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DRUGS

INTRODUCTION

The use of chemical agents to reduce tension or to give pleasure is as old as mankind. Our own society produces and promotes a wide variety of such substances, e.g. alcohol, tobacco, barbiturates, coffee, tea, etc. More recently certain pleasure-agents have been widely used by young people of our communities. The use of any of these substances contains an element of risk to mind and body, and with some substances, e.g. the opiates, the risks are very high. The possession and/or use of some substances is punishable by law. Every young person in our society will sooner or later have to make a choice whether to use some of these substances or not. We believe that such a choice should be an informed choice and it is for this reason that we have prepared this information booklet. It is in your interest to read it carefully and thoughtfully. If you are interested in further information or literature contact your Health Service, 517 Pine Avenue West, Local 5444. The reference literature listed is available at the Health Service.

John G. Lohrenz, M.D.
Director,
McGill University Health Service

FACTS ABOUT

alcohol

What is known about alcohol?

The alcohol in beverages is ethyl alcohol or ethanol. It can be produced naturally (by allowing certain fruits, vegetables, or grains to ferment) or synthetically. Generally, the alcohol content of beer is 5 per cent by volume and of distilled spirits (whisky, rum, gin, etc.) 40 per cent. The natural alcohol content of wine ranges from 7 to 14 per cent; fortified wines (sherry, port, vermouth, etc.) contain 12 to 20 per cent alcohol. *Roughly speaking, a pint of beer, a 4-oz. glass of wine, or a 3-oz. glass of fortified wine contains about the same amount of alcohol as a drink containing 1½ ounces of spirits.*

SHORT-TERM EFFECTS: Alcohol depresses the central nervous system to a degree that depends on amount drunk, rate of drinking, amount and kind of food in the stomach, and size, tolerance, and emotional state of the drinker. Generally speaking, one or two drinks reduce inhibitions in such a way as to make talk and emotional expression come more easily. Emotions expressed — e.g., pleasure, anger — depend on preceding mental state and the drinker's surroundings.

Taken over a short period, three or four drinks usually produce flushing, dizziness, and poor co-ordination. Still larger doses alter perception and have an even greater effect on behavior. When body content of alcohol is equivalent to about eight drinks, staggering, blurred vision, and loss of balance are likely. Extremely large doses can kill by knocking out the process that controls breathing. However, this rarely happens: consciousness almost always disappears before a lethal dose is consumed.

LONG-TERM EFFECTS: Most people can use moderate amounts of alcohol throughout an entire adult lifetime without apparent damage to physical or mental health, job performance, or family life. However, about 2.7 per cent of Canadian drinkers (about 306,800 people) are victims of alcoholism — dependence on alcohol that is harmful physically and/or psychologically.

HAZARDS OF HIGH-RISK DRINKING: Some authorities use the terms *low-risk* and *high-risk* to distinguish behavior unlikely to lead to alcoholism from behavior likely to do so. Statistically it appears that the dividing line comes at, or slightly below, six drinks per day. Signs of developing alcoholism include irregular or unsatisfactory performance at work; loss of interest in work, hobbies, or family; frequent hangovers; blackouts (periods the drinker cannot later recall); and a pattern of alcohol-related traffic accidents (heavy drinkers are much more likely than others to be involved in automobile accidents).

Many heavy drinkers are seeking to escape through the use of a chemical, alcohol, from the responsibility of facing and solving problems. Unfortunately, heavy drinking tends to increase the number and severity of the drinker's problems. Increasing difficulties may cause him to seek chemical relief more often, and gradually the quantity he must drink to escape becomes greater.

Alcoholism is a major factor in loss of employment, disruption of family life, and mistreatment or neglect of children. It costs millions of dollars in lost production, accidents, and personnel turnover. Research studies suggest that the children of alcoholics tend to become maladjusted themselves; if such people use alcohol they are more likely

to do so in a hazardous way.

Many heavy drinkers suffer from loss of appetite, vitamin deficiencies, gastritis, infections, skin lesions, and sexual impotence — conditions that can usually be corrected by a period of abstinence from alcohol under medical treatment. Some also develop peripheral neuritis, liver damage, or cardiovascular disorders. Severe cases may be characterized by Wernicke's syndrome (mental confusion) or Korsakoff's psychosis (loss of memory). In physically dependent persons, withdrawal reactions ranging from shakes to delirium tremens (tremors and hallucinations) occur. Some of these conditions can cause death. Fatal accident and suicide rates are higher for heavy drinkers than for the general population.

CONSEQUENCES OF LOW-RISK DRINKING: For most people who stay well below their danger point, drinking is a source of social enjoyment and relaxation. Nevertheless, use of alcohol can sometimes create problems even for people who are in no immediate danger of becoming alcoholics.

When inhibitions are markedly reduced, people may say or do things they otherwise would not; sometimes these are a source of embarrassment or worse. Young people are especially vulnerable. Anyone who drinks a great deal over a short period may suffer headache, nausea, and other symptoms of hangover next day. Weight-conscious people must consider that whisky, gin, and rum contain about 105 calories per 1½ oz. drink, plus any calories in mixers. A 4-oz. glass of dry white wine contains about 90, a 3-oz. glass of dry sherry 120, a 12-oz. bottle of beer 144 calories, some cocktails much more.

Many traffic accidents are related to use of alcohol. A blood alcohol level of .05 per cent or higher produces driving impairment in most people. In a 160-lb. person this level is usually produced by two ordinary-sized drinks if they are consumed in a short time. The less experience a person has with either drinking or driving, the less alcohol it takes to produce impairment. Many pedestrians hit by cars have high blood alcohol levels.

