<td>10</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Except for lawful research, clinical, or medical</td>
<td>2nd offense</td>
<td>1</td>
<td>10</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>purposes, no person, with intent to induce in­</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>toxication or similar physiological effects,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>shall purchase, possess, have under his control,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>use, or administer to another any harmful in­</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>toxicant.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HARMFUL INTOXICANT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>does not include beer or intoxicating liquor,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>but means any compound, mixture, preparation,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or substance the gas, fumes, or vapor of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>which when inhaled can induce intoxication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>excitement, giddiness, irrational behavior,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>depression, stupor, unconsciousness, asphyxiation,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or other harmful physiological effects and includes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>without limitation the following;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) any volatile organic solvent, or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>plastic cement, model cement,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fingernail polish remover, lacquer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>thinner, cleaning fluid, gasoline,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or other preparation containing a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>volatile organic solvent;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) any aerosol propellant;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) any fluorocarbon refrigerant;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) any anesthetic gas.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OHIO LAWS - DANGEROUS DRUGS

<table>
<thead>
<tr>
<th>OHIO LAWS - DANGEROUS DRUGS</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Minimum Fines</th>
<th>Maximum Fines</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION 4729.51 (C)</td>
<td>1st offense</td>
<td>1</td>
<td>1</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>No person shall purchase for the purpose of re-</td>
<td>2nd offense</td>
<td>1</td>
<td>10</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>sale, possess for sale or sell a dangerous drug.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OHIO LAWS - HALLUCINOGENS</td>
<td>Minimum Sentence</td>
<td>Maximum Sentence</td>
<td>Minimum Fines</td>
<td>Maximum Fines</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>SECTION 3719.41</td>
<td>1st offense</td>
<td>1</td>
<td>1</td>
<td>$ 1,000.00</td>
</tr>
<tr>
<td>Purchase, use of, possession or control of, with intent to produce hallucinations or illusions.</td>
<td>2nd offense</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3rd &amp; subsequent</td>
<td>10</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>SECTION 3719.44 (A)</td>
<td>1st offense</td>
<td>2</td>
<td>15</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>No person shall:</td>
<td>2nd offense</td>
<td>5</td>
<td>20</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>steal any hallucinogen from a person authorized to use or possess hallucinogens; physician, pharmacist, manufacturer, wholesaler, or obtain a prescription from a second physician while being treated by another physician; or have carnal knowledge of another person knowing such other person is under the influence of an hallucinogen.</td>
<td>3rd &amp; subsequent</td>
<td>10</td>
<td>30</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>SECTION 3719.44 (B)</td>
<td>1st offense</td>
<td>10</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>No person shall possess for sale any hallucinogen.</td>
<td>2nd offense</td>
<td>15</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>3rd &amp; subsequent</td>
<td>20</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SECTION 3719.44 (C)</td>
<td>1st offense</td>
<td>10</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>No person shall induce or attempt to induce another person to unlawfully use or administer any hallucinogen or employ, induce, or use a minor, or induce or attempt to induce a minor to use any hallucinogen.</td>
<td>2nd offense</td>
<td>25</td>
<td>50</td>
<td>No probation</td>
</tr>
<tr>
<td>SECTION 3719.44 (D)</td>
<td>Each offense</td>
<td>20</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>No person shall sell, barter, exchange, or give away, or make offer therefor, any hallucinogen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SECTION 3719.44 (E)</td>
<td>1st offense</td>
<td>30</td>
<td>Life</td>
<td>No probation</td>
</tr>
<tr>
<td>No person shall unlawfully dispense or administer any hallucinogen to a minor.</td>
<td>2nd offense</td>
<td>1</td>
<td>5</td>
<td>$200.00</td>
</tr>
<tr>
<td></td>
<td>2nd offense</td>
<td>1</td>
<td>5</td>
<td>$500.00</td>
</tr>
<tr>
<td>SECTION 3719.46</td>
<td>1st offense</td>
<td>1</td>
<td>5</td>
<td>$200.00</td>
</tr>
<tr>
<td>Maintaining place frequented by users; common nuisance.</td>
<td>2nd offense</td>
<td>1</td>
<td>5</td>
<td>$1,000.00</td>
</tr>
</tbody>
</table>
control of the manufacture, the flow and the consumption of narcotics. Yet, in the midst of the laws and their harsh penalties for violations, abuse and misuse of narcotics have continued to increase. Either the laws and the regulations are ineffective, maladministered and/or ill enforced, or their existence and complexities are unknown, misunderstood and/or ignored. All aspects of anticipated existing weaknesses should be explored; if the laws, for example, are weak, they should be re-examined and strengthened; if they are ignored, they should be re-evaluated in the light of present needs and realities and either amended or repealed.

Many law makers, lawyers and judges have observed that harshness of the drug laws, particularly the marijuana laws, has created a lack of respect for the law in general and, in turn, has posed a threat to the whole legal system. The question must ultimately be asked as to whether the punitive orientation of the existing drug laws or the humanitarian approach emphasized by the social therapist is singularly effective in deterring young people from using drugs. The incidence of drug abuse today (1975) is high; the use of informants for information; the ineffective prosecution, the inconsistent results of justice, the increasing support for a humanitarian treatment approach and the divergent pressure groups within the Criminal Justice System itself, all make it clear that some changes are needed.

---

8. Different drugs have differing effects, depending on their content, mode and condition of use; these differences, and their symptoms, need to be known.

Psychoactive mind-altering drugs fall under the categories of:

(1) Sedatives
(2) Hallucinogens
(3) Stimulants
(4) Narcotics
(5) Marijuana

Sedatives: These are drugs which induce sleep. Taken in small doses they can temporarily modify tension and anxiety in some people. When used without close supervision, the possibilities of taking increased amounts and becoming dependent are present. In street language, the sedatives are called "goof balls," "sleepers," and "downers." The barbiturates constitute the largest group of sedatives.73 Barbiturates are further classified into long-acting, slow starters such as phenobarbital; the intermediates such as amobarbital (amytal) and butabarbital (butisol) and the short-acting fast starters such as the secobarbital (seconal) and pentobarbital (nembutal).74

The following explanation of terms is given in order to make the understanding of abused drugs easy:


(1) Physical Dependence — This refers to an altered physiological state brought about by repeated administration of a drug which requires continued use of a drug to prevent the appearance of a characteristic self-limited illness called an abstinence or withdrawal syndrome.75

(2) Abstinence syndrome (symptoms) — This is a self-limited illness, beginning with yawning, perspiration, rhinorrhea (copious mucous discharge from the nose) and lacrimation, progressing to dilation of the pupils; waves of gooseflesh and twisting of various muscle groups are present while the presence of hot and cold flashes as well as restlessness may become extreme. There is elevation of systolic blood pressure, respiratory rate and rectal temperature. Retching (strong involuntary effort to vomit), vomiting and diarrhea are present in the more severe syndromes. Also, there is either a complete or almost complete anorexia (loss of sleep) and rapid loss of weight...76

(3) Emotional Dependence — This refers to the use of drugs as a major means of adaptation to life stresses and is related in complex ways to effects of psychological or physiological symptoms such as pain, anxiety and sexual problems. All addicting drugs create emotional dependence, but not all create physical dependence.77

(4) Psychological Dependence — This refers to a state where an individual becomes psychologically dependent upon a drug to the extent that when the drug is no longer available, the individual becomes ill as ease, restless and irritable. Another name for psychological dependence is habituation.


Without further discussion of abused drugs, subsequent tables (Tables 4, 5, 6 and 7) will present a simplified version of commonly abused drugs, including other aspects whose knowledge and understanding would be helpful. In Table 4, the distribution of drugs taken by male patients prior to heroin abuse is shown; in Table 5, the use and index of sociability of the most current drugs are portrayed; and in Table 6, common signs and symptoms of patients with psychoactive drugs are shown; Table 7 is a narcotic identification chart.

Summary

Central concepts gleaned from the author's orientation to the broad social dimensions of the drug abuse and treatment problem are offered in the following:

(1) The scope of drug abuse and addiction is international and growing.

(2) The problem is intimately tied into social history and social conditions.

(3) The development of agencies for direct dealing with drug addiction is recent, and, in the United States, sponsored primarily by the federal government.

(4) Educational programs have been undeveloped or narrowly conceived in programs of agencies now operating.

Although the number of patients, the percentages reflected and the index of sociability contained in either Table 4 or 5 may not be representative of Uhuru, knowledge of these statistics can guide Uhuru in the preparation of its drug distribution and index of sociability--both of which can further assist in rehabilitation planning.
### TABLE 4

**DISTRIBUTION OF DRUGS TAKEN BY MALE PATIENTS PRIOR TO HEROIN***

<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Patients</th>
<th>% (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines (oral)</td>
<td>40</td>
<td>82</td>
</tr>
<tr>
<td>Cannabis</td>
<td>37</td>
<td>76</td>
</tr>
<tr>
<td>Methyl-amphetamine (inj.)</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Cocaine injections</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>L.S.D.</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Morphine</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Methadone</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Benzhexol</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Opium</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pethidine</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Preludin</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>


### TABLE 5

**USE AND INDEX OF SOCIABILITY OF THE MOST CURRENT DRUGS N = 958***

<table>
<thead>
<tr>
<th>Drug</th>
<th>Use N</th>
<th>Use %</th>
<th>Index of Sociability</th>
</tr>
</thead>
<tbody>
<tr>
<td>L.S.D.</td>
<td>229</td>
<td>24</td>
<td>1:5</td>
</tr>
<tr>
<td>Opium</td>
<td>194</td>
<td>20</td>
<td>1:2</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>409</td>
<td>42</td>
<td>1:1</td>
</tr>
<tr>
<td>Hashish</td>
<td>884</td>
<td>92</td>
<td>1:9</td>
</tr>
<tr>
<td>Alcohol</td>
<td>580</td>
<td>61</td>
<td>1:11</td>
</tr>
</tbody>
</table>

TABLE 6
COMMON SIGNS AND SYMPTOMS OF PATIENTS WITH MIND/MOOD ALTERING DRUG TOXICITY*

<table>
<thead>
<tr>
<th>Suggested Symptoms</th>
<th>Sedative</th>
<th>Narcotics</th>
<th>Hallucinogens</th>
<th>Stimulants</th>
<th>Solvents</th>
<th>Tranquilizers</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convulsions</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0*</td>
</tr>
<tr>
<td>Depression</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0*</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0*</td>
</tr>
<tr>
<td>Agitation (Restlessness)</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0*</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>0</td>
<td>0</td>
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Suggested Symptoms:
- Convulsions
- Depression
- Hallucinations
- Agitation (Restlessness)
- Aggressive behavior
- Paranoia
- Psychosis
- Disorientation
- Ataxia
- Pain raking
- Parkinsonism
- Slurred speech
- Lacrimation
- Nystagmus, lateral

**Pupils**
- Pinpoint
- Dilated
- Normal
- Running nose
- Jaundice
- Skin rash
- Needle tracks
- Gooseflesh
- Respiratory
- Depression
- Tachycardia
- Cramps
- Fever

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<tr>
<th>Pupils</th>
<th>Sedative</th>
<th>Narcotics</th>
<th>Hallucinogens</th>
<th>Stimulants</th>
<th>Solvents</th>
<th>Tranquilizers</th>
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NOTE: This table is intended to list common signs. It does not preclude rare exceptions.

# TABLE 7
## NARCOTICS IDENTIFICATION CHART*

<table>
<thead>
<tr>
<th>Drug Used</th>
<th>Physical symptoms</th>
<th>Look for</th>
<th>Dangers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glue sniffing</td>
<td>Violence, drunk appearance, dreamy or blank expression</td>
<td>Tubes of glue, glue snars, large paper hands or handkerchiefs</td>
<td>Lung, brain or liver damage, death through suffocation or choking, anemia</td>
</tr>
<tr>
<td>Heroin</td>
<td>Stupor/drowsiness, needle marks on body, watery eyes, loss of appetite, blood stain on shirt sleeve, running nose</td>
<td>Needle or hypodermic syringe, cotton tourniquet string, rope, belt, burnt bottle caps or spoons, glassine envelopes</td>
<td>Death from overdose, mental deterioration, destruction of brain and liver, hepatitis, embolisms</td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
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<td></td>
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<tr>
<td>Codeine</td>
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<td></td>
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<tr>
<td>Cough Medicine (containing codeine and opium)</td>
<td>Drunk appearance, lack of coordination, confusion, excessive itching</td>
<td>Empty cough medicine bottles</td>
<td>Causes addiction</td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana tea, gage, reefers)</td>
<td>craving for sweets, increased appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSD (acid, sugar, Big O, cubes, trips)</td>
<td>Severe hallucinations, feelings of cocainement, incoherent speech, cold hands and feet, vomiting, laughing and crying</td>
<td>Cubic sugar with discoloration in center, strong body odor, small tube of liquid</td>
<td>Suicidal tendencies, unpredictable behavior, chronic exposure causes brain damage - LSD causes chromosomal breakdown</td>
</tr>
<tr>
<td>STP</td>
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<tr>
<td>Amphetamines</td>
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</tr>
<tr>
<td>Methamphetamine (speed, dynamite)</td>
<td>Aggressive behavior, giggling, silliness, rapid speech, confused thinking, no appetite, extreme fatigue, dry mouth, shakiness</td>
<td>Jar of pills of varying colors, chain smoking</td>
<td>Death from overdose, hallucinations - methamphetamine sometimes cause temporary psychosis</td>
</tr>
<tr>
<td>Barbituates (bark, blue-devils, candy, yellow jackets, phennies, pot, blue heavens, goof balls, downs)</td>
<td>Drowsiness, stupor, dullness, slurred speech, drunk appearance, vomiting</td>
<td>Pills of varying colors</td>
<td>Death from overdose, or causes addiction, convulsions and death as a result of withdrawal</td>
</tr>
</tbody>
</table>

(5) Nevertheless, there is rhetoric in support of a stronger educational component; the problem is to develop a sound approach.

(6) Seeking such an approach, the author internalized from his reading and discussion the following as important items to know:

(a) The fact that drug addicts, like other persons, are seeking to meet their basic human needs; they are like everyone else in this respect.

(b) The sub-culture developed by addicts is strong because it offers response to basic needs in individuals whose needs are not met otherwise at a particular time in their lives.

(c) The sub-culture feeds on weaknesses in society, particularly poverty, unemployment, crime, broken homes, and alienation from the mainstream culture.

(d) The sub-culture reaches youth at a time when they are most needing personal adequacy.

(e) Rehabilitation which is successful needs to supply conditions for developing personal adequacy.

(f) Addicts will turn toward help from outside the sub-culture when they sense that their needs can no longer be fulfilled by taking drugs or by primary involvement in the sub-culture.

(g) Health is a crucial factor in personal disintegration and rehabilitation.

(h) The legal aspects are complex and ever present; dealing with them is mandatory.

(i) Abused drugs are diverse in composition and various in their effects; keeping up to date on practices, symptoms and treatment is itself a problem.
Summarizing in other terms, the following are questions which came to be prominent in the author's inquiry as he sought to educate himself concerning the broad social dimensions of the drug abuse and treatment problem:

(1) What is the range and extent of the drug abuse and addiction problem?
(2) What effects are associated with drug abuse and addiction?
(3) What are the local, state and federal responses to the problems of addiction?
(4) What are the different treatment modalities and the philosophical grounds upon which they are based?
(5) What are the current practices of existing drug treatment programs?
(6) How have current practices met the needs and problems of the addict?
(7) Are the current treatment practices comprehensive enough to focus on rehabilitation?
(8) What is the status of education in the programs of drug-treatment agencies?
(9) Is there a clear distinction between education and counseling in current practices and methods?
(10) How may education and counseling activities be made to relate effectively?
(11) What are the basic human needs, the meeting of which is requisite to human fulfillment?
(12) What is the nature of the ghetto drug sub-culture and its relation to the incidence of addiction?
(13) What are the motivational and supporting elements of the drug sub-culture?
(14) What are the pressures that drive some people into drug abuse practices?
(15) What are the sources for these pressures in the backgrounds of those who enter the sub-culture?