Combining alcohol with tranquilizers, antihistamines, or barbiturates and other sedatives can be dangerous. These drugs add to the effects of alcohol; some may intensify them. Many accidental deaths have been caused by taking too many barbiturate capsules after drinking. Combining alcohol with amphetamines may offset sleepiness produced by alcohol without counteracting other effects of intoxication.

TREATMENT: Medical treatment can help alcoholics who are in severe withdrawal states or who have physical illnesses arising out of their alcoholism; however, most therapists believe that treatment for alcoholism must also take psychological and social factors into account.

What is *not* known about alcohol?

Why do some people become alcoholics? (Although we have a fairly good understanding of the physical processes involved, not enough is known about the psychological aspects.)

What determines the dividing line, *for a particular individual,* between low-risk and high-risk drinking?

Who uses alcohol? Why?

In our society, people commonly drink to celebrate important events, relax and promote sleep, relieve social or physical discomforts, quench thirst, increase appetite for and enjoyment of food, or make a get-together more enjoyable.

In Canada, about 75-80 per cent of the population over the age of 15 uses alcoholic beverages to some extent. A 1968 Toronto study indicates that some people under 15 also use alcohol. Of Grade 7 students surveyed, about 23 per cent said they had used alcohol at least once per month during the preceding six months. For Grade 9, the figure was nearly 42 per cent.

In 1968 the vast majority of Canadian drinkers in the over-15 group — about 85½ per cent of them — drank no more than an average of three pints of beer a day, or their equivalent in wine or spirits. About 9 per cent drank three to six pints or their equivalent, about 3 per cent consumed six to nine, about 1 per cent nine to twelve, and about 1½ per cent more than twelve per day. As a group, men are heavier users of alcohol than women, boys than girls.

Alcohol and the law

Many laws regulate manufacture, possession, and consumption of alcohol. The most relevant of these are well known.

Under legislation which has recently come into effect, it is illegal to drive with a blood alcohol level of .08 per cent or higher. It is also illegal for a driver to refuse to submit to a breathalyzer test. Refusal can result in the same punishment as driving with a .08 level. This law does *not,* however, make it legal to drive while impaired even if blood alcohol level is lower than .08.

FACTS ABOUT

amphetamines

What is known about amphetamines?

The amphetamines are a group of synthetic stimulants that have been used medically as appetite inhibitors and for relieving mild depression. They are useful in treatment of hyperkinetic brain-damaged children and in management of narcolepsy. Many people take overdoses of prescribed amphetamines. Others take illicitly obtained amphetamines to produce excitement and euphoria (a sense of well-being).

The most commonly used amphetamines are dextroamphetamine sulphate (Dexedrine or Bi-Phetamine), methamphetamine hydrochloride (Methedrine or Desoxyn), and amphetamine sulphate (Benzedrine). Amphetamines are popularly known as pep pills. Methamphetamine, especially in injectable form, is often referred to as speed, crystal, or meth.

APPEARANCE: Amphetamines are white crystalline powders usually sold in tablets or capsules of various sizes, shapes, and colors. They are also available in powder form or in solution (in ampoules for injection).

TYPE OF ACTION: Amphetamines are chemically similar to adrenalin, an alerting hormone produced in the human body, and to drugs such as ephedrine which have been used for centuries in the form of plant products.

METHODS OF USING: When used as prescribed, amphetamines are generally taken by mouth as capsules or tablets. Some users of illicitly obtained amphetamines also take tablets or capsules. Some sniff amphetamine powder. Some inject the drugs. Some combine two or more methods.

SHORT-TERM EFFECTS: Amphetamines act on the sympathetic and central nervous systems and on certain metabolic processes. Respiration and circulation are speeded up. Pupils are dilated. Appetite is suppressed. Shortly after taking moderate oral doses, users become more alert and energetic and can carry on activities for longer periods before becoming tired. Many report increased concentration; they believe, sometimes mistakenly, that their work has improved.

With larger doses, users become talkative and restless. They are excited, euphoric, and more self-confident than usual. Dryness of mouth, sweating, and sleeplessness are common.

With still larger doses, these effects are more pronounced. There are nearly always some other psychological effects such as a sense of power or superiority, nervousness, irritability, anxiety, memory lapses, or hallucinations. Sexual desire is sometimes heightened, sometimes eliminated. Rapid-fire speech, blurred vision, dizziness, tremors, headache, diarrhea, palpitations, and cardiac arrhythmias have also been reported.

Large intravenous doses produce a "rush": sudden, overwhelming euphoria.

DURATION OF ACTION: This depends on user and dose. Amounts ordinarily prescribed affect most people for about three or four hours. Abusers, however, may begin with a massive intravenous dose and take more every few hours to maintain a "run". Some stay awake and high for as long as 72 hours before "crashing" — i.e., sinking into a long sleep followed by depression. Chronic high-dose oral users may stay high, sleeping occasionally, for several weeks.

HAZARDS: *Physical risks* of frequent and heavy use include weakness, skin trouble, nutritional problems, ulcers, pneumonia, and convulsions. Serum hepatitis, sometimes a result of using unsterilized needles, can cause permanent liver damage that may produce chronic illness and premature death. Particularly large doses of amphetamines occasionally cause sudden death from cerebral hemorrhage or cardiovascular collapse.

Use of amphetamines to increase stamina may impose strain on systems of the body by artificially prolonging stress.

Accidental overdoses occur among small children who find tablets and capsules and eat them as "candies", and among adults whose developing tolerance makes them uncertain as to proper dosage.

Psychological risks include severe depression, paranoid psychosis with delusions of persecution, and drug dependence.