(16) What are the health conditions and practices of the drug sub-culture?

(17) What are the laws affecting illegality of drug abuse practices and what response do these laws and their enforcement elicit from offenders?

(18) What drugs are being used in an abusive or addictive way? What are their effects under varying conditions?

The next chapter turns attention to the interviewing of clients, the style and structure of the interview, and the utility of the content.
CHAPTER III

INTERVIEWS WITH CLIENTS

Research has reported a close correspondence between the cognitive structure which physicians hold for their professional work and the information they then collect from their patients. The cognitive structure determines what the physician takes to be valuable in guiding his action within his role, and, when he takes a case history or makes a physical examination, he seeks and reports what fits his frame of reference.\(^1\) While this is necessary and understandable as a mode of procedure, much other information is formally excluded, and what is excluded may have consequence for the patient.

If a treatment modality is to relate to a patient's problem, it stands to reason that the patient's problem definition would benefit not only from the physician's selectively gathered inputs, but also from inputs provided by the patient himself. For the educator, the patient's inputs are critical since it is upon the perceptions of himself and his world that a patient builds when he educates himself.

Means need be provided for clients in a drug abuse treatment program to show their self-perceptions under conditions where they feel free to share their perceptions with educators who, in turn, help to provide programs which can assist the clients in growing their learning and their strength from the core of knowledge which they already accept as their own. One means to such sharing is the interview.

This chapter is given to consideration of the interview as limited and styled for the educator-and-client at the time of entry connection. Illustrations of dialogues are offered in a selection of cases.

**Style and Structure of the Interview**

Two psychological hazards to meaningful interviewing are latent in the situation. One is a tendency on the part of the professional staff and the general public to see the addict as a "deviant." The addict can seize on this perception as an excuse for not taking responsibility for himself as other people are expected to do for themselves; classed as outside the normal human pale, the addict can justify his own failure as the true consequence of his "peculiarity." Yet, arrival at a point of wanting treatment implies wanting the normal human condition, the non-deviant status among those who are human like everybody else. It is this drive on the part of the addict-wanting-treatment that underlies the prospect of his educational efforts succeeding for him. The educator's approach in the interview needs to be based on the assumption that the client wants
to help himself.

The second hazard in the situation, related to the first, is the tendency on the part of the professional clinical staff to see the clients as persons who have to be outsmarted and out manipulated, since the "deviancy" of the clients seems to lie in their already highly developed capacity to outsmart and out manipulate those who are not in their intimate drug-associated family. To be outsmarted is to have one's professional competency undermined. To work day after day in an environment which presents such threats is strenuous and eroding. A defensive stance and competitive attitude tends to develop between clients and clinicians which subtly, if not obviously, seeps through the psychological climate.

Such a climate is unfavorable to what the educator needs to have and do. An educational program for addicts cannot work where the students do not work for themselves. The educator's interview needs to be done on grounds where it is clear to all that there is no advantage to be gained by anyone outsmarting anyone else. Self-perceptions of a client are to be taken for what they are represented by him to be; if later these perceptions prove to have been misleading, they can be discarded for those that prove to be more dependable. This is the normal line for learning, familiar to educators as the accepted and necessary pathway to growth for the learning person.

The educator's interview is, therefore, structured to focus on the learnings which the addict accepts and expresses as his own. The client is addressed as one who can teach the educator what the client knows, thus making it clear from the beginning that the basis
for educational activity is to be to learn for one's self.

In his interviewing of Uhuru clients, the author sought understanding of who the client is, how he feels, and why he feels the way he does. Experience in preliminary experimentation with styles of interviewing soon taught that such information was more readily gotten by indirect questioning than by direct questioning. For example, an indirect question like, "what is the health of an addict like?" would lead to a ready response, while a direct question like, "what was your health condition while you were an active drug addict?" would lead to a limited reply. The indirect format let the client both state his knowledge and do it with feeling. It provided some cover of ambiguity under which he could protect himself from judgments of himself which were still too hard to bear or from making a personal revelation which he felt he could not trust to someone he had not yet sufficiently tested. The indirect style was, therefore, used.

Although the interviewer held in mind a pattern of questions he wanted to ask of each client, the questions actually used in specific cases varied in content, depending primarily on where the client seemed most free to express himself in his portrayal of the world he knew. Often the direction and limit of a dialogue appeared to be a function of the socio-economic and/or racial background of the interviewee. In the sampling of cases presented below, variation according to background will become apparent.

Though each of the four cases has its own dialogue pattern, it yet catches content which is generally suggestive of other cases. The four cases can, therefore, be taken as supplying somewhat
generalizable content for the population of the local agency. However, the main aim is not to test content; it is, rather, to test and show a structure and style for an educator's interview, taken as process. At this stage in educational development, the author is primarily interested in testing an interview method for himself and for possible suggestion to others who might want to make their own trials under similar conditions.

Anonymity has been preserved by concealing the real names and addresses; the language has been edited from the tapes to add further protection of identity and to convert oral expression into a form closer to the demands of clarity-in-writing where such seemed necessary to have readable meaning.

Interview Reports

Case No. 1

Miss W arrived at the author's office on invitation at 2:00 p.m. Miss W comes from a middle-class Black family. She has two brothers (26 years and 21 years old) and a sister (23 years old). Miss W is 30 years old (1974). She has a father who was once a bellman, now retired, and a mother who is a housewife. The parents are still living together. Although Miss W claims to come from a middle-class family, her parents are living in a "run-down" neighborhood, inhabited mostly be lower-class Blacks. The last occupa-

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2This position is taken in compliance with the Federal regulation which requires confidentiality in all Federally drug funded programs.
tion of Miss W's father was that of bellman, which would hardly qualify his income as middle-class. Miss W, herself, has a high school diploma and has taken crash courses on typing and secretarial duties. She speaks fluently and types at an average speed. Miss W started taking drugs (marijuana, later acid--LSD) at the age of 23 because of insecurity. Miss W has been communicating only with her mother. After briefing Miss W on the purpose and nature of the interview, she became excited and eager to talk with the author.

Author: Miss W, what is a typical addict and a drug abuser to you?

Miss W: My answer will, of course, be different from others, but based upon my experience, an addict is one who depends on some drugs to solve his problems. These drugs may be obtained either illegally or legally from the hospital through a person who works in the hospital. A drug abuser is one who indiscriminately uses drugs so long as there are drugs and he can fulfill his needs.

Author: Is an addict generally immature and irresponsible?

Miss W: No, an addict is like any normal person with some few exceptions. He uses drugs like any other member of the "normal" society to solve his problems which may be lack of employment, lack of love, lack of status, etc. He may appear to be irresponsible because of the use of his money to obtain a "fix" (a "fix" is a street term for the dose that is needed by the addict to relieve his problem). He may use the money that is meant for the family to purchase drugs with an intention of replacing the money. This money may or may not ever be replaced. In fact, it is rarely replaced. When this sort of spending continues, the addict's family may find itself in a serious financial situation.
Author: What do you mean when you say the addict uses drugs to solve his problems which may be unemployment, etc.?

Miss W: I mean he uses the drugs to cope with the frustration of "not having a job."

Author: Do you call that an escape?

Miss W: No, "escaping" implies the addict's refusal to look for a job--which is never the case. Coping means he is using drugs to manage the painful feeling of not obtaining a job after he made many attempts to find one.

Author: Why doesn't he find the job?

Miss W: For various reasons, such as lack of skills, lack of proper education, discrimination, some past criminal record, not finding the kind of job whose pay can be adequate to fit/buy his needs, etc.

Author: Can an addict quit his dependence on drugs?

Miss W: He may; but quitting drugs is a decision that must be made by the addict himself; no treatment or individual can make him quit if he is not determined to do so. But good programs that meet the needs and concerns of the addict can actually help. But so long as the habit is willfully maintained, the addict will commit crimes, such as stealing, cashing forged checks, boosting, etc., to obtain money for his fix.

Author: Going back to my question--is the addict irresponsible and immature?

Miss W: No, he is clever for the most part. In fact, he is cleverer than most "normal" people, and delights himself in beating off the so-called intelligent person. How can he be immature and stupid--when he excels in falsely cashing checks in banks and in obtaining money from the more educated in the streets by means of tricks? He knows the psychology of the mind and the best conditions to win his game. The pusher-shooter (the man who sells and uses drugs at the same time) knows how to sample out and calculate his dosage in order to maintain his customers. Isn't this a skill of
mathematics? An addict is familiar with laws and regulations and the technicality that can free him for the most part.

Author: If the addict is so good in his game, why is he ever busted (arrested)?

Miss W: That's the trick, no condition is permanent; a little mistake can bring him before the law but every mistake adds to his wealth of experience and to the improvement of his strategy.

Author: What is the health condition of an addict like?

Miss W: Again, experience differs, but, generally, an addict is so busy thinking about means to obtain money for his fix that he doesn't worry about his health and other responsibilities. This neglect is not because of ignorance, but because his priority is on drugs. You see, a quarter of heroin costs about $25 for a fix, and if an addict needs five fixes a day, he must think of a way to obtain roughly $125 to $200 to maintain himself for a day. Multiplying this for a week, it takes quite a lot to keep going for a week.

Author: What makes an addict eventually decide to quit his habit?

Miss W: The life of an addict is a hopeless life after all, he gains nothing but publicity and low esteem. He lives constantly in fear; if he is married, his family loses and his children suffer. The loss of family is very painful to a Black addict and this might force him to consider quitting.

Author: Can an addict be actually "cured?"

Miss W: Yes, he can. People who are incarcerated (imprisoned) for, say, seven years have lived behind the prison walls without drugs and the desire for drugs. But once out, they have immediately gone back to their habits because of the existence of the initial problems to which they return. Many have completely abandoned their habits because their initial problems have improved and their will
is strong enough to resist the habit. However, the desire is always there. I have not been on drugs since I joined the program for about four months now, but the desire is still there. Once the problems are removed and the addict has alternative positive endeavors to occupy his mind, the chances for his recovery are great.

Author: How can the desire be eliminated?

Miss W: (Pausing for about three minutes) With time and by avoiding association with former drug addict companions, and by having some worthwhile activity to occupy the mind.

Author: What is the world of an addict like?

Miss W: The world of an addict is one where members are very supportive of each other. Members show concern and protection for all--these concerns and protection are generally lacking in the "square" society.

Author: Can the addict adjust to the square society once he quits his habit?

Miss W: It depends on the addict. Some addicts inherit the drug world; they are born into it by parents who are themselves addicts. This kind of person knows only of the conditions of the drug world; he has no way of knowing and understanding the life and condition of the so-called "square" society. For such individuals, adjustment is painful, time consuming and perhaps impossible. To them, the square society is strange and abnormal. Education will be highly beneficial to this group. But for those who come from the square society, their adjustment is less painful and gradual, but once the adjustment is made, recovery can be complete.

Author: Is education (in a drug treatment center) needed for the individual who was a member of the square society prior to his having joined the drug world?

Miss W: Education is needed by everyone who is an addict. Unfortunately, the addict's education is always conceived in terms of going
to complete high school and going to college. The addict's educational needs are more than getting into high school and colleges. "Do I make sense?"

Author: Thank you, Miss W, for your time and knowledge which I promise to pass on to others.

Miss W: Thank you for the opportunity you gave me.

Case No. 2

Mr. X came to the author's office at 2:15 p.m. on an invitation. The purpose of the interview, as usual, was explained and confidence enhanced. Mr. X is 18 years old, he is White, from a lower-class family. Mr. X has three brothers (ages 15, 13, and 11) and a sister (17 years old). None of his brothers or sister are on drugs. Mr. X has a tenth grade education and was brought up by his parents until the age of 13. From then on, he was reared by his mother who was then separated from her husband. Since 13, Mr. X has been a run-away child and has rebelled against parental authority. Insecure feelings had developed because of his mother's separation from his father—a separation which later ended in divorce.

Mr. X started his drug experience by sniffing gasoline and glue, later getting hooked on acid (window panes and mescaline—his definition of acid).

Author: Mr. X, what, to you, is an addict?

Mr. X: An addict can be classified into two groups: the psychological and the physical addicts. The former is not physically addicted but feels the need to have drugs. The latter gets sick if he stops from using drugs; both cannot face reality and must turn to drugs as a crutch.
Author: How does the drug help him face reality?

Mr. X: By making him feel great (like he is somebody); by calming down his anxieties and fear of failure and a sense of rejection, etc.

Author: Does that make an addict appear irresponsible?

Mr. X: Yes, because he has got the brain to understand what is happening, but is unable to devise positive approaches to deal with his problems.

Author: Why can't he use his brain?

Mr. X: "Ah, you've got me there;" I guess it's because he has not learned how to use it.

Author: If I may use you, Mr. X, as an example, do you mean you did not learn how to use your brain?

Mr. X: Yes, the American society is not based on reality. People expect you "to do your own thing," to learn by mistake and the hard way. I was not taught what the world is and how to confront the world. I was left alone and drug taking is a way of learning. Only society makes a fuss about the addict when, in fact, they had caused the situation by not preparing the individual for the crises ahead.

Author: If you had been taught by your parents, would you have been prepared to listen to them and accept their values?

Mr. X: I don't know; the society seems to be against that. Parental values are not regarded as sound, but they are, and it takes a lifetime to realize that. The structure must be changed. Education should change it.

Author: Why do people take drugs?

Mr. X: For various reasons, such as the complexity of the system, loneliness, boredom, lack of satisfying jobs, etc.
Author: Is the drug culture able to meet the reasons you just cited?

Mr. X: To some extent, members share the problems of each other; they offer support, you are not alone; you share your trip (experience of a visit to the world of fantasy). New experiences are discussed, protection and love are given and received.

Author: Is the drug sub-culture a healthy society?

Mr. X: Health usually declines. An addict does not care about his clothes or where he sleeps. He may not shave. His meals are irregular; he loses weight and appetite. Money that could be spent for food is spent on drugs. Generally, his mental capacity and awareness ability declines; he is always "care free."

Author: How does the addict see the larger society?

Mr. X: He is resentful of the larger society for not caring for those on drugs, for not legalizing drug use, the sale and possession of drugs. It is the larger society that causes addiction in the first place. The larger society is square in the sense that they talk against drugs, but are unwilling to do something about it.

Author: Can addicts quit drugs?

Mr. X: Yes, quitting it makes you see the beauty that was not obvious under the influence of drugs, even the beauty of sunshine begins to take a form different from what it used to be.

Author: What makes an addict eventually quit drugs?

Mr. X: As most addicts mature, they are better able to define their goals and better able to check their gains against losses. For the most part, the losses outweigh the profits. At some point in time, an addict becomes bored of his habits, is tired of being looked down on or being busted. An addict never makes it anyway; his progress is always on the decline. An addict's future has nothing to offer; an addict's drug taking is always a
block to his progress. Sooner or later all addicts realize that the best way is to start a family, be able to handle their problems without drugs and be able to think straight, etc. All these reasons make an addict finally decide to quit drugs.

Author: How can an addict be helped?

Mr. X: By making him feel needed, wanted and important. He should be helped in defining his goals and in realistically reaching those goals. His problems should be understood and he should be sincerely helped and encouraged in solving his problems.

Author: Who should be the best source of help to the addict?

Mr. X: An ex-addict is the best source. An addict is willing to listen to someone who has passed through his experiences; an addict does not trust the professional who only talks but does not understand what the addict is going through.

Author: Since the addict does not trust the professional, does that mean the professional should not be used in drug treatment institutions?

Mr. X: No, they (professionals) have got the knowledge for the most part. They are trained, and training is good, but they can reach the addicts more effectively by working with the ex-addicts. The ex-addicts know the language of the streets, they understand the specious appearances of most addicts (front appearances), they understand the rationalization techniques of most addicts--all of which may not be understood by the non-addict professionals.

Author: What do you think of education in an addict's rehabilitation process?

Mr. X: Education is the biggest part of rehabilitation. Education should teach ways of handling problems, teach how to handle money and how to use idle time.
Author: Thank you, Mr. X, for being a part of this interview. Your responses have been very educational. Once more, thank you.