When taken as usually prescribed, tolerance to amphetamines builds up slowly. With larger doses, it develops more rapidly. Soon it takes more amphetamine to produce the same effect. Some people increase their doses still more to heighten the experience. Those who inject amphetamines are especially likely to become dependent: some develop a "needle habit" — dependence on the act of injecting.

Amphetamine abusers sometimes experience aggressive impulses leading to anti-social behavior (e.g. attacks on other people). Those who drive risk accidents caused by this aggressiveness or by dizziness, delusions, hallucinations, or exhaustion. There is evidence that amphetamine abusers have even higher traffic accident rates than abusers of alcohol, barbiturates, or tranquillizers.

Amphetamines interact in various ways with other drugs. They can transform a sleepy drunk into a wide-awake, active one. Used with LSD, methamphetamine prolongs and intensifies the LSD experience. The up-and-down cycle of amphetamine and barbiturate use can lead to combined dependence on these drugs. (Barbiturate dependence is believed by many to be the most dangerous form of physical dependence.)

Finally, analysis of illicit drugs in the laboratories of the Addiction Research Foundation of Ontario has indicated that some tablets and capsules sold as amphetamines contain some other drugs instead. Taking an unknown drug can be especially hazardous.

TREATMENT: Wilthdrawal from heavy amphetamine abuse is accompanied by severe mental depression but not, apparently, by serious physical withdrawal symptoms. Because of the possibility of complications such as malnutrition, pneumonia, and hepatitis, however, a physician should be consulted. Psychotherapy is often indicated.

What is *not* known about amphetamines?

How common is psychological dependence in therapeutic use? In non-therapeutic use?

Does physical dependence develop? If so, what is its extent and nature?

How are people under medical treatment with amphetamines affected by other drugs in various quantities — e.g. marihuana, LSD, alcohol, antihistamines, anesthetics? *How are chronic large-dose users of amphetamines affected* by these other drugs?

Does chronic large-dose use, especially by needle, involve long-term hazards other than those listed above?

Who abuses amphetamines? Why?

Some people who have been treated with amphetamines for weight reduction or other reasons. Some have taken doses heavier than prescribed; others have become dependent after prolonged use.

Some people who began by using amphetamines to improve or sustain performance — e.g. athletes, pilots, soldiers, truckers, students, housewives, entertainers, executives.

Some users of other drugs (e.g. heroin) who switch to amphetamines when cut off from their usual supplies.

People who use amphetamines, alone or in combination with LSD, marihuana, or some other drug, to produce perceptual alterations and/or euphoria. These people are usually under 30 and are often members of a drug-oriented group.

In many of the above cases, abuse begins when medical use gets out of hand. In other instances, a person's initial contact with the drug may occur in association with other drug-oriented persons who urge him to experiment with it. Frequently, an amphetamine abuse problem is related to some basic emotional difficulty from which the user gets relief through using the drug. Once the pattern is established, it may be perpetuated, at least in part, by a desire to banish ensuing depressions.

Amphetamines and the law

It is against the law to traffic in amphetamines or substances so represented, or to possess them for the purpose of trafficking. Trafficking includes manufacturing, selling, importing, and delivering without proper authorization. Trafficking or possession for the purpose of trafficking can result in a sentence of up to 18 months on summary conviction, up to 10 years on indictment. Even if sentence is suspended, a convicted person will carry a criminal record.

FACTS ABOUT

cannabis (MARIHUANA, HASHISH, ETC.)

What is known about cannabis?

Marihuana and hashish are obtained from the plant Cannabis, whose name comes from the Greek word *kannabis,* meaning hemp.

APPEARANCE: Marihuana is composed of the flowering tops and upper leaves of the female hemp plant. Hashish is obtained from the resinous material exuded by these tops and leaves.

Marihuana ranges in color from greyish green to greenish brown and in texture from a coarse substance that looks like oregano to a fine substance that looks like coarse pepper. Seeds and pieces of stem may be found.

Hashish is sold in solid-looking cakes or blocks. Its color ranges from light brown through medium brown to nearly black. Its texture varies from crumbly to hard.

The smoke of marihuana or hashish smells a little like burning leaves or rope.

ACTIVE INGREDIENTS: The active ingredients are a group of substances called cannabinoids. The characteristic action apparently is due mainly to a group of these called tetrahydrocannabinols (THCs), of which Delta 1 seems the most active. Pure THCs of a naturally occurring type have only recently been synthesized. Hashish contains a higher proportion of cannabinoids than marihuana, and this is presumably why it is more potent than marihuana.

METHODS OF USING: Marihuana is usually smoked in hand-rolled cigarettes. These are thinner than ordinary cigarettes and have twisted or folded ends. Marihuana can also be smoked in a pipe or brewed into a tea.

Hashish is generally smoked in a pipe or placed on the burning tip of a tobacco cigarette and the smoke inhaled through a tube.

Both marihuana and hashish can be consumed in cooked foods.

SHORT-TERM EFFECTS: These depend on the user, the dose, and the setting. The most common effects are a feeling that tiredness has vanished, a sense of exhilaration, feelings of perceptiveness and self-confidence, talkativeness, outbursts of laughter. With heavier doses, there is generally some perceptual distortion and even hallucinations (the latter with high doses). Appetite is often stimulated, and there may be rapid beating of the heart and reddening of the eyes.

Inexperienced users generally report fewer and less intense effects. However, such users sometimes have panic reactions, particularly if they are apprehensive.

In the process of "coming down" from a high, a user may feel lethargic and sleepy. He may suffer from slight nervous irritability or a feeling of sluggishness the next day.