Mr. X: It is a pleasure being here.

Case No. 3

Case No. 3 is a Black male addict, 21 years old, from a lower-class family. He has four brothers (ages 24, 19, 17 and 16) and a sister (30 years old). His mother is deceased. Father has now been retired from maintenance duty. Case No. 3, Mr. Y, went as far as the eleventh grade and started taking drugs at the age of 15 because of his residence in a neighborhood largely inhabited by addicts.

Author: What is an addict?

Mr. Y: An addict is a normal person like anyone else, but once he gets hooked on drugs, he cares about nothing.

Author: Why does he get hooked on drugs while others do not?

Mr. Y: It depends on the individual. People get what is available. An addict gets what is available and without labor, in the sense that he does not have to wait in line in the doctor's office for a prescription. Besides, many other people get hooked on drugs prescribed by the doctors, but since they have a steady supply and the money to buy their fix, they don't get busted and people don't read about them. An addict is just unfortunate.

Author: Do addicted drugs actually help people forget about their problems?

Mr. Y: Actually they only help people to cope; the problems are always there; under the influence of drugs, the problems might be forgotten, but they are always there.
Author: Are addicts clever and stable emotionally?

Mr. Y: Any individual who obtains illegally from $50 to $200 a day in stealing to survive without being caught ought to be clever. Many addicts do this several times until they are busted. As for emotion, I don't know if the addict is different from any other person emotionally. Reacting and showing resentment over frustrations is not a sign of an unstable emotion. A change has to be made and heroes have to initiate the changes. Addicts are heroes and they are beginning a process of change by going contrary to what people expect. When people understand the reasons for taking drugs, they will change what is wrong. Right now, society does not want to listen and addicts will continue to multiply.

Author: Tell me what the drug sub-culture is like?

Mr. Y: It is a place where things happen; people buy and sell drugs, people cheat and get killed. It is the addict's second home if he has got one in the first place. It is a place where addicts, prostitutes--you name it--hang out.

Author: It sounds like a hell to me, and if I am correct--why are people there--in hell?

Mr. Y: Hell--yes. But hell is hell for people who refuse to conform (laugh). But suffering has a way of uniting those who are suffering. Addicts show love and concern. I cannot describe it in words, you've got to be there to experience it. I guess the advantages outweigh the disadvantages.

Author: What are the health and eating habits of an addict like?

Mr. Y: The average addict does not eat much; he may lose his eating and sexual appetites. All the addicts eat are hot dogs, potato chips, hamburgers and these are eaten in a haste since the addict is always "on the run." As for health, this is generally poor. Look man, an addict has no time to worry about his health, food or shelter;
he is only concerned about getting money to buy drugs.

Author: How responsible is an addict?

Mr. Y: He is responsible to himself; as for any other responsibilities, an addict is not concerned. Take my case, for example, there were times when my baby needed milk and I had to withhold the money in order to buy my dope. Money making is easy with most addicts, but the money goes for dope first.

Author: What makes an addict quit drugs eventually?

Mr. Y: The thought of jail; the painful memory of making money but being left with nothing; the frustration of staying out most of the time, the guilt feeling for family neglect, etc.

Author: Suggest ways by which an addict may be helped.

Mr. Y: By counseling, by being encouraged and understood. By giving him training to develop his skills. By discussing the problems of the addicts, the nature of the society, the past experiences of addicts and ways for defining an alternative better future.

Author: Thank you, Mr. Y, for your time and rich experiences which you have been kind to share with me.

Mr. Y: Thank you for inviting me. I feel good to know that my inputs will be welcomed.

Case No. 4

Case Number 4 is a White middle-class fellow, 21 years old. He has two brothers (ages 19 and 13)—neither of whom is on drugs, although the youngest is reported to have a drug-prone tendency. Parents are living together. Father is a supervisor at X industry and mother is a teaching assistant at Y school. Case Number 4 is
married, his wife works at W Insurance Company. Case No.4 is a junior in college, majoring in one of the allied medical sciences. He has been using drugs for one year "because of the difficult transition from a bachelor to a married man and of having to work while in school to support his family." In making this transition and adjustment, his marriage was becoming strained. He copes with his domestic problems through a steady intramuscular administration of drugs which are accessible to him.

Being a student in a health related field, he was able to understand the danger of drugs; he sought help voluntarily. Behavioral changes in him were also detected by his friends and relatives who became concerned as to what was happening to him. Later, an overdose brought him to a hospital where his illness was incorrectly diagnosed. He later confessed the reality of his illness to both his wife and parents who encouraged his seeking help. He came to Uhuru as a result. He was not heavily addicted, had not much association with the drug culture, and knew very little about the experiences of other addicts.

Interview with Case No. 4 was brief, partly because of his lack of experience and partly because his responses were generally those he gained from reading and not by actual experience.

Author: What really made you decide to seek help?

Mr. Z: The overdose I took; the decline in my health, the deterioration of my marriage, the painful withdrawal symptoms.

Author: What else can you say that can be helpful to others?
Mr. Z: The life of addiction is miserable. A community-based program like Uhuru would be highly beneficial to most addicts. Although the mental stress of therapy is hard to bear, the disciplinary aspect and the encounter group experiences are significantly helpful.

Author: Have you any experience with the methadone maintenance program, and if you do, isn't that helpful too?

Mr. Z: From what I have heard, it is only substituting another drug for the one the addict has been taking. It is, in my opinion, palliative, not curative. Besides, it does not seem to deal with the root problems.

Author: Thank you for sharing your experiences with me.

Mr. Z: I am glad to share the little I have. If I remember something else, I will be delighted to call you up.

Observations

From these interview reports, taken as illustrations of what happened in the author's experience with the interview, it may be possible to suggest what such interviewing offers the educational developer. The following are some of the main learnings derived, first concerning the process of interviewing, and second, concerning the content.

Concerning the process of interviewing, the following are derived guidelines to purpose, audience, style and structure:

1. The underlying aim is to open up an avenue to honest and direct communication between the educator and the client.

2. There is little correlation between level of formal schooling and level of learning of the
drug addict when the subject of interest is drug-related matters; clients of little formal schooling may be sophisticated and advanced in the education they have received in the drug subculture.

3. The derivation of information about the background from which the client has come is helpful in sensing what the client may feel most free to talk about.

4. Clients are more likely to be able to talk freely about drug-related matters when the questions are indirect rather than direct, i.e., when the questions focus on these matters as general conditions in the external setting, rather than on these matters as specific to the person of the interviewee. As evidenced in the fourth interview, conversation tends to stop short when the focus is directly on the person of the client.

5. While the interview is styled indirectly, the course of the interview is to be determined by what the client responds to "directly," i.e., by what he responds to with sensitivity and feeling. It is the expressed feeling that cues the interviewer to what has direct meaning in the personal life of the client. The interview should be free to follow that line since, ultimately, the educator and the client will need to know and accept the personal ground on which a course of self-owned education can proceed for the client.

6. The interviewer needs to take the initiative in asking the questions to be pursued in the interview. In that way, he can most readily "show his hand" as to what he's about; the client needs that knowledge in order to feel comfortable in responding. Later, after initial interviewing, the time should come when the client can initiate questions to be asked of the educator, if he so wishes.

7. When the interviewer is an educator who is not himself a past or present addict, the best ground for structuring questions is the ground of the educator's own evident lack of knowledge. The educator asks questions because he needs to know; he accepts the client as his teacher. Communication can then be both personally sincere and professionally functional in exemplifying the pursuit of learning; the
educator is a clear and honest model for what he would have education be for the client, i.e., a means of self-teaching and self-development.

Concerning the content derived from the interviews, the following statements are offered as illustration of what the author was gleaning from his interviewing experience concerning the clients and the world in which they see themselves to be living. As is appropriate to an early stage of learning, these statements are presented as the author's initiating hypotheses to be tested by further inquiry and experience; they are not offered as conclusions presumed to have been tested.

As of the time of writing, the author hypothesizes:

1. That addicts are individuals who resort to drugs as a means of coping with their personal problems.

2. That addicts won't be able to get control of their habit except by simultaneously finding ways of dealing with their personal problems.

3. That an educational program that works will necessarily be diversified to meet the personal problem needs of the different persons involved; the drug habit may be common to all, but the cause for becoming habituated has its own pattern in each case.

4. That an educational program that works will have to have means of knowing specifically, in each case, what is working and what is not; the sensitivity of that check-out is likely to determine much of the success or failure of the program.

5. That addicts who have reached a stage of seeking help to overcome their habit are individuals who see themselves as "normal human beings," not different from other humans who also have problems to face; the pattern of problems in each specific case may be different, but the struggle to overcome problems is common to all people, a part of the normal "human condition."
6. That agency programs can aid the addict in deciding to quit drugs, but that the critical decision to do so lies entirely with the addict.

7. That crimes committed by the addict are means by which he can sustain his habit, and that programs for dealing with addicts as criminals will not work, apart from successful treatment of drug addiction.

8. That the maturity level of the addict is a crucial factor in the breaking of the addiction cycle.

9. That this maturity level is reached when the addict perceives the drug sub-culture and habit as offering an unsatisfying way of life.

10. That the addict is resentful of the larger society, a society he calls "square," and that an educator who's seen as "square" and not as personally oriented to the human dimension of life for everyone will be resented, too.

11. That the drug sub-culture offers a "whole way of life" (personal, social, economic), the attraction of which can be met only by another culture which is also a "whole way of life" and more attractive.

12. That an educational program which works will have to be a part of that new "whole way of life."

13. That there is a group of addicts who have never experienced an alternative existence outside the drug sub-culture; helping them offers a special problem.

14. That a low priority is given in the drug sub-culture to health, making health an important area in rehabilitative programs.

15. That the drug sub-culture gets much of its drawing power from its ability to provide a "family" to many who have not otherwise had a stable and full feeling of family in their existence; that while the educational program is sensitively focused on supporting the strength of each individual in his coping with his personal problems, it needs also to provide groups within which the individual can be supported in a "family" way.
Summary

In the experience of the author, an educator who is assigned a role as a developer of a program of education for clients in a drug abuse treatment center can benefit substantially from personal interviews with clients of the agency who may be participants in an educational program. The author foresees that, for him, individual interviews will be essential, not only at the beginning of contact with clients (as in the present case), but later on as an educational program gets under way and operates. A successful educational program for these clients cannot succeed apart from personal connection between the persons responsible for guiding the development of the educational program and those who are to benefit from its operation.

In the initiating interview, the process of interviewing appears to benefit from an aim toward honest and direct communication at whatever level is then possible; a role on the part of the educator of one who has a lot to learn from the clients, no matter the level of the client's formal schooling; the use of questions indirectly phrased rather than directly phrased; a willingness on the part of the educator to take the initiative in the interviewing process; and a willingness, as well, for the educator to change the pattern of his interview in order to respond to the feeling and background of the individual client.

In the initiating interview, what can come out as valuable content is a rich range of hypotheses to guide further inquiry and experience concerning such items as the motivation for drug addiction,
individual differences in motivation, commonality of assumption and concern, critical individual needs, critical common needs, level of individual maturity, impact of the drug sub-culture, residual attitude toward society and "education," and cues to what might work and not work in an educational program for the persons interviewed.

In the following chapter, attention is given to the use of a personal problem checklist to give further perspective to the place of personal concerns in an educational program for clients of a drug treatment center.
Interviewing is a valuable procedure, but not the only procedure for getting data on the concerns of individuals. Survey by means of a personal problem checklist offers a way to relatively quickly get data from groups of individuals, showing both their individual patterns of concern and, cumulatively, tabulations showing what areas of problems are of most frequent concern to individuals in those groups. For the educator who is developing a program for given clients, the group data from such surveys offers cues to educational materials and methods most likely to be responded to with personal involvement by those then present.

The survey instrument chosen for use by the author was Gordon and Mooney's Adult Problem Check List. It was selected because it contains areas of personal problems judged by Uhuru counselors to be representative of major areas of common concern among clients of Uhuru: e.g., health (H), economic security (ES), self-improvement (SI), personality (P), home and family (HF), religion (R), and occupation (O). Items in the Check List are phrased for personal

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reference, e.g., "4. Gradually losing weight," "55. Needing a job," "84. Not really having a home." The respondent, on reading the Check List, first underlines the items that are of concern to him; then, on reviewing the items he has underlined, he circles the numbers in front of the items of most concern to him.

Items marked by the individual are easily visible in a three-page fold-out of six columns of forty-eight items per column. Items in the columns are presented in groups of six for each area, eight groups to a column (288 items in all). This makes for ease in counting marked items by area (going across columns), while also distributing response over the areas as the respondent reads and marks. The Check List is thus conveniently made for use with individual cases or for scoring by areas of problems and for collating results for groups of clients.

Procedure

Because it was assumed that problems might change under the impact of treatment, two groups of clients were chosen for the survey: the first, a pre-treatment group, made up of individuals who had been in treatment for no more than one to three days, and an in-treatment group, who had been in treatment for thirty days or more. General experience had indicated that behavioral changes begin to appear in about thirty days.

The base population was composed of clients, male or female, eighteen to forty years of age, from Uhuru and the Alum Creek
Therapeutic Community of Columbus, Ohio. The two communities were assumed to be homogeneous, since they were similar in addicts' characteristics, in treatment philosophies, and in the geographical location from which their clients were drawn.

The selection from the base population was random within the two treatment levels--the number of cases selected for the pre-treatment survey group being forty and the number of cases selected for the in-treatment survey group being forty.

A special cover sheet was prepared for the checklist, eliminating the need for a name and asking for information on years of addiction, days of treatment, and whether or not treatment had been previously undertaken in any other drug treatment center. While the added items of information were not needed for the research reported here, they were requested for use in later follow-up.

During the administration of the checklist, the author explained the purpose of the project, assured the respondents of anonymity, and reviewed the instructions to be followed in marking the checklist. Sufficient time was given to complete the list, with breaks when necessary in individual cases. The author or his assistant (an ex-addict who was not part of the study) was present throughout the response period in order to protect privacy and individuality in the marking process.

After the checklists were marked, each was scored in two ways: (a) by counting the number of items circled, and (b) by counting the number of items underlined (including those also circled) in each of the problem areas, the resulting figures being posted to
the appropriate spaces on each checklist. The problem area scores for the pre-treatment group of cases (Group A) were then summed and means were computed. The same procedure was followed for the in-treatment group of cases (Group B).

Table 8 presents the data for items circled (i.e., of most concern); Table 9 repeats the data from Table 8 on area means and arranges the listing of areas in rank order. Tables 10 and 11 follow the same pattern as Table 8 and 9, but employ the data for items underlined (i.e., of some concern). Table 12 compares the rank order as between items circled and items underlined in each of the two client groups.

To compare rank orders statistically, the Spearman Rho correlation \( r_s = 1 - 6 \frac{\sum D^2}{N(N^2 - 1)} \) was used to show the linear relation of the rank ordering of areas, as between any two rank orderings being compared. In addition, the Index of Forecasting Efficiency (100% \( \sqrt{1-p^2} \)) of each derived Rho was determined in order to know how much of the given correlation could be attributed to relationships beyond chance. These figures are appended to the tables comparing rank orders.