DURATION OF ACTION: This also depends on the user, the dose, and the setting. One marihuana cigarette, for instance, may affect the user for one to several hours.

HAZARDS: Many users of marihuana also use other drugs, particularly stimulants and hallucinogens, in doses or ways that could result in serious physical or psychiatric damage. In a 1968 study of 350 Toronto marihuana smokers who volunteered for the project or were referred by the courts, three out of four had had some experience with these other drugs.

Another danger is that users may retreat into chronic Cannabis use in order

to avoid having to cope with everyday problems.

What is *not* known about cannabis?

Some researchers believe that long-term use of Cannabis may result in psychic dependence, chronic lethargy and (when smoked) lung damage. It is not certain, however, what proportion of any large group of users will suffer such consequences. It is also not clear whether the damage seen in some countries is due to the use of Cannabis or to the type of life with which it is associated.

Although it is known that many marihuana users also use other drugs, there is no reliable information about the proportion of all marihuana users who do so. It is also not certain which drug is most often used first.

Cannabis users state that different batches of marihuana and hashish produce varying degrees of intoxication and different kinds of effects. To what extent is this psychologically caused, to what extent chemically? Assuming chemical differences are involved, are these, in any individual batch, mainly the result of growing climate, methods of preparation, or storage conditions, or of contamination by other drugs?

Does use of Cannabis interfere with short-term memory? If so, is this because it lessens ability to concentrate when receiving new stimuli from outside? If there is this type of interference, what effect would it have on the learning process?

What effect does Cannabis have on driving? Although there has been one widely publicized study purporting to show that a marihuana-intoxicated driver is much less of a highway hazard than a driver intoxicated with alcohol, this study did not eliminate the possibility of bias among subjects. Also, it is clear that quantities of marihuana and alcohol used were not equivalent. There is a need for more research on marihuana and driving.

Who uses cannabis? Why?

In Canada and the United States, Cannabis appears to be in more common use among young people (especially those who are members of drug-oriented groups) than among people over 30. There are persistent reports of Cannabis use among business and professional people in older age groups; however, there are no statistics on this. Most reports and surveys about Cannabis use fail to distinguish occasional from regular users.

Marihuana is often used in groups — especially by beginning smokers. It appears that becoming a member of such a group is a prime motivation for many.

In a 1968 study of 6,447 students in Metropolitan Toronto intermediate grades and high schools, 6.7 per cent reported using marihuana at least once in the preceding six months.

In other parts of the world, Cannabis has been widely used among some segments of the population as a social drug.

Cannabis and the law

Except under authorization of the Minister of National Health and Welfare, possession of marihuana or hashish is an offence under the federal Narcotic Control Act. Cultivation of the marihuana plant is also such an offence.

(*Possession* covers much more than having a drug in one's possession. It also means (1) knowingly having it in the custody of *another person,* (2) keeping it in any place, and (3) *being part of a group* in which one is aware of and consents to the possession of a drug by another person.)

Importing, exporting, and trafficking in marihuana or hashish are also forbidden. (*Trafficking* includes selling, giving, sending, transporting, and distributing.) Possession for the purposes of trafficking is also an offence.

Making a genuine offer to traffic is an offence, as is trafficking in any substance represented to be marihuana or hashish.

Unlawful possession or cultivation can result in a prison sentence of up to seven years.

Under new legislation which came into effect recently, persons accused of possession of drugs covered by the Narcotic Control Act may be prosecuted in one of two ways: by way of indictment or by way of summary procedure. On summary conviction, maximum sentences are somewhat less severe than on conviction by way of indictment, the only procedure formerly allowed. (Where a person is accused of possession *for the purpose of trafficking,* however, prosecutors must in all cases proceed by way of indictment.)

Importing or exporting marihuana or hashish calls for a *minimum sentence of seven years.* The maximum is life imprisonment.

Trafficking in marihuana or hashish, or possession for the purpose of trafficking, can result in sentences of up to life imprisonment.

Even if sentence is suspended, a convicted person will carry a criminal record.

FACTS ABOUT

lsd

What is known about lsd?

Lysergic acid diethylamide is usually referred to as LSD (from the German *l*ysergsaure *d*iathylamid) or acid.

APPEARANCE: LSD is a white, odorless, tasteless powder.

ACTIVE INGREDIENT: LSD is a synthetic chemical produced from a substance found in a fungus (ergot) that grows on rye.

METHODS OF USING: LSD is usually taken in the form of a tablet, a capsule, or an impregnated sheet of blotting paper.

SHORT-TERM EFFECTS: These depend on the user, the dose, and the setting. The user's mood, expectations, and previous experience with LSD may also influence the effects.

Users report many visual effects such as perceiving intensified colors, distorted shapes and sizes, and movement in stationary objects. Auditory distortions also occur, as do distortions of time and place, and there is sometimes difficulty in hearing.

Other physical effects reported are slight tremors, numbness, tingling, chills, nausea, and weakness. Cold, sweaty palms, goosepimpled skin, loss of appetite, and hyperventilation (taking in too much oxygen) are also common. Heart beat, blood pressure, and temperature are elevated and pupils are dilated.

Emotional reactions to these symptoms are varied. Feelings of heightened self-awareness are reported, as are mystical and ecstatic experiences. Some users say they feel dissociated from their bodies. Less pleasant reactions such as depression, tearfulness, dizziness, or disorientation may be experienced.

The same user may have both "good trips" and "bad trips" on different occasions. Sometimes there may be both pleasant and unpleasant experiences within the same trip.

It appears that some people find the effects of LSD mainly pleasurable because these effects are novel and intriguing, and because they give rise to unusual experiences. Others may be disturbed and experience more of the negative emotional effects.