Findings

From the foregoing tables, the following observations may be made:

1. That clients are willing to respond to the Adult Problem Check List under the conditions given: Group A underlined an average of 75 items as of some concern (Table 10) and circled 50 of those as of most concern (Table 8); Group B underlined an average of 57 items as of some concern (Table...
### TABLE 8

**PROBLEM AREAS:**

RAW AND MEAN SCORES OF ITEMS MARKED AS OF MOST CONCERN

<table>
<thead>
<tr>
<th>PROBLEM AREAS</th>
<th>GROUP A, N=40 (Pre-Treatment)</th>
<th>GROUP B, N=40 (In-Treatment)</th>
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<tr>
<td></td>
<td>Score</td>
<td>Mean</td>
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<tr>
<td>Health</td>
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**TABLE 9**

PROBLEM AREAS RANKED ACCORDING TO MEANS OF ITEMS MARKED AS OF MOST CONCERN

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<td>Rank</td>
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<td>0</td>
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Comparing Rank

Spearman Rho .917

Index of Forecasting Efficiency 60%
TABLE 10

PROBLEM AREAS:
RAW AND MEAN SCORES OF ITEMS
MARKED AS OF SOME CONCERN*

<table>
<thead>
<tr>
<th>PROBLEM AREAS</th>
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<th>GROUP B, N=40 (In-Treatment)</th>
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*Includes items circled as of most concern.
TABLE 11
PROBLEM AREAS RANKED ACCORDING TO MEANS OF ITEMS MARKED AS OF SOME CONCERN

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<thead>
<tr>
<th></th>
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<td>Rank</td>
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<td></td>
<td>Spearman Rho</td>
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<td>Index of Forecasting Efficiency</td>
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</tbody>
</table>

*Includes items circled as of most concern.
TABLE 12

COMPARISON OF RANKS OF PROBLEM AREAS BY LEVELS OF CONCERN AND BY CLIENT GROUPS

<table>
<thead>
<tr>
<th></th>
<th>GROUP A</th>
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<th>GROUP B</th>
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<td>Rank By Items</td>
<td></td>
</tr>
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<td>Underlined</td>
<td>Circled</td>
<td>Underlined</td>
</tr>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
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<td>Home &amp; Family</td>
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<td>Occupation</td>
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<td>Health</td>
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<td>Religion</td>
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<td>Courtship</td>
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<td>Spearman Rho</td>
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<td>Index of Forecasting Efficiency</td>
<td>96%</td>
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<td>100%</td>
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</table>
10) and circled 36 of those as of most concern (Table 8).

2. That being under treatment thirty days or more appears to reduce the number of personal problems with which the clients are concerned; the level of items underlined and of items circled drops by about one-fourth, as between Group A and Group B (see point above).

3. That areas of problems appear to maintain about the same rank order:

(a) whether the clients are just entering the program (Group A) or have been in the program thirty days or more (Group B), (Tables 9 and 11).

(b) whether the computation is done from the base of items circled as of most concern or from the base of items underlined as of some concern (Table 12).

4. That the four main areas that persistently place in the top ranks of 1, 2, 3 and 4 are problems of Personality, Economic Security, Self-Improvement, and Home and Family (Table 12).

5. That problems in the field of Health tend to come next at the rank of fifth (Table 12).

6. That problems in the area of Courtship tend to move up in rank after treatment has gotten under way; ranking eighth in Group A, the area comes to rank sixth in Group B (Table 12).

7. That problems in each of the areas of Occupation and Religion tend to move down in rank after treatment has gotten under way; ranking fifth in problems circled in Group A, Occupations moves to seventh in problems circled in Group B; ranking seventh in problems circled in Group A, Religion moves to eighth in problems circled in Group B (Table 9).

8. That problems in the area of Sex are consistently ranked at the bottom, i.e., ninth out of nine areas, whether in Group A or Group B, and whether circled or underlined (Table 12).
Implications

From the foregoing findings, the following would appear to be hypotheses worth using as guidelines to further action and testing:

1. That a personal problem checklist is usable by and for clients of a therapeutic drug treatment center; clients will respond under conditions where an educator needs the data to guide the development of an educational program which has personal relevance and meaning for the clients.

2. That changes in personal problems occur as treatment progresses, and that a personal problem checklist can offer cues to the changes.

3. That the main change is to reduce the number of problems, overall, while the rank order of areas of concern remain much the same.

4. That, for the client population sampled, an educational program focused on content and methods fitting to each of the areas of Personality, Economic Security, Self-Improvement, Home and Family, and Health would apparently reach the personal concerns, and maximize the chances of personal involvement, of many of the clients.

5. That for the two areas of Occupations and Religion, activities for this clientele would be more appropriately timed for clients on entry to treatment than later, and that, for the area of Courtship, activities for this clientele would be more appropriately timed later.

6. That problems in the area of Sex are either inappropriately phrased in the checklist to catch concerns in this area, or that the area is not significantly problematic for these clients.

Additional Hypotheses

Beyond the findings and interpretations which are suggested by the quantitative data of the survey, there are additional hypotheses derived from the experience of using a personal problem
checklist; these have to do with activities and policies in the development of an educational program which is intentionally related to the self-expressed and self-owned problems of the clients.

1. The making of a group survey is just one of the uses to which a personal problem checklist can advantageously be put.

2. The problem checklist is case-specific as well as group-specific; it may provide data of self-owned relevance to the individual clients as well as data of relevance to a specific group of which the client is a member.

3. It is, therefore, possible to use the problem checklist results to initiate educational programs for individuals as well as to initiate educational programs for a group in which the individual is a counted participant; individual efforts can be integrated with group effort such that the work of each can support the other.

4. The fact that the problem checklist results are individual makes the results relevant to clinical activity as well as educational activity; such data invite and encourage integration of the clinical and educational components of the total program of the agency. Since, historically, the tendency has been to separate the two programs without clear ways by which each supports the development of the other, this is a valuable asset in efforts to integrate this program of the agency.

5. Although problem checklist data could be so obtained as to be mutually available and mutually used by clinicians and educators, it is necessary that the educator make his own response to the client in relation to problem checklist administration and follow-up, since it is important that the client personally know that the educator intends educational activity to be personally relevant to the client. This kind of education is not likely to have been previously experienced by the client; he is likely to assume that "education" refers to a traditional schoolroom setting where activity is focused on the student's acquiring a
given academic or vocational skill—not on the solution of problems important in the lives of individual students.

6. Participation by a client in marking a checklist in response to an educator's invitation indicates at least a tentative willingness on the client's part to take some responsibility in his educational program. He should respond to the next step in the program if the program is designed to be relevant to what he has first expressed as of concern to him.

7. When, in response to an educator's invitation, a client marks a problem checklist, he is already making an educational response; he is taking responsibility for recognizing and expressing them in a way inviting his further work with them and on them; he is systematically reviewing the subject matter of his own life problems; he is also inviting further communication with the educator.

8. Having in mind the initial interview of the educator with the client, as discussed in the previous chapter, the content of a client's problem checklist offers good material for a second (or later) interview where the intent is to move client and educator into educational programs which have recognized personal value for the client. The 288 items in the checklist can be thought of as 288 questions asked by the interviewer, and the markings by the client can be thought of as his response to those questions. The checklist can significantly reduce the time needed to get a ground established for development of relevant individual and group programs.

9. Small groups are sometimes better than large groups or individual programs alone for dealing with certain kinds of problems. A problem checklist offers a convenient way of identifying clusters of clients (within a larger group) who might be congenial and ready for mutual sharing in a small group setting. These clusters can be identified by specific items marked or by areas of problems having high priority or heavy marking by given individuals.

10. A problem checklist, when used on two (or more) different individuals or groups, or the same
individual or group at two (or more) different times, can show, in their comparative results, cues to appropriate programs in the problems that are common and in the problems that are different. Commonness and difference may be reflected:

(a) in the number of problems marked.

(b) in the level of intensity of concern (circled and underlined).

(c) in the kind of problem considered of concern (by problem area).

(d) in specific items marked.

11. When a problem checklist is used before and again during or after a given course of treatment, the comparative results offer cues helpful in the evaluation of the program of treatment. The checklist becomes an evaluation instrument.

12. For the kind of educational program envisioned here, the use of the problem checklist as an evaluation instrument would be particularly appropriate, since the program is to be built from initial information on personal problems of concern to the clients and is to be developed as means of helping in the solution of those problems.

13. The contents of the problem checklist can be thought to represent the problem side of "the curriculum of life," or of "the curriculum of the experiencing of life;" it suggests that what is working to educate the addict is the full array of what he is exposed to and undergoes. What the author aims for, as educator in the work of an agency, is to engage those activities that recognize the main and inevitable curriculum and then go on to strengthen problem-solving capacities of the clients so that the living can be more fulfilling.

14. Any given problem or area of problems exists in a context of related problems; the unraveling of one leads to others. For any given individual, the best entering place may lay in an item or area then recognized by the client as of major
importance, but, before long, the course of struggle and learning will have to deal with a total complex of problems, resources, conditions, activities, relations, programs, etc., in order to have a sound basis for development. The educator can expect such ramification and spreading to occur.

15. Most addicts are likely to have been misguided and defeated so often in their previous trials at solution of their personal problems that they are generally skeptical of any new efforts which are not concretely specific in direction of solution and in evidence of progress made when such progress does, in fact, occur.

The following section delineates a way of taking a next step with clients such that they can concretely realize a direction in which to give their effort and measure their progress.
CHAPTER V

SUGGESTED STEPS IN FOLLOW-UP

Granted that ways are available through interview and the use of personal problem checklists to get data on the personal concerns of clients, the next needed step is to build from the initial expression of those problems toward their solution. Believing that each client needs his own self-owned way toward solution, and that groups of clients need to be able to support one another in their efforts toward solutions, the author sought from the literature those devices and procedures which appeared promising in carrying out these activities. In the work of Geoffrey Garwick,¹ the author found a promising way by which an educator could work with an individual client in mapping progress, by concrete steps, toward solution of his personal problems, and, in the work of Gerald Edwards,* he found group procedures which appeared particularly useful in creating group support for individual effort in overcoming addiction. In the following two sections, these procedures are illustrated or described.


*See Footnote on Page 104.
A Next Step in Work with Individual Clients

Assume a client has marked problems in each of the three areas of Personality, Economic Security, and Self-Improvement, and that the following are the items marked:

**Personality**

19. Lacking leadership ability
20. Lacking self confidence
68. Lacking ambition
115. Speaking or acting without thinking
264. Sometimes feeling forced to perform certain acts

**Economic Security**

7. Living in an undesirable location
11. Unfair landlord or landlady
55. Needing a job
57. Disliking financial dependence on others
59. Going into debt

**Self-Improvement**

13. Wanting to develop a hobby
16. Wanting to learn how to dance
17. Lacking skill in sports or games
61. Having a poor memory
205. Wanting more chance for self-expression

In interviewing with the client, assume that both the client and the educator see that progress in solution of these problems would make a substantial contribution to a better life for the client. Either during the interview sessions, or in the presence of a small group of clients having similar problems, the client and the educator work out a five level goal-attainment scale, beginning at the present level of the problem and scaling toward a level which would represent solution, illustrated as follows:
Area of Personality

19. Lacking leadership ability
   (a) Will not accept leadership in any task
   (b) Volunteers leadership of a group reluctantly and only when he is appointed
   (c) Volunteers leadership of a group four times a week
   (d) Volunteers leadership of a group readily and even without being asked
   (e) Volunteers and asks for leadership of groups

20. Lacking self confidence
   (a) Cannot complete a task without checking with someone else
   (b) Completes assigned task by checking with his supervisor four times a day
   (c) Completes a day assignment by checking with his supervisor only twice a day
   (d) Completes a day assignment by checking only once with his supervisor
   (e) Completes assigned tasks without checking with his supervisor

68. Lacking ambition
   (a) Cannot state a single goal he wants to pursue
   (b) Has been able to list one goal he wants to pursue
   (c) Has freely listed five different goals and has stated reasons for those listings (choices)
   (d) Is consistent with the listing on goals in the previous goal attainment level
   (e) Has well defined goals and goal-reaching strategies

115. Speaking or acting without thinking
   (a) Talks without considering the effects of what he says
   (b) Five out of seven times he speaks without consideration for the consequences of what he says
   (c) Three out of seven times he speaks without consideration for the consequences of what he says
   (d) One out of seven times he speaks without consideration for the consequences of what he says
   (e) He considers the consequences of what he says every time he speaks
264. Sometimes feeling forced to perform certain acts

(a) Cannot resist acting on peer pressure
(b) Seven out of ten times he acts on peer pressure
(c) Five out of ten times he acts on peer pressure
(d) Three out of ten times he acts on peer pressure
(e) One out of ten times he acts on peer pressure

Area of Economic Security

7. Living in an undesirable location

(a) Does not consider improving the condition of his apartment or moving into a better living facility
(b) Has considered improving the conditions of his living facility
(c) Has moved his residence to a better location
(d) Has bought new sets of furniture to replace the old worn outs he was using
(e) Keeps and maintains his apartment in a good looking condition

11. Unfair landlord or landlady

(a) Does not want to confront his landlord or landlady about his apartment repairs
(b) Has asked a co-tenant to talk to his landlord about the repairs of his apartment
(c) Has reported the unfair treatment of his landlord to the Housing Authority Department
(d) Has decided to find an alternative residential quarters
(e) Has finally moved to a different location as a solution to the problem of an unfair treatment by his landlord

55. Needing a job

(a) Does not locate a single job
(b) Has located one job after two months of search
(c) Has located three jobs and has decided to accept one
(d) Is keeping his job and is considering taking training to update his skills
(e) Is attending an in-service training program to update his professional skills
57. Disliking financial dependence on others
   (a) Calls his friends for financial assistance eight times a month
   (b) Calls his friends for financial assistance four times a month
   (c) Calls his friends for financial assistance two times a month
   (d) Calls his friends for financial assistance once a month
   (e) Does no longer call his friends for financial assistance

59. Going into debt
   (a) Pays one out of the seven debts he owes
   (b) Pays three out of seven debts he owes
   (c) Pays five out of seven debts he owes
   (d) Pays six out of seven debts he owes
   (e) Has now paid all his debts

Area of Self-Improvement

13. Wanting to develop a hobby
   (a) Has no hobby whatsoever
   (b) Has been able to identify one hobby of interest
   (c) Has started reading on the hobby of interest
   (d) Has begun practicing on photography as a hobby
   (e) Has begun practice on two different hobbies: photography and swimming

16. Wanting to learn how to dance
   (a) Cannot decide when to begin his dancing practice
   (b) Has talked with his clinician on taking dancing lessons
   (c) Has begun reading about various aspects of dance
   (d) Has enrolled in a dancing class
   (e) Has completed the first series of his dancing lessons

17. Lacking skills in sports or games
   (a) Cannot determine how to develop his interest in sports
   (b) Has talked with the physical development coordinator about his future participation in sports
(c) Has begun to participate in basketball and in tennis
(d) Has achieved an average grade in basketball performance
(e) Has an excellent record in basketball playing

61. Having a poor memory

(a) Cannot remember what he reads
(b) Has recalled two out of six concepts taught in his therapeutic class
(c) Has recalled four out of six concepts taught in his therapeutic class
(d) Has recalled five out of six concepts taught in his therapeutic class
(e) Has recalled all the therapeutic concepts presented in class

205. Wanting more chance for self-expression

(a) Is cold and withdrawn in group discussion
(b) Has been appointed to lead one out of seven weekly discussions
(c) Has been appointed to lead three out of seven weekly discussions
(d) Has requested his leadership to be increased to five out of seven
(e) Has now gained confidence both in leadership and in self-expression

Granted that problems are interrelated, an advantage is gained when each of the problem-solution evaluation scales is posted to a single sheet as shown on pages 98, 99 and 100. Used as a record and check-off sheet, this provides a ready way by which the client and educator can keep track of progress made and the levels of attainment yet to go. The sheet provides substantial content for further conferences between the client and educator (or content for group activity where other group members are similarly involved), constantly putting the emphasis on concrete steps.

The aim is to teach and to learn problem-solving when the problems are personal. It takes thinking, attention, systematic
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<tr>
<th>Scale Level</th>
<th>PROBLEM AREA</th>
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<tbody>
<tr>
<td></td>
<td>Personality</td>
</tr>
<tr>
<td>1</td>
<td>1. Will not accept leadership in any task.</td>
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<td></td>
<td>2. Cannot complete a task without checking with some one else.</td>
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<td></td>
<td>3. Cannot state a single goal he wants to pursue.</td>
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<td></td>
<td>4. Talks without considering the effects of what he says.</td>
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<td></td>
<td>5. Cannot resist acting on peer pressure.</td>
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<tr>
<td></td>
<td>1. Does not consider improving the conditions of his apartment or moving into a better living facility.</td>
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<td>2. Does not want to confront his landlord or landlady about his apartment repairs.</td>
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<td>3. Does not locate a single job.</td>
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<td></td>
<td>4. Calls his friends for financial assistance 8 times a month</td>
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<td></td>
<td>5. Pays 1 out of 7 debts he owes.</td>
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<tr>
<td>2</td>
<td>1. Volunteers group leadership reluctantly and only when he is appointed.</td>
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<td></td>
<td>2. Completes assigned task by checking with his supervisor 4 times a day.</td>
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<td></td>
<td>3. Has been able to list one goal he wants to pursue.</td>
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<td></td>
<td>4. 5 out of 7 times he does not consider the effects of what he says.</td>
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<td>5. 7 out 10 times he acts on peer pressure</td>
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<td>1. Has considered improving the conditions of his present apartment.</td>
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<td>2. Has asked a co-tenant to talk to his landlord about the repairs of his apartment.</td>
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<td>3. Has located one job after 2 months of search.</td>
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<td>4. Calls friends for financial assistance 4 times a month.</td>
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<tr>
<td></td>
<td>5. Pays 3 out of 7 debts he owes.</td>
</tr>
<tr>
<td>1</td>
<td>1. Has no hobby whatsoever.</td>
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<td></td>
<td>2. Cannot decide when to begin his dancing practice.</td>
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<tr>
<td></td>
<td>3. Cannot determine how to develop his interest in sports.</td>
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<tr>
<td></td>
<td>5. Is cold and withdrawn in group discussions.</td>
</tr>
<tr>
<td>2</td>
<td>1. Has identified one hobby of interest.</td>
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<td></td>
<td>2. Has talked with his clinician about taking dancing lesson.</td>
</tr>
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<td></td>
<td>3. Has talked with the physical development coordinator about his future participation in sports.</td>
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<td>4. Has recalled 2 out of 6 concepts taught in his therapeutic class.</td>
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<td>5. Has been appointed to lead 1 weekly discussion.</td>
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<tr>
<td>Scale Attain. Level</td>
<td>PROBLEM AREA</td>
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<tr>
<td></td>
<td>Personality</td>
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</table>
| 3                  | 1. Volunteers group leadership 4 times a week.  
|                    | 2. Completes assigned task by checking with his supervisor only twice a day.  
|                    | 3. Has freely listed 5 different goals, stating reasons for those listings (choices).  
|                    | 4. 3 out of 7 times he does not consider the effect of what he says.  
|                    | 5. 5 of 10 times he acts on peer pressure.  | 1. Has moved his residence to a better location.  
|                    | 1. Has reported his landlord to the Housing Authority Dept.  
|                    | 3. Has located 3 jobs and has decided to accept 1.  
|                    | 4. Calls friends for financial assistance twice a month.  
|                    | 5. Pays five out of seven debts he owes.  | 1. Has started reading on the hobby of interest.  
|                    | 2. Has started reading on various aspects of dance.  
|                    | 3. Has begun participation in basketball and tennis.  
|                    | 4. Has recalled 4 out of 6 concepts taught.  
|                    | 5. Has been appointed to lead 3 weekly group discussions.  |
| 4                  | 1. Volunteers group leadership readily and even without being asked.  
|                    | 2. Completes assigned task by checking only 1 time with his supervisor.  
|                    | 3. Is consistent with the goals listed in level 3 above.  
|                    | 4. 1 out of 7 times he does not consider the effects of what he says.  
|                    | 5. 3 out of 10 times he acts on peer pressure.  | 1. Has bought a new set of furniture for his new apartment.  
|                    | 2. Has decided to find an alternative residential quarters.  
|                    | 3. Is keeping his jobs and is considering taking training to update his skills.  
|                    | 4. Calls his friends for financial assistance once a month.  
|                    | 5. Pays 6 out of 7 debts he owes.  | 1. Has begun practicing on photography as a hobby.  
|                    | 2. Has enrolled in a dancing class.  
|                    | 3. Has achieved an average grade in basketball performance.  
|                    | 4. Has recalled 5 out of 6 concepts taught.  
<p>|                    | 5. Has requested that his group leadership be increased to 5 times a week.  |</p>
<table>
<thead>
<tr>
<th>Scale Attain. Level</th>
<th>PROBLEM AREA</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Personality</td>
</tr>
</tbody>
</table>
| 5                  | 1. Volunteers and enthusiastically asks for group leadership.  
                    | 2. Completes his assignment well without checking with his supervisor.  
                    | 3. Has well defined goals and goal-reaching strategies.  
                    | 4. He considers the consequences of what he says every time he speaks.  
                    | 5. 1 out of 10 times he acts on peer pressure.  

|                    | 1. Keeps and maintains his apartment in a good looking condition.  
                    | 2. Has finally moved to a different location as a solution to the problem of unfair treatment by his landlord.  
                    | 3. Is attending an in-service training program to update his skills.  
                    | 4. Does no longer call his friends for financial assistance.  
                    | 5. Has now paid all his bills.  

|                    | 1. Is practicing on 2 hobbies: photography and swimming.  
                    | 2. Has completed the 1st series of his dancing lesson.  
                    | 3. Has an excellent record in basketball playing.  
                    | 4. Has recalled all therapeutic concepts taught.  
                    | 5. Has gained confidence in leadership and in self-expression.  

effort consistently applied, and a search for creative vehicles of activity that can help the individual move from one concrete step to another. More explicitly, the approach through specific personal problems and specific goal attainment scales presumes equal specificity in curriculum planning and activity. The appropriate curriculum will be that set of activities which fits to the attainment of the goals, given the problems from which they stem. Why this is so may be illustrated from the example we are using.

One of the problems checked has been "lacking leadership ability;" in the process of goal attainment scaling, the wording for the intake level had been "will not accept leadership in any task." The causes for this condition are not given, but apart from the solution being relevant to the causes, there cannot be movement toward the goal. Such questions as the following arise:

(1) Is it because he hasn't learned how to do tasks, i.e., he hasn't been taught how to work?

(2) Is it because he's been taught not to try by parents or others who have negatively criticized him whenever he did try?

(3) Is it because he's trying to get even with a world which has seemed to have no place for him to try to do anything of his own? Is it an attempt to get even?

(4) Is it because he doesn't want to do anything unless he's sure in advance he can do it better than anyone else in his surrounding? Is it competition he fears? Is it perfection he wants?

(5) Is it because, in his present setting, he sees himself as the one with low status in education, language ability, social class, etc.?

(6) Is it because he doesn't have the energy, i.e., he has something wrong with him, health wise?
If the primary cause is given by the answer to the first question, then the appropriate curriculum will have to do with the client's learning how to work. If the primary cause is given by the answer to the second question, then the appropriate curriculum will have to do with the client's learning how to do tasks where criticism is done in a new way, i.e., constructively and with affection. If the primary cause is given by the answer to the third question, then the appropriate curriculum will have to do with clinical and personal procedures leading to the client's learning that he is loveable in his own right and is loved; he has a place in the world. Thus the curricula change as the answers to the diagnostic questions change.

Because this is the case, curriculum building has to begin with programs designed to fit individual cases. The curriculum for the individual becomes a naturally developing part of the progression as the client and educator become introduced to one another through the opening interview, proceed to an exchange of understanding in connection with items checked on the problem checklist, and together work out specific goal attainment steps for recognizing and measuring progress toward solution. The constant inference in all these steps is that action is to be taken to achieve a new capacity. Thinking out what those actions need to be, locating the resources, arranging situations for experimental trial, keeping track of what's working and what isn't, etc.—these are the curriculum.

As the programs for individuals form, the manner in which dyads, small groups and large groups may provide support will tend to emerge. Following the illustration, if the client's need is to "learn how to
work," he can be put on a house or community work crew where the leader and group members understand that instruction in how to do the tasks at hand is a natural part of the procedure; if the client's need is to experience criticism which is constructive and supporting, then assignments should be made in settings where the personnel know to avoid negative criticism, and, instead, supply encouragement at every forward step, making clear how further specific improvements would provide still further satisfactions; if the client's need is to re-discover himself as wanted in the world and as having a place in it, then the need, at first, is for some one person to be able to get through to the client that he is, indeed, loved and loveable.

Thus the curriculum arrangements need to flow from the consideration of needs to be met in individual cases. This calls for constant creation of fresh designs of situations and activities as the consequences of on-going activities become apparent. One can guess and predict, in advance, what is likely to be possible and desirable, but one cannot prescribe. This emphasizes the need for the educator to have in his repertoire as a great a range of curriculum resources as he can manage to assemble.

The following section provides a few illustrations of group methods that might provide support to individuals in their efforts to solve their personal problems.

Suggested Supplementary Group Activities

Thus far, the literature on teaching methods that are of proven value in therapeutic treatment programs for drug addicts is
highly limited. The suggestions below are drawn and adapted from the single source thus far discovered. The intent is simply to illustrate what teaching situations become when the aim is to support individuals in their struggle to make progress against drug addiction.

1. The Process Wheel -- The intent of this method is to graphically show the individual client that he is not alone in his struggle with his problems. This is a pen and paper technique where clients may be asked to draw a wheel with a number of spokes. A question of What, or Why, or Who, or How, or virtually any other question about a topic that the educator may wish to discuss, is written on the top of the wheel. The clients are then asked to write above each spoke an answer to the question. Questions for effective answers, such as "Why are you lonely" may also be raised. In each case, the client produces answers which are most meaningful to him. By sharing these wheels in pairs or in small groups, clients can determine how others feel and often resolve their anxieties by learning that their own perceived inadequacies are widely shared and need not be a source of concealment. Process Wheels can be used in a variety of ways that suit the situation of the class and allow the clients the opportunity for introspection and for sharing.

2. Force Field Analysis -- The intent of this method is to bring to the surface the "forces" that drug addicts feel their behavior to be controlled by. When brought into the open, there is an opportunity for the individual to better see what might be mastered and controlled by his own decision and action. This fits well to the step-by-step principle of the goal-attainment scale previously discussed. Here, with a pen and paper, clients may be asked to represent those forces which are influencing the decision they may make. Encouraging and discouraging forces are identified and assigned values. If a decision

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should concern stealing to sustain drug habits, clients may identify forces such as social pressure, withdrawal symptoms and tension as forces which influence their stealing habits (encouraging forces) and also such forces as spouse's wishes, legal consequences and guilt may be mentioned as pressures which operate against the decision (discouraging forces). The sharing of this information by the class can lead to more informed decisions by the clients.

3. The Fishbowl -- The intent of this method is to show the individual client that others can help him and he can help them; companions can help one another if they give themselves to it. Clients form two concentric circles; the inner group is given a topic which they discuss, while the outer group observes. At appropriate times, the educator stops the discussion and allows clients in the outer circle to feed back to the inner group (Group 1) their ideas about what has been said about the subject or the way the topic was handled. Perceptions of Group 1 by Group 2 in terms of "Mary was quiet most of the time," or "John seems to be angry," or "Juan has dominated the discussion," etc., may be expressed. After the feedback, the inner circle continues the discussion with the new information as a stimulant. At appropriate intervals, the fishbowl can be stopped and the inner and outer circles interchange or change for a new set. This method not only develops and expands integrative and cognitive goals, but is also an excellent technique for promoting communication.

4. Role Playing -- The intent of this method is to strengthen the capacity of the individual to act as if he can solve a problem by practicing taking the role of the solver; he is then better able to act appropriately in the real situation. This technique considers behavior change as the goal. Clients may be assigned role situations that are designed to gain insights into certain subject areas--for example, the problems of the addict. Each client is asked to act out a particular role as if he were the person in that role. If not knowing how to respond in a job interview is a factor of "an employment problem," this role may be acted out by one client responding the way he normally responds at job interviews and by another
responding the way he ought to have responded. The usefulness of this technique depends upon the situations designed and the roles assigned. Carefully planned and delivered, this process may achieve many therapeutic benefits.

5. Prescriptions -- The intent of this method is to strengthen the individual client in his ability to see and to say what needs to be done to solve a problem; he prescribes actions that ought to be taken by himself or by others, and others prescribe for him, developing group support by this means. This is a powerful method for behavioral changes. In this case, clients give each other prescriptions for desirable changes in behavior. Prescriptions may be given in dyads or in large groups and may be received from one person or a large number of individuals. The purpose here is to encourage clients to experiment with new behaviors. Prescriptions should be followed up in subsequent sessions to emphasize their importance to support clients attempting new behavioral activities and to change or modify the prescriptions given. Clients can gain a sense of importance if others listen to their advice and those receiving the prescriptions gain support from their peers who demonstrate through exercise and follow-up that they care. (Although the prescription method is an element of the traditional group and encounter sessions of most T.C.'s, actual prescriptions should be given in love and in an atmosphere that is free from verbal attacks.)

Although the educator can equally prescribe, clients would more likely respond to a peer in the context of a helpful relationship than to an authority in a moralistic framework.

Summary

Having experimented with an interview method and a problem checklist method for getting at the personal problems of clients, and having found these methods to be productive, the problem for the developer of an educational program is then to find methods to move

3Parenthesis is the author's insertion.
clients from the level of problem expression toward the level of problem solution. The foregoing chapter has illustrated a method adapted from the work of Geoffrey Garwick to help the individual client concretely realize a direction in which to give his effort and measure his progress in the solution of his personal problems, and has described methods adapted from descriptions given by Gerald Edwards of procedures by which groups of clients can provide support to one another during their struggle with drug addiction.

From experience with the interview and the problem checklist, and from the promise of the teaching procedures reviewed here, the author concludes that means are at hand for creating educational programs which can be personally meaningful to clients in drug addiction treatment centers. The next stage in development would be a laboratory trial in an action setting.

The following, and final, chapter provides a perspective for undertaking such a trial.
CHAPTER VI

OVERVIEW, CONCLUSION AND RECOMMENDATIONS

Overview

This study is the outgrowth of the author's involvement as a member of the staff of Uhuru, an agency for the treatment of drug addiction in Columbus, Ohio, in the role both of a planner and evaluator in close working relationship with the educational department. The study presents content and procedures found by the author to be relevant to the development of an educational program for Uhuru, designed to be client relevant. The report is offered as a potential aid to others who may have similar roles in similar agencies at similar early levels of educational program development.

Upon entering his post, the author's first need was to gain an overall orientation to the social phenomenon of drug addiction. He discovered:

(1) that the scope of drug abuse and addiction is international and accelerating

(2) that addiction is intimately tied into complex social and historical conditions

(3) that educational programs have been relatively undeveloped and narrowly conceived in programs of agencies now operating

(4) that the addict's sub-culture is a highly organized system that apparently offers response
to basic needs in individuals whose needs are not met otherwise at a particular time in their lives

(5) that rehabilitation which is successful needs to supply conditions for the development of human adequacy

In Chapter II, these and related items of information are presented.

A second need was to get to know the clients of the center as individuals. The author conducted interviews and learned:

(1) that clients are more likely to be able to talk freely about drug-related matters when questions are focused on general conditions in the external setting rather than on matters that are specific to the person of the interviewee

(2) that addicts resort to drugs as means of coping with their personal problems

(3) that while the pattern of human problems may be different for different individuals and different groups (e.g., drug addicts), the struggle to overcome human problems is universal and a part of the normal "human condition."

(4) that education can be an important part of the rehabilitation process when it is diversified and adapted to meet the personal problem needs of the different people involved

(5) that the drug sub-culture offers a "whole way of life" (personal, social, economic), the attraction of which can be met only by another culture which is also a "whole way of life" and more attractive.

In Chapter III, sample protocols and further discussion is provided.

A third need was to get a quicker and more systematic way to get to the personal problems of the clients since drug addiction seemed so intimately tied to struggles with personal concerns. The author utilized a personal problems checklist, and discovered:

(1) that problem checklists can be used by therapeutic community drug treatment centers as
tools for the identification of human problems which, in the case of addicts, may be addiction-related

(2) that the length of stay in treatment appears to positively correlate with problem intensity reduction

(3) that changes in personal problems occur as treatment progresses and that a personal problem checklist can offer cues to the changes

(4) that the problem checklist is both case and group specific and can provide data of relevance to individuals as well as to groups of which individuals may be members

(5) that the data provided by the problem checklist makes possible the development of drug abuse educational programs that are both case-specific and group-specific

Chapter IV reports the procedures of the survey, the data derived, and further interpretation of the results and values of using a personal problem checklist approach to educational programming.