DURATION OF ACTION: This depends on the person and the dose. A "trip" may last from 2 to 10 hours. There may be recurrences ("return trips") days, weeks, or months later even if no more LSD is taken. Psychotic breakdowns have occurred (see Hazards), and these have occasionally lasted for months. Acute depression is also an occasional after-effect.

HAZARDS: These may include anxiety or panic while under the influence of the drug. Such experiences, or feelings of omnipotence, appear sometimes to lead to suicide, homicide, or other forms of anti-social behavior.

Convulsions, chronic anxiety, and (in unstable personalities) prolonged psychotic reactions have also been produced.

Also, a number of studies have suggested that there is damage to chromosomes (the transmitters of inherited characteristics) as a result of using LSD. (The full significance of this is not yet known. See below).

Laboratory analysis of illicit drugs by a group of Toronto scientists has shown some tablets and capsules to be LSD as claimed, while others variously contained relatively harmless, moderately dangerous, or extremely dangerous substances. Some contained no psychoactive ingredients at all.

TREATMENT: Users having "bad trips" need to be placed in a protected situation in which sensory stimulation is minimized. In severe cases, the best place is a hospital. Psychotherapy may be indicated.

What is *not* known about lsd

What is the proportion of "bad trips" among users who obtain LSD illicitly?

What is the specific action of LSD on the brain? While some aspects of its action are now understood, there is more to be learned.

Can the drug cause irreversible brain damage?

How does tolerance develop and dissipate? It appears that both development and dissipation are rapid, but more research is needed before definite conclusions can be drawn.

Why do hallucinations sometimes recur?

Can LSD damage unborn children if taken during pregnancy?

Can LSD cause abnormalities in unborn children if taken by a mother and/or by a father prior to pregnancy?

Can LSD cause leukemia by damaging blood cells of the user?

Is LSD valuable in psychotherapy and in the treatment of alcoholism and other forms of drug dependence?

Who uses lsd? Why?

Most non-medical users of LSD are people under 30, many of whom are members of drug-oriented groups.

Many report that a "good trip" removes anxiety and other psychological pain. "Trips" are therefore seen as a way of escaping pressures associated with day-to-day living.

However, many young people say they are not looking for escape. They maintain that they are seeking increased self-awareness, self-acceptance, and a deeper understanding of life through experiencing the visual and auditory hallucinations and other effects produced by LSD.

Seeking acceptance in an LSD-using group is sometimes also a reason for using the drug.

Lsd and the law

Under a new bill which has recently come into effect, *possession of LSD is illegal, as is trafficking and possession for the purpose of trafficking.* Trafficking includes manufacturing, importing or exporting, transporting or delivering, and selling.

Under this new legislation, persons accused of possession of LSD, trafficking in LSD or possession of LSD for the purpose of trafficking may be prosecuted in one of two ways: by summary procedure or by indictment. On conviction after indictment, the penalty for possession is up to three years in prison or a fine of up to $5,000, or both. The maximum penalty for trafficking or possession for the purpose of trafficking is ten years. Where summary procedure is used, the maximum penalties are somewhat less severe.

Even if sentence is suspended, a convicted person will carry a criminal record.

FACTS ABOUT

solvents

What is known about solvents?

Solvents commonly encountered as drugs of abuse include polystyrene cements (especially "airplane glue"), nail-polish remover, lighter fluid, cleaning fluids, anesthetics, and gasoline.

ACTIVE INGREDIENTS: The intoxicants in these substances include such volatile hydrocarbons as hexane, cyclohexane, benzene, and naphtha (all of petroleum origin), as well as acetone, ethylacetate, carbon tetrachloride, and toluene. The principal intoxicant in model airplane cement is toluene. (Some substances also contain alcohol.) The volatile hydrocarbons are lipid soluble — that is, they readily form solutions with fats but not with water.

METHODS OF USE: Users inhale fumes in as concentrated a form as possible, frequently by holding a bag or cloth containing a solvent over the face. Solvents are occasionally mixed with carbonated beverages for drinking.

SHORT-TERM EFFECTS: These can range from mild intoxication to exhilaration and disorientation. Within a few minutes, most sniffers experience confusion, slurred speech, dizziness, and euphoria (a sense of well-being). There will also be distortions of perception, visual and auditory hallucinations, and delusional ideas. As the concentration of an intoxicant in the brain cells increases, the user becomes drowsy and finally unconscious. Excessive nasal secretion, watering eyes, and poor muscular control also are symptoms of solvent use.

DURATION OF ACTION: This depends on the extent of inhalation and will usually range from five minutes to half an hour. However, a sniffer who remains with his supply and inhales from time to time may stay intoxicated for many hours.

COMPLICATIONS: Tolerance develops within the body, so that increasingly large amounts of a substance are required to attain the desired effect.

Symptoms of psychological dependence occur which include craving and habituation. Upon withdrawal, the user may experience restlessness, anxiety, and irritability.

Inhaling of solvents has been known to induce aggressive behavior — e.g., fighting and setting fires — and dangerous actions such as trying to fly from a roof. Explosions causing death have resulted from smoking and inhaling gasoline fumes at the same time.

Death has also occurred from suffocation when a user has lost consciousness with his head in a plastic bag or with a mass of hardening cement blocking his air passages.

What is *not* known about solvents?

How do solvents produce their effects on the human body? (Most researchers believe, however, that they have some effect on the structure and function of the fat components of cell membranes, including those of the nervous system.)

Does physical dependence occur?

Can users who are psychologically normal become psychologically dependent on solvents?

Is physical injury directly caused by sniffing and if so, is it lasting? Damage to kidneys, liver, blood cells, and chromosomes (the transmitters of inherited characteristics) has been suspected but not definitely established.

Does damage to chromosomes occur and, if so, is it related in any way to the development of diseases of the blood with which leukemia is occasionally associated?

Can damage to chromosomes, if it occurs, be passed on to offspring?

Will children who are solvent-sniffers tend, as they grow older, to move on to the use of other drugs?

Who abuses solvents? Why?

Solvents are abused mainly by children ranging in age from eight to sixteen, with the average age being about fourteen.

Such children tend to belong to one of three categories: those who have anti-social personalities, those who are troubled and depressed by circumstances at home or at school, or those who are relatively normal but who enjoy taking risks because they are bored and adventurous.

Many users are from poor socio-economic backgrounds and distorted or broken homes. However, some young people who are more fortunate also sniff solvents.

Solvent sniffers are usually seeking to reduce mental stress or to achieve feelings of well-being and new sensory experiences such as hallucinations.

Some sniffers, however, may engage in this activity in order to become accepted in a solvent-sniffing group.

There is more glue sniffing among boys than girls. According to a study conducted in 1968 in Grades 7, 9, 11, and 13 of Metropolitan Toronto schools by the Addiction Research Foundation, 7.4 per cent of the boys had sniffed glue at least once in the preceding six-month period, as compared with 4.2 per cent of the girls.

Solvents and the law

There is, at present, no specific legislation with regard to solvent sniffing. However, some glue sniffers have been held in some courts to be juvenile delinquents.

FACTS ABOUT

opiates

What is known about opiates?

Opium — from the Greek word *opion,* meaning poppy juice, is an analgesic (pain reliever) which is obtained from the oriental poppy, *Papaver somniferum.* Opium and its products (such as morphine and codeine) and its derivatives (such as heroin and dilaudid) form the group of drugs called *opiates.*

The opiates are highly effective in the treatment of short-term acute pain such as that resulting from surgery, fractures, or burns and that occurring in the later stages of terminal illnesses such as cancer.

Drugs such as meperidine (Demerol) and methadone are synthetic pain relievers — also very effective — that were introduced in the hope that they would be non-addictive. They are, however, just as habit-forming as the opiates and are similarly capable of producing tolerance and physical dependence.

APPEARANCE: The opiates are powders of several different colors. They are usually seen in the form of capsules or tablets. They are also available in syrups, ampoules, suppositories, or elixirs.

ACTIVE INGREDIENTS: The pharmacologically active constituents of opium are alkaloids. There are over twenty of these, but only two — morphine and codeine — are in widespread clinical use. (The synthetics meperidine and methadone are also widely used in medicine.)

METHODS OF USING: Opium may be eaten or smoked. The opiates are usually injected but may be sniffed or taken orally or rectally.

TYPE OF ACTION: Opiates briefly stimulate the higher centres of the brain, then depress activity of the central nervous system. As the dose is increased, respiratory depression becomes progressively more marked; death may occur from respiratory paralysis.

The experience of pain involves two distinct aspects: there is the original sensation of pain and there is the reaction to that pain. Used as analgesics, the opiates do not appear to reduce a patient's perception of pain but rather to alter his reaction to it.

SHORT-TERM EFFECTS: A therapeutic dose of an opiate, used for relief from pain, produces a state of contentment, detachment from concern, and freedom from distressing emotion. If the same dose is taken in the absence of pain, the person may suffer from restlessness and discomfort. A larger dose will cause euphoria (a heightened sense of well-being). Sometimes nausea and vomiting also occur. With moderately high doses, mental and physical activity is impaired, the body feels warm, the extremities heavy, and the mouth dry. Sleep soon follows. In very large doses the person cannot be roused, his pupils are contracted to pinpoints, and his skin is cold, moist, and bluish. Other effects include flaccid skeletal muscles, shallow breathing, falling blood pressure, and shock; there is also some danger that the tongue may fall backward and block the airway.

DURATION OF ACTION: This depends on the opiate used, the amount taken, and the degree of established tolerance and dependence of the individual. A therapeutic dose lasts about three to four hours.

HAZARDS: Risks of frequent and heavy use of opiates include constipation, loss of appetite, serious loss of weight, and malnutrition. Hepatitis, tetanus, and other infections often occur as a result of using unsterilized needles. Also as a result of the use of unsterilized needles, abscesses develop. The walls of the veins break down from repeated puncturing. Permanent scar tissue is formed.

The opiates induce physical and psychological dependence with unusual rapidity. Tolerance builds up rapidly — larger doses are required to produce the same effect. Withdrawal from these drugs after large amounts have been taken causes severe physical reactions. Some of the withdrawal symptoms are nervousness, anxiety, sleeplessness, running nose and eyes, sweating, enlargement of the pupils, muscle twitching, severe aches of the back and legs, hot and cold flashes, vomiting and diarrhea, and increased breathing rate, blood pressure, and temperature. Abrupt and complete withdrawal occasionally results in death.

Opiates induce psychological dependence that is very hard to treat. People who have been withdrawn from physical dependence on an in-patient basis typically become addicted once again as soon as they return to an environment similar to the one in which dependence developed. There is, however, a tendency to stop taking opiates as dependent persons grow older.

Another hazard is criminality. As tolerance increases, more of the drug (most often heroin) is needed to avoid withdrawal symptoms. To support the cost of the habit, it is usually necessary to turn to theft or prostitution.

Accidental deaths occur when users misjudge dosages. Because people who sell opiates on the illegal market typically "cut" the drug with some other substance to increase the bulk, it is hard for users to judge dosages accurately, and accidental overdoses — sometimes lethal — are not unknown.