A fourth need was to find procedures which might be used to help individual clients gain direction and support for their personal efforts to solve their problems. To gain direction, the author proposed an adaptation of Garwick's "Goal Attainment Scaling," illustrating its use in connection with items marked on the problem checklist. The advantages of the method are:

(1) that it fits to the individual case; goal scaling is done for each individual in turn

(2) that it fits the personal problem solving approach; goals are generated with respect to each personal problem in turn

(3) that it strengthens the skills of personal problem solving: clarification of the problem; visualization of concrete goals, attainable by feasible steps; planning of instrumental activities; and evaluation of results, both of the activities
undertaken and of the level of progress attained by the client

(4) that it allows for close working relations between the client and educator at all stages along the line

(5) that it invites support not only from the educator but from other clients who are undertaking the same disciplined steps

To provide support, the author proposed group procedures described by Edwards, selecting a set:

(1) that graphically shows the individual client that he is not alone in his struggle with his problems (The Process Wheel)

(2) that speaks to those forces which seemingly control drug taking behaviors in an effort to gain mastery over such forces through rational decision making (Force Field Analysis)

(3) that teaches how people can be helped by other people if they give themselves to it (The Fishbowl)

(4) that promotes the acting out of a role in order to strengthen an individual's capacity to act that role appropriately in real situations (Role Playing)

(5) that shows how group support and recovery may be quickened by the ability of an individual client to see and say what specifically needs to be done to solve a problem (Prescription)

Chapter V illustrates the procedure of goal attainment scaling for the solution of personal problems and describes the group procedures recommended.

Conclusion

The author's conclusion is that sufficient means are at hand to undertake a laboratory trial of an educational program which is linked to the solution of personal problems of the clients of Uhuru.
Recommendations

The following statements are framed as supporting considerations for the laboratory trial proposed in the above conclusion. It is recommended:

(1) that addiction and drug abuse behaviors be taken as problem-determined, and that treatment of addiction be designed to identify and resolve client problems

(2) that drug-abuse education in an agency such as Uhuru be conceived as a meaningful, active problem-solving force in the addicts' rehabilitation process

(3) that, given this role as primary for education in Uhuru, the traditional role of education as schooling for graduation or vocational training in outside institutions be included but viewed as finally instrumental to the primary educational function of personal problem solving

(4) that the educational program be an integral part of the total rehabilitation program of Uhuru, working very closely with the clinical component and diversifying its functions and mode of treatment to reflect the needs of the addicts and the rehabilitation emphasis of Uhuru

(5) that the characteristics of the clients and the range of problems they bring in for treatment provide the initial (and on-going) basis for the planning and development of Uhuru educational services

(6) that the clients be given as much responsibility for program initiation, operation and development as they can individually take for themselves and one another

(7) that the input of clients be included at all levels of program planning, operation and evaluation

(8) that as rapidly as individual clients develop themselves and learn constructive modes of their own behavior, they be given opportunity and responsibility to help develop and teach others who could benefit
(9) that efforts be made to respond to the clients as "normal people" who, like other people, have basic human needs to fulfill, and that, accordingly, efforts be made to drop responses to clients that afford them an escape from responsibility through a presumption of "deviancy".

(10) that the first and chief criterion to be applied to the evaluation of any given client-treatment in any modality be the effect it has on the capacity of the individual affected to better direct, heal, teach and develop himself.

(11) that advantage be taken of every opportunity to show the intimate connection and necessary reciprocating flow between helping others to direct, heal, teach and develop themselves and accomplishing the same for oneself.

(12) that Uhuru consider the minimum criterion level of its in-house program to be what is required to off-set the attraction of the drug sub-culture as source for fulfillment of the client's basic human needs.

(13) that Uhuru consider the minimum criterion level of its community out-reach program to be the connections required to off-set dependence on Uhuru (for the fulfillment of the client's basic human needs) with dependence on resources and personnel in the larger community where the ex-addict is ultimately to sustain himself.

(14) that since the experience of ex-addicts with addiction problems makes their work with addicts particularly effective, Uhuru design its educational activities to utilize on its staff those clients who are particularly effective in teaching themselves and other clients to meet their personal problems and to become drug-free.

(15) that, in view of the size, seriousness, and complexity of the drug abuse problem in society, Uhuru consider its responsibility to be not only the treatment of its clients, but further, the preparation of its successful clients as potential personnel for service in programs designed to alleviate the drug abuse problem in society.

(16) that drug abuse prevention programs among youth be recognized as a primary social need, and that Uhuru consider preparation of such programs and
personnel to be part of their community outreach responsibility and activity

(17) that group processes be evaluated in terms of their contributions to individual clients' self-development

(18) that administrative organization and staff arrangements be similarly evaluated in terms of their contribution(s) to the self-development of individual clients

(19) that, in the administrative structure and arrangements, all members of the staff be considered actual or potential "educators," and that the role of the educational developer be accordingly structured to grant him access to all staff members individually, or in groups, for consultations, workshops and other in-service activities designed to heighten the quality of the teaching and learning done within the operation of the total Uhuru program

(20) that the role of the educational developer be structured, also, to grant him access by direct contact to individual clients in order that he can directly learn what is needed and what is accomplished with respect to teaching-learning in personal problem solving by clients in Uhuru, and that his role be also structured to let him be free and responsible for setting up arrangements and activities exclusively aimed at educational goals, per se, when his personal leadership, or that of another "educator," is needed in such activity

(21) that the work done to date in educational development in Uhuru, and reported in this study, be considered the "first phase," necessarily given to exploration of the operational field, initial trial of ways to work and of instruments to use, and clarification of the conceptual basis for and educational program in such an institution; that the laboratory trial proposed here be considered the "second phase," necessarily given to trying out the activities, methods of work, role structurings, and basic conceptions arrived at in the course of the "first phase;" and that a "third phase" be anticipated when, through the presently proposed experimentation, operational specifications may be derived for the amounts and kinds of time, money, space, resources, organization and personnel needed for effective educational development of a client group of a given size and character.
By the close of the "third phase," the level of generalization and specification should be sufficient to allow the experience of Uhuru to be viewed as a proposed model for consideration by other experimenting and developing therapeutic drug treatment centers.
Narcotic Drug Import and Export Act*

This act as amended limits the importation of crude opium and coca leaves to the quantity necessary to supply medical and legitimate requirements only. Licenses are issued to three manufacturers only to import drugs for processing and resale to a larger number of pharmaceutical houses in the United States. The importation of opium for smoking is prohibited without exception.

Narcotic Hospital Law

Two Federal hospitals administered by the United States Public Health Service were authorized by this law to treat addiction patients. One was opened at Lexington, Kentucky (1935) and the other at Fort Worth, Texas (1938). The establishment of these centers was apparently a response to public pressure and a recognition that addiction was solely a perverse criminal action, but a symptom of underlying personality or emotional disorder which needed treatment, particularly of psychiatric nature, if rehabilitation is to be accomplished. These centers provide treatment for both voluntary patients and those sentenced by the Federal courts.

Narcotic Information Act

Under this act persons who give information concerning violation of the narcotic laws may be rewarded. This provision for rewards is a valuable tool of the Federal enforcement agency.

Marijuana Tax Act

This law sets up taxes and regulations concerning the importation, manufacture and trafficking in marijuana which are similar to those specified for opium and cocaine under the Harrison Narcotic Law.

Narcotic Transportation Act

This law makes it unlawful to use vehicles, vessels or aircraft to conceal or transport contraband drugs; the regulation provides for seizure of the means of transport if so used.

Opium Poppy Control Act

This law prohibits the growth of opium poppy in the United States except under license. Since there is no need to produce this drug in the United States, no license has been issued and there is no intention by the Bureau of Narcotics to issue this license in the immediate future. The law provides penalties for anyone who might grow the opium poppy clandestinely.

Drug Abuse (Narcotic) Control Act

This law, from February 1, 1966, gave the Food and Drug Administration strict inventory control, from manufacturer to consumer, over barbiturates, amphetamines and other drugs to be determined as dangerous. It limited the number of times a pharmacist might refill a prescription and made it an offense to possess the drug without a prescription. Other drugs to be included administratively were expected to be peyote, mescaline, LSD, DMT, Psilicybin and some tranquilizers. Special penalties were provided for the sale of drugs to be covered by this act to juveniles (under 21 years of age).
MEMORANDUM

TO: Uhuru Family  
FROM: Louis Haynes  
RE: Weekly Schedule  
DATE: April 21, 1975

MONDAY, APRIL 21, 1975

<table>
<thead>
<tr>
<th>Time</th>
<th>C.O.D.</th>
<th>O. Atiba</th>
<th>J. Claytor</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00</td>
<td>L. Haynes</td>
<td>Wake-up</td>
<td>Nightman/Family</td>
</tr>
<tr>
<td>6:15</td>
<td></td>
<td>Physical Development</td>
<td>Family</td>
</tr>
<tr>
<td>6:30</td>
<td></td>
<td>Personal Hygiene</td>
<td>Family/Kitchen</td>
</tr>
<tr>
<td>8:00</td>
<td></td>
<td>Breakfast</td>
<td>C.O.D./Family</td>
</tr>
<tr>
<td>9:00</td>
<td></td>
<td>Morning Meeting/Planning</td>
<td>Ramrod/Counselor</td>
</tr>
<tr>
<td>10:00</td>
<td></td>
<td>Job Functions/One on One Counseling</td>
<td>M. Holt/J. Showalter</td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td>Static Groups II,III</td>
<td>O. Atiba/B. Turner</td>
</tr>
<tr>
<td>1:00</td>
<td></td>
<td>Lunch/Free Time</td>
<td>Kitchen/Family</td>
</tr>
<tr>
<td>2:00</td>
<td></td>
<td>Seminar</td>
<td>Louis Haynes</td>
</tr>
<tr>
<td>5:00</td>
<td></td>
<td>Basketball</td>
<td>Family</td>
</tr>
<tr>
<td>7:00</td>
<td></td>
<td>Dinner/Free Time</td>
<td>Family/Kitchen</td>
</tr>
<tr>
<td>9:00</td>
<td></td>
<td>Encounter Group</td>
<td>C.O.D./Family</td>
</tr>
<tr>
<td>10:00</td>
<td></td>
<td>Them Changes</td>
<td>C.O.D./Family</td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td>House Closes</td>
<td>C.O.D./Expeditors</td>
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Night duty begins
### TUESDAY, APRIL 29, 1975

<table>
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<tr>
<th>Time</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>6:00</td>
<td>Wake-up</td>
<td>M. Holt</td>
</tr>
<tr>
<td>6:15 - 6:30</td>
<td>Phy. Development</td>
<td>夜夜/Nightman/Family</td>
</tr>
<tr>
<td>6:30 - 8:00</td>
<td>Pers. Hyg. &amp; Break.</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>8:00 - 9:00</td>
<td>Morning Meeting/Planning</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>9:00 - 10:00</td>
<td>Job Functions</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>10:00 - 11:00</td>
<td>Seminar</td>
<td>夜夜/Family/Kitchen</td>
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<tr>
<td>10:00 - 11:00</td>
<td>Seminar for Orientation</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>p.m.</td>
<td></td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>12:00 - 1:30</td>
<td>Lunch/Free Time</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>1:30 - 4:00</td>
<td>Orientation Static</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td></td>
<td>Group I</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td></td>
<td>Horse Back Riding (if possible)</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>1:30 - 3:00</td>
<td>Seminar (Surprise)</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>3:00 - 5:00</td>
<td>Outside Activities</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td></td>
<td>(touch football, basketball, jogging)</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>5:00 - 7:00</td>
<td>Dinner/Free Time</td>
<td>夜夜/Family/Kitchen</td>
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<tr>
<td>7:00 - 9:00</td>
<td>Group Session</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>9:00 - 10:00</td>
<td>Them Changes</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>10:00 -</td>
<td>House Closes</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>12:00 Midnight</td>
<td>Night Duty Begins</td>
<td>夜夜/Nightman/Family</td>
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<tr>
<td>2:00 Afternoon</td>
<td>Staffing</td>
<td>夜夜/Family/Kitchen</td>
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12:00 N - 9:00 p.m.  O. Atiba

### WEDNESDAY, APRIL 23, 1975

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<tr>
<td>6:00</td>
<td>Wake-up</td>
<td>夜夜/Nightman/Family</td>
</tr>
<tr>
<td>6:15 - 6:30</td>
<td>Phy. Development</td>
<td>夜夜/Family</td>
</tr>
<tr>
<td>6:30 - 8:00</td>
<td>Pers. Hyg. &amp; Break.</td>
<td>夜夜/Family/Kitchen</td>
</tr>
<tr>
<td>8:00 - 9:00</td>
<td>Morning Meeting/Planning</td>
<td>夜夜/Family/Kitchen</td>
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夜夜/Nightman/Family
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 - 11:45</td>
<td>Job Functions/One on One Counseling</td>
<td>Ramrod/Counselor</td>
</tr>
<tr>
<td>10:00 - 11:00</td>
<td>Orientation Seminar &quot;Respect&quot;</td>
<td>O. Atiba/B. Turner</td>
</tr>
<tr>
<td>12:00 - 1:30</td>
<td>Lunch/Free Time</td>
<td>Kitchen/Family</td>
</tr>
<tr>
<td>1:30 - 4:00</td>
<td>Orientation Seminar &quot;Education&quot;</td>
<td>T. Fullove</td>
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<tr>
<td>1:30 - 3:00</td>
<td>Job Function/One on One Counseling</td>
<td>Ramrod/Counselors</td>
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<tr>
<td>3:00 - 5:00</td>
<td>Seminar (Reporting System)</td>
<td>M. Holt</td>
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<tr>
<td>5:00 - 7:00</td>
<td>Dinner/Free Time</td>
<td>Kitchen/Family</td>
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<tr>
<td>7:00 - 9:00</td>
<td>Encounter Group</td>
<td>C.O.D./Family</td>
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<tr>
<td>9:00 - 10:00</td>
<td>Them Changes</td>
<td>C.O.D./Family</td>
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<tr>
<td>10:00 -</td>
<td>House Closes</td>
<td>C.O.D./Family</td>
</tr>
<tr>
<td>12:00</td>
<td>Night Duty Begins</td>
<td>C.O.D./Nightman</td>
</tr>
<tr>
<td></td>
<td>12:00 N - 9:00 p.m.</td>
<td>M. Holt</td>
</tr>
<tr>
<td></td>
<td><strong>THURSDAY, APRIL 24, 1975</strong></td>
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**C.O.D.**

| A. Habari | L. Haynes | J. Jordan |

<table>
<thead>
<tr>
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<th>Activity</th>
<th>Who</th>
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<tbody>
<tr>
<td>a.m.</td>
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<tr>
<td>6:00</td>
<td>Wake-up</td>
<td>Nightman/Family</td>
</tr>
<tr>
<td>6:15 - 6:30</td>
<td>Phy. Development</td>
<td>Family</td>
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<tr>
<td>6:30 - 8:00</td>
<td>Pers. Hyg. &amp; Break.</td>
<td>Family/Kitchen</td>
</tr>
<tr>
<td>8:00 - 9:30</td>
<td>Morning Meeting/Planning</td>
<td>C.O.D./Family</td>
</tr>
<tr>
<td>10:00 - 11:00</td>
<td>Orientation (Educational evaluations)</td>
<td>B. Turner</td>
</tr>
<tr>
<td>9:30 - 11:45</td>
<td>Ramrod/Expeditor Training</td>
<td>L. Haynes</td>
</tr>
<tr>
<td>p.m.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00 - 1:30</td>
<td>Lunch/Free Time</td>
<td>Kitchen/Family</td>
</tr>
<tr>
<td>1:30 - 4:30</td>
<td>Family at COSI</td>
<td>B. Turner/O. Atiba</td>
</tr>
<tr>
<td>3:00 - 7:00</td>
<td>Dinner/Free Time</td>
<td>Kitchen/Family</td>
</tr>
<tr>
<td>7:00 - 9:00</td>
<td>Seminar (Workshop)</td>
<td>Steve Sloan</td>
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<tr>
<td>9:00 - 10:00</td>
<td>Them Changes</td>
<td>C.O.D./Family</td>
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<td>10:00 -</td>
<td>House Closes</td>
<td>C.O.D./Family</td>
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<tr>
<td>12:00</td>
<td>Night Duty Begins</td>
<td>C.O.D./Nightman</td>
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<td>Passes to be in at midnight (to individual counselors)</td>
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<td>12:00 N - 9:00 p.m.</td>
<td>M. Yisreal</td>
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FRIDAY, APRIL 25, 1975

C.O.D. M. Holt

Z. Boggs P. Brewer

a.m.