TREATMENT: Medical treatment is indicated for severe withdrawal states and for addiction-related illnesses. Methods of treating opiate dependence itself have included imprisonment, hospitalization, out-patient programs, programs in communities of former addicts such as Synanon and Daytop, and individualized treatment methods such as the methadone maintenance program in which another narcotic is substituted which does not prevent the addict from leading a normal life. Although some of these methods appear more promising than others, there seems to be no one treatment which is appropriate for all patients.

What is *not* known about opiates?

Which method of treatment is most effective for a particular patient? Opiate dependence appears to be so individual that the results of specific treatment methods cannot be predicted with much accuracy.

Who uses opiates? Why?

Persons dependent on opiates and synthetic analgesics are often grouped in three main categories: "medical," "professional," and "criminal" or "street."

The "medical" addict is a person who has some medical condition on which addiction has been superimposed, or who became addicted through medical treatment.

The "professional" addict is an opiate-dependent person who is a member of the medical profession or a

related profession: some pharmacists, nurses, and veterinarians are included in this group.

The "street" or "criminal" addict category includes people who are known to have a criminal background or associations, even though they may have no criminal record. The Department of National Health and Welfare reports that in 1968 there were 3,459 of these addicts in Canada, as compared with 200 medical and 145 professional addicts.

Most "street" addicts begin using opiates for the extremely pleasurable "high" or for escape from problems, especially those produced by oppressive social conditions, or for both reasons. People continue using opiates in order to avoid the extremely unpleasant symptoms of withdrawal.

Opiates and the law

Except under authorization of the Minister of National Health and Welfare, possession of opiates (except for restricted amounts of codeine) is an offence under the federal Narcotic Control Act. Cultivation of the opium poppy is also such an offence. Hospitals, physicians, and pharmacists and veterinarians are permitted to keep supplies of opiates. Patients may obtain them only on prescription. (Heroin, however, is no longer imported into Canada, even for use in medical practice.)

In Canada, tablets containing not more than one-eighth grain of codeine phosphate and liquids containing not more than one-third grain of codeine phosphate per fluid ounce may be sold legally without a prescription if they contain at least two other medicinal ingredients in certain quantities and if they are clearly labelled in a particular way as containing codeine.

Trafficking in opiates is forbidden. (*Trafficking* includes selling, giving, sending, transporting, and distributing.) Possession for the purpose of trafficking is also an offence. Except with proper authorization, importing and exporting are illegal.

Unlawful possession or cultivation can result in a prison sentence of up to seven years.

Importing or exporting opiates without proper authorization calls for a *minimum sentence of seven years.* The maximum is life imprisonment.

Trafficking in opiates, or possession for the purpose of trafficking, can result in sentences up to life imprisonment.

The Health Service does not endorse or even agree with all of the ideas presented below, but consider this literature representative and useful to know.

Literature of interest for further reading:

PREVENTION OF NARCOTICS ADDICTION AND SUBSTANCE ABUSE; Bd. of Ed. of the City of N.Y., Curriculum Bulletin 1966-67 Series No. 16

SMOKING AND HEALTH, A report of the Royal College of Physicians on smoking in relation to cancer of the lung and other diseases; McClelland & Stewart

DRUG ABUSE: ESCAPE TO NOWHERE; Published by Smith Kline & French Laboratories, Philadelphia, in co-operation with the Am. Assoc. for Health, Physical Education & Recreation, a department of the National Education Assoc.

DRUGS ON THE COLLEGE CAMPUS; Helen H. Nowlis, Ph.D., NASPA

ALCOHOL AND COLLEGE YOUTH; National Institute of Mental Health

LOYOLA CONFERENCE ON STUDENT USE AND ABUSE OF DRUGS; a professional programme of Canadian Student Affairs Association

UTOPIATES; Blum Richard Hosmer & Assoc., Atherton Press 1964

PSYCHEDELICS & THE COLLEGE STUDENT; Student Committee on Mental Health, Princeton University

THE FACT SHEETS IN THIS BOOKLET WERE ORIGINALLY PUBLISHED BY THE EDUCATION DIVISION OF THE

ADDICTION RESEARCH FOUNDATION

An Agency of the Province of Ontario.

Note: All drug legislation is currently being reviewed by The Commission of Inquiry into the Non-medical Use of Drugs.

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THE NURSES ARE COMING
THE NURSES ARE COMING !

AREN'T YOU ?

C.U.S.

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PSI U HOUSE

3429 PEEL ST.

8:30 P.M.

(MONTREAL GENERAL
NURSES WILL BE
THERE !)

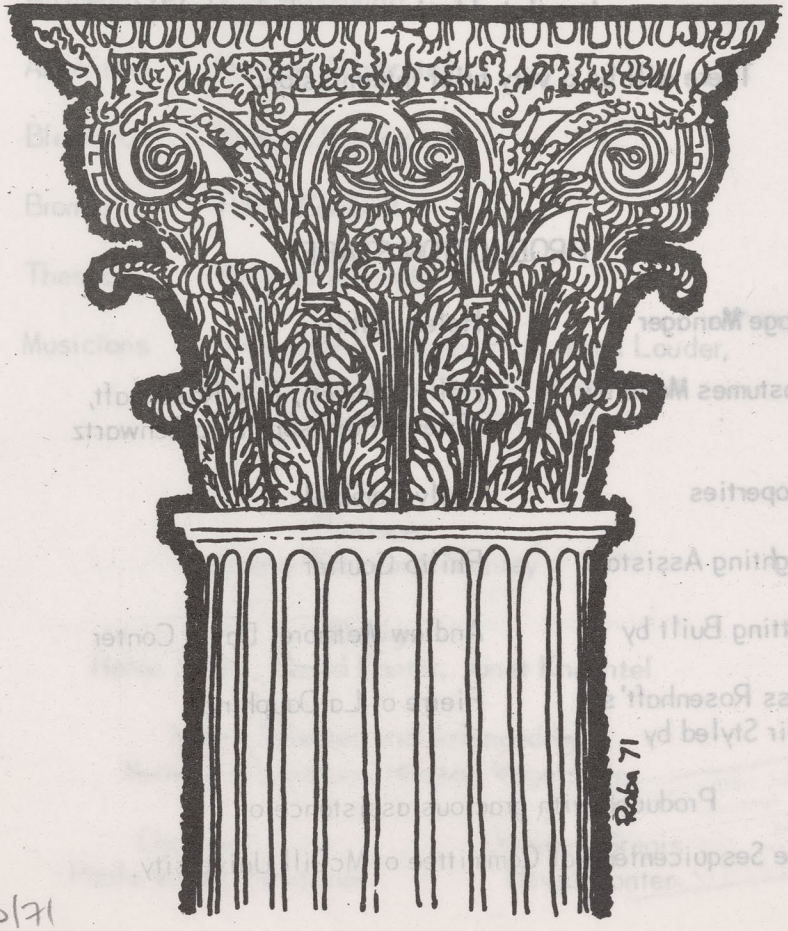
10¢ Beer

Band.

Plautus' AMPHITRUO

Amore captus Alcumenas Iuppiter
Mutavit sese in formam eius coniugis,
Pro patria Amphitruo dum decernit cum hostibus.
Habitu Mercurius ei subservit Sosiae.
Is advenientis servum ac dominum frustra habet.
Turbas uxori ciet Amphitruo, atque invicem
Raptant pro moechis. Blepharo captus arbiter
Uter sit non quit Amphitruo decernere.
Omnem rem noscunt. geminos illa enititur.

McGILL UNIVERSITY DEPARTMENT OF CLASSICS



17 feb 71

"Now, **Gallants**, I shall tell ye the Argument of this **Tragedy**.-- Why that Frown now?-- Is't because I call it a **Tragedy**? Why I'm a God; I'll transform it, if ye please, out of **Tragedy** into **Comedy**, and ne'er alter a Verse. Are ye willing or not? But what a blockheadedly Question was that for a Deity to ask, as tho' he cou'd be ignorant of your pleasures? I know your Minds to a tittle, and I'll make it a Hodg-podg, a **Tragi-Comedy**; for there's no reason to have it all **Comedy**, when Kings and Gods are Actors in it. But how shall we do, now a Slave has the principal Part? Why as I told you before, it shall be a **Tragi-Comedy**!"

Prologue, Plautus' **Amphitruo,**
translated by Laurence Echard, 1716

There will be a very brief intermission.

PRODUCTION STAFF

Stage Manager	Helen Saibil
Costumes Made by	Holly Cambell, Eve Rosenhaft, Valerie Patteson, Ella Schwartz
Properties	Holly Cambell
Lighting Assistant	Philip Coulter
Setting Built by	Andrew Wetmore, David Conter
Miss Rosenhaft's Hair Styled by	Pierre of La Dauphine

Produced with gracious assistance of

The Sesquicentennial Committee of McGill University.

Plautus

AMPHITRUO

Newly translated by the class of Classics 316 and performed by members of the class.

(The text for the lines missing after l. 1034 has been taken from Laurence Echard's translation of the **Amphitruo** published in 1716.)

Mercury	Simon Cuttler
Sosia	David Conter
Jupiter	Jeremy Wentworth-Stanley
Alcmena	Eve Rosenhaft
Amphitruo	Michael Silverstein
Blepharo	Stanley Lipsey
Bromia	Holly Cambell
Thessala	Brigitte Albrecht
Musicians	Judy Cohen, Harvey Fink, Fred Louder, Adrian de Vries, Herman Vogelstein, David Weigans, and Sherry Flett

Producer
Jeremy Wentworth-Stanley

Design
Helen Saibil, David Conter, Janet Knechtel

Music Selected and Arranged by
Micheal Silverstein, Herman Vogelstein

Choragus
Paola Valeri Tomaszuk

Dominus Gregis
David Conter

We gratefully acknowledge the co-operation of
the McGill Players' Club
and everyone else who assisted us in this production

EAST PAKISTAN RELIEF FUND

MCGILL UNIVERSITY CENTER. 3480 MCTAVISH STREET. MONTREAL 110.
TEL. (514) 843-8894, 845-6484.

November 20, 1970.

As you know, the people of the coastal areas of East Pakistan have recently suffered from one of the biggest tragedies of the century: estimated one million dead, several millions homeless, starvation, epidemics. The New York Times called the disaster "more harrowing than Hiroshima and Nagashaki".

The goverment of Pakistan, the Secretary General of the United Nations, the International Red Cross and other organizations have appealed to the conscience of mankind to come to the aid of the survivors.

As a part of this global effort to mobilize material help a committee has been formed in Montreal to collect money, medicine, clothings and food.

All cheques or money orders should be made out to:

EAST PAKISTAN RELIEF FUND
3480 McTavish Street, Room No. 416
Montreal 110, P.Q.

The Canadian Red Cross will issue official receipts for all monetary donations.

ALL CONTRIBUTIONS ARE TAX DEDUCTIBLE.

The committee hopes that you and your friends will be generous.

Yours truly,

Saeed Mirza

Saeed Mirza
Chairman

P.S. The committee also needs volunteers to collect donations, clothings, and medicine, etc., from various parts of the city.