7:00 Wake-up C.O.D./Family
7:15 - 7:30 Phy. Development Family
7:30 - 9:00 Pers. Hyg. & Break. Family/Kitchen
9:00 - 10:00 Morning Meeting/ Planning C.O.D./Family
10:00 - 11:45 Family at the Library O. Atiba/E. Kali

p.m.

12:00 - 1:30 Lunch/Free Time Kitchen/Family
1:30 - 4:30 Job Functions/One on One Counseling Ramrod/Counselor
5:00 - 7:00 Dinner/Free Time Kitchen/Family
7:00 - 9:00 Role Play C.O.D./Family
9:00 - 10:00 Them Changes C.O.D./Family
12:00 Night Duty Begins C.O.D./Nightman

12:00 N - 9:00 p.m. L. Haynes

SATURDAY, APRIL 26, 1975

C.O.D. E. Kali

S. Coleman W. Earthman

a.m.

9:00 - Wake-up Nightman/Family
9:00 - 11:30 Pers. Hyg. & Break. Kitchen/Family

p.m.

12:00 - 4:30 Car Wash Family
5:00 - 7:00 Dinner Kitchen
7:00 - 11:00 Movie C.O.D./Family
11:00 - House Closes C.O.D./Family
12:00 Night Duty Begins C.O.D./Family
<table>
<thead>
<tr>
<th></th>
<th>C.O.D.</th>
<th>E. Kali</th>
<th>J. Showalter</th>
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<td>S. Coleman</td>
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<td>Wake-up</td>
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<td>Pers. Hyg. &amp; Break.</td>
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<td>12:00 - 5:00</td>
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<td>Visits/Free Time</td>
<td>C.O.D./Family</td>
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<td>5:00 - 7:00</td>
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<td>Dinner/Free Time</td>
<td>Kitchen/Family</td>
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<td>7:00 - 10:00</td>
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<td>Free Time</td>
<td>C.O.D./Family</td>
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<td>10:00</td>
<td></td>
<td>House Closes</td>
<td>C.O.D.</td>
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<tr>
<td>12:00</td>
<td></td>
<td>Night Duty Begins</td>
<td>C.O.D./Nightman</td>
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</tbody>
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**SUNDAY, APRIL 27, 1975**
ADMINISTRATIVE PROCEDURES

The Clinical Director is responsible for all administrative procedures of the Clinical Component.

The Administrative duties are the direct responsibility of the Administrative Coordinator. The Administrative Coordinator:

(a) maintains the Master File
(b) maintains all Log Books

I. Filing

The Filing System is as follows:

A. Client Files are divided into two sections:

1. Administration -- Program forms which are informational in nature.

2. Clinical -- Forms which are only pertinent to the treatment process. Attached is a package of all forms used. CLIN -- denotes Clinical; ADMIN -- denotes Administrative.

B. Copies are distributed as follows:

1. Administration Forms -- Originals go to the Administrative Assistant. A copy is kept in the clinical component by the Administrative Coordinator in the Master File.

2. Clinical Forms -- Originals are kept in the Master File by the Administrative Coordinator; a copy goes to the Clinical Director.
C. Coding:

Each client is assigned a Program Number upon entry. This Program Number is his for life. Program Numbers run in order 001, 002, 003.... Files are kept by Program Number and not by name.

II. Reporting

All Clinical Staff members are responsible for various reports.

A. Weekly Reports

Each staff member must submit to the Clinical Director a weekly progress report. This report concerns itself with the progress of the department for the previous week and plans for the next week. These reports are also given orally and submitted during the weekly Clinical Planning Session.

B. Monthly Reports

Each staff member must also submit a monthly progress report on his department and plans for the following month. The Clinical Director submits a monthly report on the entire clinical component to the Administrative Assistant.

C. General Reports

There are several reports on clients which must also be submitted as suggested in the package of forms. Examples of these reports are incident reports, job change reports, etc. In addition, progress reports on clients must also be submitted. These progress reports are submitted by the counselor assigned to an individual. The client chooses his counselor with the approval of the Clinical Director.

D. Active files are kept in the top drawer of the Master File. Inactive files are turned over to the Administrative Assistant for filing.

E. Confidentiality

All files are confidential and kept under the supervision of the Administrative Coordinator. Only the Administrative Coordinator, the Clinical Director or his delegate have keys to the file cabinet. Even staff members must have written authorization to review client files.
F. General Filing

Each staff member keeps general files pertinent to their department. Component files are kept in duplicate by the Administrative Coordinator and the Clinical Director. This means the schedules, menus, personnel records, reports and other component materials as well as memos, correspondence, etc., to and from the Clinical Director are kept in duplicate.

III. Fiscal Management

The clinical component receives petty cash funds not to exceed $50.00 monthly. The Clinical Director or his delegate are the only ones who can authorize spending of petty cash funds.

A. Bookkeeping

All expenditures are recorded on numbered vouchers (see appendix). Expenditures are also recorded in an Expenditure Analysis Sheet as well as logged in a Petty Cash Ledger.

B. Client Personal Cash

All clients monies are also kept in a central cashbox. All deposits and withdrawals are authorized by staff and recorded in a Client Personal Cash Journal.

IV. Induction Procedures

The following is an outline of induction procedures.

A. Initial Contact

1. Can be with any staff member who will fill out a Prospect Application on the individual.

2. He will then report orally to the Senior Addiction Specialist and also in writing on an Introduction and Observation Report.

3. The Senior Addiction Specialist will then schedule an appointment with the Clinical Induction Committee.
B. Screening

1. The Clinical Induction Committee is made up of the Senior Addiction Specialist who is Chairman, the Social Worker, the Education Coordinator, an Addiction Specialist, the Nurse and one or two Senior Residents. It is a standing committee.

2. After each member has reviewed the written material, the formal interview takes place. The formal interview is designed to determine if the prospect is sincere, if the program can meet his needs, etc.

3. After the formal interview the prospect is asked to leave the room. During this time the committee discusses the prospect. It is decided then to accept or dismiss the application.

4. If accepted, the Committee formulates by consensus which treatment plan it feels is best for the prospect. This becomes the Recommended Treatment Plan.

5. The prospect is then called back into the room and given the committee's recommendations. All treatment plans are explained to him, including the reasons for the Recommended Treatment Plan. However, it is the prospect's choice of which plan he desires. This becomes the Plan of Choice. It is desired that the Recommended Plan and the Plan of Choice coincide. However, if they do not, a stipulation is placed on the Plan of Choice. If for any reason the prospect fails on the plan of his choice, he must accept the Recommended Treatment Plan.

6. After the Treatment Plan has been solidified, the client is assigned a Program Number.

C. Induction

This process is handled by the senior clients. The senior client will:

1. Screen the new client's clothes and other belongings.

2. Give him a shower.
3. Introduce him to the Family.

4. Orientate him about the policies and procedures.

5. In conjunction with the Senior Addiction Specialist, assign the new client a job function.

D. Orientation

This is a very critical period in treatment. It is during this time that the individual really becomes involved in the program and its goals.

1. The new client is constantly orientated into the program, urged to ask questions and make observations.

2. He meets all the staff individually.

3. Each staff department compiles a Profile on the new client as it relates to their department.

E. Profiles

These are information gathering sessions where each staff member of a particular department spends time with the new client to collect information which includes:

1. Senior Addiction Specialist (Clinical Profile)
   a. Psychological/Psychiatric Testing;
   b. Clinical Induction Committee Report;
   c. Files and other data from other Programs that the individual may have been in, if possible; and
   d. Any other clinical information.

2. Addiction Specialist (Legal Profile)
   a. Arrest History;
   b. Current Legal Status;
   c. Records from other penal institutions, if possible; and
   d. Any other pertinent legal data.
3. Education Coordinator (Education Profile)

   a. Intelligence Test Results;
   b. Interest Test;
   c. Transcripts from other Educational Institutions; and
   d. Other training, etc.

4. Nurse (Medical Profile)

   a. Medical History;
   b. Results of a complete physical;
   c. Report of current medical status;
   d. Reports from other medical institutions, if possible.

5. Social Service Coordinator (Social Service Profile)

   a. Report on Home Environment;
   b. Report on relationship with parents;
UHURU CULTURAL ARTS CENTER
765 East Long Street
Columbus, Ohio 43203

Director: Olu Makinde

Schedule For Classes And Workshops
Period of January 10 - March 30, 1975

**Monday**
Karate -- 7:00 - 9:30 p.m.
  Instructor: Jerry Clayton*
  Location: Ball Room

African Music -- 7:00 - 10:00 p.m.
  Instructor: Olu Makinde*
  Location: Multi-Purpose Room

**Tuesday**
Adult Dance -- 7:00 - 9:00 p.m.
  Instructor: Dr. William McCray
  Location: Ball Room

Children's Art -- 4:00 - 6:00 p.m.
  Instructor: Walter Neil
  Location: Art Room

Children's Music -- 4:00 - 6:00 p.m.
  Instructor: Olu Makinde
  Location: Multi-Purpose Room

**Wednesday**
Fashion Class -- 7:00 - 9:00 p.m.
  Host: Charisma Modeling Group
  Location: Multi-Purpose Room

African Music -- 7:00 - 9:30 p.m.
  Instructor: Olu Makinde
  Location: Music Room

**Thursday**
Yoruba Language Class -- 7:00 - 9:00 p.m.
  Instructor: Olu Makinde
  Location: Conference Room
Friday

Fine Art -- 4:00 - 6:00 p.m.
Instructor: Walter Neil
Location: Art Room

Karate Class -- 7:00 - 9:30 p.m.
(Adults and Children)
Instructor: Jerry Claytor
Location: Ball Room

Arts Impact -- 7:00 - 10:00 p.m.
and Public Seminar
Host: Olu Makinde
Location: 800 North Nelson Road

Saturday

Karate for Beginners -- 11:00 a.m. - 1:00 p.m.
Instructor: Jerry Claytor
Location: Ball Room

Photography for Beginners -- 11:00 a.m. - 1:00 p.m.
Instructors: Steven Sloan
Mwana Yisrael
Location: Dark Room

*Indicates paid staff; other instructors are volunteers.

All classes, with the exception of the Arts Impact Seminar take place at 765 East Long Street, Columbus, Ohio 43203.
THE UHURU PHILOSOPHY

Our union is one that was destined to be, for all things that are, are so with cause. Whether we be here as healer or to be healed, or as teacher or to be taught, we are now here, so we are one, and because it was meant to be.

WISDOM, WILL, AND LOVE being at one with God, and understood as the unchanging Truth, our direction is so defined.

Through Wisdom we will understand ourselves.

Through Will we will withstand that which would otherwise change our defined direction.

Through Wisdom and Will we will understand and generate LOVE: first in ourselves then in our brethren.

Armed with the unshakable Truth, we will disperse ourselves throughout our troubled world and demonstrate the power manifested in us:

- We will teach by being willing to learn;
- We will strengthen men's souls by yielding not to temptation;
- We will instill courage in our brethren by standing fast for what we believe;
- We will instill pride by being proud;
- We will make men love by loving.

For we, the Family of UHURU, understand: That only through WISDOM, WILL AND LOVE can Truth, the ultimate Freedom, be known.
The following are the Uhuru Basic Policies, Principles, and Tools. The word "basic" is underlined to signify that these apply to both staff and clients. These should not be confused with Clinical Staff Policies which apply only to clinical staff members.

These are simply guides to some of the policies, principles and tools that Uhuru is governed by. They change from time to time and others are added from time to time. But they are all basic.

CARDINAL POLICIES

1. Only general drugs such as aspirin, pepto-bismol, etc., will be allowed in the facility. Illegal drugs and alcohol will not be allowed. All prescription drugs and legal drugs which are addictive or powerful will be tightly controlled.

2. No violence or threat of physical violence in the facility.

3. No sexual activities within the facility.

UHURU PRINCIPLES

These principles are basic humanistic principles which speak to no particular faith, religion or specific set of values. We do not force specific ideals or values on individuals, except those kinds of general human values that apply to people.

1. Honesty -- To be honest in all that we say, do, and think; totally honest.

2. Respect -- Respect of individuals as human beings. To respect their views and cultural differences, to respect their status and existence. Self respect.

3. Consistency -- Be consistent in everything you do, think, and say.

4. Responsibility -- Don't ever shun your responsibilities whatever they may be. Always strive to meet them, even if you don't agree with them.

5. Confrontation -- When you have questions, ask. There is always a proper place and way to express your feelings, ideas and concerns.

6. Initiative -- Always strive to do a little better than you did yesterday. And don't always have to be told what to do, but do it on your own, if it's right.
THERAPEUTIC TOOLS

1. Pull-up -- Verbal reminder about neglect of responsibilities, negative attitudes, and general faults. Usually among residents.

2. Dumps -- Verbal reprimands designed to "embarass" a client into realizing the above. Usually among residents.

3. Blast -- Verbal reprimands given by senior residents.

4. Haircut -- Verbal reprimands which become necessary because of repeated acts of neglect, negativity and faults, or because of some paramount negative act or fault. Haircuts are given by staff with senior residents sometimes included. Often learning experiences (signs, or other tasks) will accompany haircuts.

5. General Meeting (G.M.) -- Highest form of reprimand, given by family (staff and clients).

GROUPS

A. Encounter -- These groups are specially designed to deal with the day to day relationships that develop in therapeutic communities. Not only do they deal with surface relationships, but the underlying causes of feelings (usually the hostile feelings) in these relationships. These groups usually involve 8 to 10 persons, including staff members.

   1. One-on-One -- Encounter between two individuals with one or two staff members present.

   2. Trap -- Encounter to delve into male/female relationship. To probe.

B. Static -- Static groups are designed to "get inside" an individual to find out "what makes him tick." His past, his fears, his problems, his hang-ups, as much about him as possible is brought out by him and by what others observe and relate to.

   1. Probe -- 8 to 12 hour static group.

   2. Marathon -- 24 to 48 hour static group.

       The extended length of time is to break defenses that individuals put up when they are confronted with the reality of themselves.

OTHER

1. Seminars
2. Data Sessions -- Group explaining the meanings and use of these principles, tools, and policies.

3. Rap Sessions -- Sessions in which client and staff rap about anything positive and constructive.

4. One-on-one -- Individuals getting together to rap constructively and positively.

UHURU JARGON

1. No free lunch -- Everything you get, you earn.

2. Grow or go -- Adhere to rules, be sincere in your efforts to change, or the treatment process is ineffective.

3. Apathy -- Don't care attitudes have no place.

4. What goes around comes around -- Reap what you sow.

5. Act as if -- Think positively.

6. Deal with it -- Again, when things don't seem to be going your way, don't allow it to get you down. Keep on keeping on.

7. Contracts (tips) -- When clients don't apply the tools properly because of friendships, etc.

8. Pulling covers -- Being responsible for pointing out to your fellow client his faults, negative acts, etc., and pointing them out to others when he doesn't.

9. Bad rapping -- Discussing anything destructive to individuals, fellow clients or the program.

10. Cop to it -- Be honest about your negative actions and attitudes.

11. Drop a slip -- Use the encounter box when hostile feelings arise instead of breaking regulations and expressing your feelings in the wrong place at the wrong time.

12. Got an attitude -- Facial expressions, speech, and generally the things you do and say are a key to your inner feelings. If those inner feelings are negative, be conscious of them and try not to display them in the above mentioned ways.
Blacks Against Drugs, Inc.

ROSTER
BOARD OF TRUSTEES
AS OF JANUARY 1, 1975

CHAIRMAN
Robinson, James T., Jr.
Director, Public Affairs
Lazarus Department Store
Town and High Streets (16)
463-2284
One of Uhuru's Originators

1ST VICE CHAIRMAN
Germany, Roger
Executive Director
Hilltop Civic Council
2388 W. Broad Street
279-6314
Owner, Germany's Barber Shop
Mayer's Furniture Store

2ND VICE CHAIRMAN
Vacant

TREASURER
Smith, Ms. Reita
Youth Coordinator
State Manpower Planning Council
8 E. Long Street (15)

SECRETARY
Clarke, Ms. Virginia
Director, WVKO Radio
4401 Carriage Hill Lane (20)
451-2191

Anglen, Reginald
Public Relations
School for Blind
5220 N. High Street (14)
888-1972

Bolden, James
Director, Department of Personnel
State of Ohio
30 E. Broad Street, Room 2802 (15)

Frazier, Fran Curtis
Supervisor, Exceptional Children Clinic
Ohio State University
Ramseyer Hall, Rms. 159-059
Woodruff Ave. & N. High St. (01)
422-7716

Frye, Charles
Personnel Administrator
Xerox Educational Center
1250 Fairwood Ave (06)
253-0982

Guy, Ms. Drue
Assistant Director
The Ohio State University Research Foundation
1314 Kinnear Road (12)
422-0702

Hines, Ms. Florence
Coordinator
Neighborhood House
Job Care Division
1026 Atcheson St. (03)
252-3545
Nelson, Dr. William E.
Director, Black Studies and
Asst. Professor Political
Sciences
The Ohio State University
232 Dieter Kunz Hall
1841 Milliken Road (01)
422-3700

Spiller, Howard
Futon Corporation
850 Mansfield Street (19)
252-0746 or 6080

Summers, Rev. Vance, Jr.
Program Council on Ministers
471 E. Broad Street (15)
228-6784

Taylor, Dr. Charles E.
Associate Director
Academy for Contemporary
Problems
Battelle Memorial Institute
1501 Neil Ave. (01)
421-7700

Wilkes, Clyde
Sales Manager, Sportswear
Lazarus West Department
Store
4141 W. Broad Street (28)
463-4864
REPORT OF CLINICAL INDUCTION COMMITTEE

Date________________ Committee Chairman______________________________

Committee Members________________________________________________________________________

________________________________________________________________________________________

Prospect's Name________________________________________________________ Age______________

Address_____________________________________________________________ Telephone________

Referred by______________________________________________________________________________

Observations/Comments:

Treatment Plan____ Recommended____ Choice____

Reasons:

Other Recommendations/Stipulations:

Program #________________ Chairman Signature________________________

Title____________________

Code:    I -- Inpatient Abstinence
         II -- Inpatient Detox
         III -- Outpatient Abstinence
         IV -- Outpatient Detox

UDP (9/73)
ATTACHMENT X

139
MEDICATION RELEASE

I, _____________________________ give permission to the nurse and C. O. D.'s at the Uhuru Family Center to administer to me those medications prescribed by a physician for me.

I also give permission to have emergency measures instituted as necessary.

Signed:

Client: __________________________
Date: __________________________

Staff Member: __________________
Date: __________________________

UDP (3/75)
ATTACHMENT 62
INTRODUCTION:

Uhuru is a therapeutic community funded with 410 money for provision of residential care with a matrix listing a static capacity of 40 persons and a dynamic-capacity of 160 persons. It was evaluated by the team on Monday and Tuesday, January 6 and 7, 1975. The evaluation team interviewed the director, Curtis Jewell, and seven other staff members, examined thirteen patient records and interviewed six patients. The team also made a thorough examination of the program's facilities and other records and equipment. The over-all impression of the program is favorable with some recommendations which will follow.

WHAT THE PROJECT AIMED TO DO:

Uhuru's 410 contract requires it to provide a therapeutic community and certain medical, legal and psychological services within
that setting for a matrix of 40 static capacity and 160 dynamic capacity. The contract began April 1, 1974 and terminates March 31, 1975.

WHAT SUCCESS TO DATE:

Based on contractual requirements, the program must be rated as successful. It has a very effectively operating legal component, has retained a full-time licensed psychologist and registered nurse and has made necessary arrangements with other community-based agencies to provide ancillary services in medical, job training and job placement areas. The program reports 74% of its referrals from the criminal justice system and 74% primarily abusing heroin. Over 40% of the currently active patients are employed. Sixteen percent are veterans. The average age is 24 years and 64.5% of its patients are Black. Over three-quarters of the patients are male.

Since March, 1974, over 100 patients have been enrolled in the program. During the nine months preceding the evaluation, intake has fluctuated from a high of 31 in November, 1974 to a low of 3 in September of 1974. Monthly terminations have also fluctuated from a high of 20 to a low of 3. During this period the actual static participation has gradually grown from 23 in April, 1974 to 33 in December of 1974. The program has averaged 11 new enrollees per month. During the 9 month period ending December 31, 1974, the program admitted 61 people for residential treatment (the other 39 were admitted for a variety of out-patient services). Of these 61, 9 were still in the program and 6 had re-entered after dropping out. This represents a retention rate of approximately 25 percent. Given
this rate of retention, and assuming that the program will continue to attract an average of 11 new enrollees per month, it can be estimated that by April, 1975, the program should be operating at slightly above 100% of static capacity.

OUTSTANDING DEFICIENCIES:

(1) Record keeping procedures need to be improved, to the extent that records are better systematized. The problem here is not so much what records are being kept, because the program generally keeps good records, but the problem lies in the way the records are collected and displayed.

(2) Urine procedures are currently weak and need to be improved.

(3) Procedures for administering prescription medicines and their security need to be clarified and distributed to staff and patients.

WHAT IS THE PROGRAM WORKING ON:

(1) Program will be seeking technical assistance from State and 648 Board to improve its information system.

(2) Nurse's station is being remodeled to improve security. Procedures will be worked out with State for administration of prescription medicines.

(3) Urine procedures will be improved.

Respectfully submitted,

S/S Don C. Pavelcik

Donald C. Pavelcik
for the Evaluation Team
REVISED COVER SHEET
MOONEY PROBLEM CHECK LIST
LEONARD V. GORDON and ROSS L. MOONEY
BUREAU OF EDUCATIONAL RESEARCH
OHIO STATE UNIVERSITY

DATE.................YEARS OF ADDICTION □ / DAYS IN TREATMENT □

OCCUPATION..............................................................AGE......SEX...........

MARITAL STATUS.......................................................NO. OF CHILDREN.....
(Single, Married, Divorced)

EDUCATIONAL LEVEL..............HAS TREATMENT BEEN PREVIOUSLY UNDERTAKEN
IN ANOTHER DRUG TREATMENT PROGRAM BEFORE ENTERING THE PRESENT PROGRAM?
YES □ NO □

DIRECTIONS

Following you will find a list of problems with which people are often faced—problems relating to health, work, family, temperament, and so on. You are to read through the list and to select those statements that represent your problems. Mark the list honestly and sincerely and you will obtain a representative inventory of your problems. Remember, this is not a test. There are no right or wrong answers. The statements that you are to underline are those that refer to you. You are assured that what you mark in the inventory will be treated in the strictest of confidence. There are three steps for you to take.

FIRST STEP: Read slowly through the list and underline each problem that suggests something that is troubling you, thus "1. Feeling tired much of the time."

SECOND STEP: After you have gone through the entire list, look back over the problems that you have underlined and circle the numbers in front of those problems that are of most concern to you, thus "1. Feeling tired much of the time."

THIRD STEP: Reply to the summarizing statements on page 5.

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50-127T THE PSYCHOLOGICAL CORPORATION
Printed in U.S.A. 522 Fifth Avenue, New York, N.Y.
Name.....................................................................................................................Date.................................................................

Occupation............................................................................................................Age..............Sex..............

Marital Status...........................................................................................................No. of Children............
(Single, Married, Divorced, etc.)

DIRECTIONS

Following you will find a list of problems with which people are often faced — problems relating to health, work, family, temperament, and so on. You are to read through the list and to select those statements that represent your problems. Mark the list honestly and sincerely and you will obtain a representative inventory of your problems. Remember, this is not a test. There are no right or wrong answers. The statements that you are to underline are those that refer to you. You are assured that what you mark in the inventory will be treated in the strictest of confidence. There are three steps for you to take.

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Second Step: After you have gone through the entire list, look back over the problems that you have underlined and circle the numbers in front of those problems that are of most concern to you, thus “1. Feeling tired much of the time.”

Third Step: Reply to the summarizing statements on page 5.
Mr. Curtis Jewell  
Director, Uhuru Drug Program  
765 E. Long Street  
Columbus, Ohio 43203

January 21, 1975

Dear Mr. Jewell:

This letter is a confirmation of our telephone conversation on January 17, 1975. Uhuru has been chosen by the National Search Panel as a State Selection for the state of Ohio. This means that Uhuru excelled in Ohio, according to our criteria for drug abuse prevention programs. Some of our considerations were: innovativeness, replicability, program format and degree of youth involvement in program planning and implementation.

You will receive shortly an official letter from Dr. Joseph Hendrick of the National Institute of Drug Abuse.

Cordially,

Pat Bastian  
Administrative Assistant
Original Appointment of Agent

The undersigned, being at least a majority of the incorporators of BLACKS AGAINST DRUGS
(Name of Corporation)

hereby appoint JAMES T. ROBINSON
(Name of Agent)

a natural person resident in the county in which the corporation has its principal office, a corporation having a business address in the county in which BLACKS AGAINST DRUGS
(Name of Corporation)

has its principal office (strike out phrase not applicable), upon whom (which) any process, notice or demand required or permitted by statute to be served upon the corporation may be served. His complete address is 1648 Country Club Road, Columbus, Ohio, 43227.

Franklin County, Ohio, 43227. (Zip Code)

BLACKS AGAINST DRUGS

WILLIAM J. BELL

REV. THOMAS J. FARLEY

JAMES T. ROBINSON

(INCORPORATORS NAMES SHOULD BE TYPED OR PRINTED DENTANT SIGNATURES)

COLUMBUS, Ohio

MARCH 15, 1971

BLACKS AGAINST DRUGS

(Name of Corporation)

Gentlemen: I hereby accept appointment as agent of your corporation upon whom process, summons, notices or demands may be served.

JAMES T. ROBINSON

By: REV. THOMAS J. FARLEY - INCORPORATOR
FOURTH. The following persons, not less than three, shall serve said corporation as trustees, until the first annual meeting or other meeting called to elect trustees.

GIVE STREET AND POST OFFICE ADDRESS

James T. Robinson  
1448 Country Club Rd., Columbus, Ohio 43227

Rev. Thomas J. Farley  
1551 E. Main St., Columbus, Ohio 43205

William I. Bell  
504 Bassett, Columbus, Ohio 43203

Waldo Tyler  
113 N. 20th St., Columbus, Ohio 43203

IN WITNESS WHEREOF, We have hereunto subscribed our names, this 15th day

of MARCH, 1971.

William I. Bell
Rev. Thomas J. Farley
James T. Robinson

IN CORPORATIONS WHERE SEVERAL TYPES OF PRINTED REMARKS OCCUR,

F.N. D. Articles will be returned unless accompanied by Form C-133 designating statutory agent.

See Section 1702(c), Revised Code.
Articles of Incorporation

BLACKS AGAINST DRUGS, INCORPORATED

The undersigned, a majority of whom are citizens of the United States, desiring to form a corporation, not for profit, under Sections 1702.01 et seq., Revised Code of Ohio, do hereby certify:

FIRST. The name of said corporation shall be BLACKS AGAINST DRUGS.

SECOND. The place in Ohio where the principal office of the corporation is to be located is Franklin County.

THIRD. The purpose or purposes for which said corporation is formed are:

1. To bring together those residents of the Black community who are concerned about drug abuse for unified constructive action on a neighborhood basis.

2. To secure the necessary funds and initiate the necessary planning for realistic community-based drug abuse programs within the Black community.

3. To serve as a link between the Black community and the existing local, state, and federal drug abuse programs, hopefully ensuring that the community will make the best use of those facets of these programs which can render direct and effective aid in the area of concern.

4. To educate the Black community as a whole to the dangers of drug abuse in terms that are meaningful to the community as "Black" and as "Community".

5. To exchange information, techniques, etc. with other local drug abuse programs in hopes of contributing to the greater city-wide effort to stem drug addiction.
RECEIPT AND CERTIFICATE
BLACKS AGAINST DRUGS

NAME

DOMESTIC CORPORATIONS
ARTICLES OF INCORPORATION AMENDMENT MERGER/CONSOLIDATION DISSOLUTION AGENT RE-INSTATEMENT CERTIFICATES OF CONTINUED EXISTENCE MISCELLANEOUS
FOREIGN CORPORATIONS LICENSE AMENDMENT SURRENDER OF LICENSE APPOINTMENT OF AGENT CHANGE OF ADDRESS OF AGENT CHANGE OF PRINCIPAL OFFICE RE-INSTATEMENT FORM 7 PENALTY

MISCELLANEOUS FILINGS
ANNEXATION/INCORPORATION—CITY OR VILLAGE RESERVATION OF CORPORATE NAMES REGISTRATION OF NAME REGISTRATION OF NAME RENEWALS REGISTRATION OF NAME—CHANGE OF REGISTRANTS ADDRESS TRADE MARK TRADE MARK RENEWAL SERVICE MARK SERVICE MARK RENEWAL MARK OF OWNERSHIP MARK OF OWNERSHIP RENEWAL MARK OF OWNERSHIP RENEWAL EQUIPMENT CONTRACT/CHATTEL MORTGAGE POWER OF ATTORNEY SERVICE OF PROCESS MISCELLANEOUS ASSIGNMENT—TRADE MARK, MARK OF OWNERSHIP, SERVICE MARK, REGISTRATION OF NAME

I certify that the attached document was received and filed in the office of TED W. BROWN, Secretary of State, at Columbus, Ohio, on the _____ day of ________________ A. D. 19____, and recorded on Roll #____ at Frame ____________ of the RECORDS OF INCORPORATION and MISCELLANEOUS FILINGS.

[Signature]
TED W. BROWN, Secretary of State

Filed by and Returned To:
James T. Robinson, Jr.
1448 Country Club Rd.
Columbus, Ohio 43227

FEE RECEIVED: $________

NAME: BLACKS AGAINST DRUGS
Mr. Curtis T. Jewell, Director  
UHURU Drug Program  
Columbus, Ohio

Dear Mr. Jewell:

You are hereby presented the Governor's Award for Community Action in recognition of your outstanding efforts to establish the UHURU Drug Program as an innovative, creative and effective program for drug abuse prevention, rehabilitation and education.

Through your untiring devotion to freeing people from drug addiction by helping them resolve the problems leading to their dependency you have helped them develop to their full potential as human beings. Your deep concern and genuine commitment to this serious problem affecting all Ohioans deserve to be commended and should serve as a model and an inspiration to others working with drug abuse programs throughout the state.

Please accept the Governor's Award for Community Action with my most sincere best wishes.

Sincerely,

JOHN J. GILLIGAN
UHURU FUNCTIONAL COORDINATING UNIT
SYSTEM DEFINITION

INTERRELATIONSHIP

Central Administration

- Central Administrative Functions

Public Relations Functions

Research & Development Functions

Therapeutic Community

- Administrative Functions

- Clinical Functions

- Social Services Functions

- Medical Functions

- Education & Correctional Functions

LARGER ENVIRONMENT

Business community

Other drug programs and resource institutions

Community

Feedback
BIBLIOGRAPHY

Books and Pamphlets


Newspapers, Periodicals and Digests


Whitman, Ardis. "We Need New Ways to Pray." Reader's Digest (December, 1969), pp. 77-80.


