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- CHALLENGE -

Mural by James A. Padgett
Howard University Art Department
Community Mural Program
Site: Freedmen's Hospital
Washington, D.C.

Donald Byrd
"Black Music and Drugs"

Jesse Barber
"Psycho-Surgery"
The nomadic tribes of Africa would remain in settled areas for only as long as the harvest was adequate for family and livestock—without exhausting the soil’s potential. The Elders’ wisdom allowed them to predict when the time to relocate was necessary. In their infinite wisdom they would send out young warriors and a few elders to seek and select a new site. When such a place was found the young warriors and elders would build a new village and prepare for the arrival of the families. The elders sent a warrior back to the prior tribal site to carry a message to those who remained behind, the message was DOMIABRA (Dōm-ē-â-brâ), which means “IF YOU LOVE ME, JOIN ME.”

The Philosophy of The Institute on Drug Abuse and Addiction

The Howard University Institute on Drug Abuse and Addiction believes that narcotics are a political tool of white racism and white supremacy. We believe that narcotic usage is a form of self-destructive behavior and a serious threat to the future of our black children. Furthermore, narcotics usage disrespects and affronts the sufferings, sacrifices, and deaths of black people for our liberation. The Institute believes that the interests of black people are best served by increasing self-knowledge, scientific and technological skills, self-help programs, and resisting injustice. Thus, the Institute is dedicated to the building of a drug-free society in the tradition of our black heritage and culture, and in the spirit of Domiabra.

CHALLENGE

The mural “CHALLENGE”, on the cover of DOMIABRA was created by Brother James Padgett. Brother Padgett, a candidate for the Master’s Degree in the Howard University Art Department, is the recipient of many awards and a member of the Howard University Mural Project Committee. Among his many works, Brother Padgett has contributed murals to the auditorium lobby of the Howard University School of Social Work at the Wall of the Shaw Community Health Center. “Challenge” will be placed in the lobby of the Annex Building I, Freedmen’s Hospital. The Howard University Institute on Drug Abuse and Addiction would like to thank the Artist, James Arthur Padgett, and Artist/Professor, Jeff Donaldson, chairman of the Howard University Art Department, for their cooperation.

A TRIBUTE TO AMILCAR CABRAL

On January 20, 1973, Dr. Amilcar Cabral, Secretary-General of the PAIGC (African Party for the Independence of Guinea and Cape Verde) was brutally assassinated at his exiled home in Conakry, Guinea. Dr. Cabral, an agronomist born 48 years ago in the Cape Verde Islands, launched the PAIGC movement for liberation in 1956 which today 7000 strong controls one-half to three-quarters of Guinea-Bissau against 25,000 to 30,000 Portuguese troops.

In liberated areas of Guinea-Bissau, Cabral and PAIGC created more than 200 primary schools along with four hospitals and 200 clinics. In ten years Cabral did more in health and education for his fellow Africans than the Portuguese did in 400 years of colonial and neo-colonial rule.

THIS ISSUE OF DOMIABRA IS DEDICATED TO THE WORK AND MEMORY OF AMILCAR CABRAL . . . IN TRIBUTE, LET US REFLECT ON A FEW OF HIS MANY TEACHINGS:

“Always bear in mind that people are not fighting for ideas, for the things in anyone’s head. They are fighting to win material benefits, to live better and in Peace, to see their lives go forward, to guarantee the future of their children.”

“... Every responsible member must have the courage of his responsibilities, exacting from others a proper respect for his work and properly respecting the work of others. Hide nothing from the masses of people. Tell no lies. Expose lies whenever they are told. Mask no difficulties, mistakes, failures. Claim no early victories.”

“The struggle against our own weakness... Our experience has shown us that in the general framework of daily struggle this battle against ourselves—no matter what difficulties the enemies may create—is the most difficult of all.”

Amilcar Cabral—Revolution in Guinea

A WONDER

Will the life story of this no-drugs and real African hero, Amilcar Cabral, ever be the subject of an independent Black movie grossing 12 to 30 million dollars from the Black community?
“HEROIN OVERDOSE”

Risks associated with drug usage are many. They may be grouped into: those which have a deleterious physiological effect on the body; those which result from impurities in compounding of the drug; those which result from contaminated “equipment”; and those which are poorly understood. The withdrawal syndrome, hypersensitivities, infections, hepatitis, endocarditis and sudden death following intravenous injections of drugs are some of the recognized risks associated with drug usage.

Death from “heroin overdose” is the most publicized hazard described in heroin addicts. The mechanism for sudden death in these people is poorly understood. For all intents and purposes, the term “O.D.” is a misnomer. Basically, deaths attributed to heroin overdose are not actually due to overdose at all. Data, derived from experimental animals and humans, indicate that the concept of sudden death from heroin overdose is not factual.

It is the exception, rather than the rule, for a person to die suddenly from an overdose of heroin or morphine. Usually death ensues hours or even days after an overdose of medication. The amounts of these drugs required to kill a non addict have been estimated to range from 120 mg. to as much as 350 mg. Literature indicates that addicts have survived even larger doses than those stated above.

Kolb and Mez. of the United States Public Health Service, showed experimentally that 7 to 8 mg., per kg. of body weight, of heroin or morphine are required to kill non addicted monkeys (when injected by vein). Relating this to humans, it would require 500 mg. or more of heroin to kill a non addicted adult. Basing this on street sales of heroin, it would require 50 bags of heroin (N.Y. type), injected in one dose, to kill.

One should also consider that virtually all “O.D.’s” are addicts. It must be assumed that they have developed a high tolerance to the drug and that enormous doses of the narcotic are needed to kill. Experimentally, some addicts have received doses of morphine in the range of 1800 mg., over a 2½ hour period, without becoming ill.

To date, there are no conclusive data to show that deaths, attributed to “O.D.”, are in fact, so caused. Carefully performed autopsies are necessary to prove a cause and effect relationship. Reviews of the American literature fail to show an acceptable scientific method which conclusively implicates heroin overdose. Usually the alkaloid is present in the blood, and tissues. However there are no pathognomonic tissue changes associated with heroin overdose.

What causes death in so called, “heroin overdose”? Usually the victim has taken the same amount of the drue that he has taken previously, however on this occasion, he dies shortly after the administration of the drug. At autopsy, one usually finds varying degrees of pulmonary edema. Some scientists have speculated that materials used to cut the heroin, such as quinine, may be instrumental in causing death. Some investigators have suggested that the victim may have already taken barbiturates or alcohol. Therefore, the combination of the narcotic and cerebral depressant may be lethal. Generally, however, it is known that most addicts do not drink alcohol and then “shoot” heroin.

In summary, the mystery surrounding death in the “heroin overdose” patient is still unsolved. Evidence suggests that the term “heroin overdose” is a misnomer and should be discarded or used in light of present day understanding.

Dr. Calvin Sampson
Professor of Pathology
Howard University

HAIL TO MRS. HALE

Mrs. Clara Hale, a widowed mother with three children who started a home for infants of working and unwed mothers 33 years ago and now maintains a home for drug-addicted babies, was honored by Harlem citizens and New York City officials.

Standing outside the new home of Mrs. Hale, “Hale House,” at 154 West 22nd Street (a five story brownstone being renovated to accommodate children born addicted to drugs) some 75 people paid homage to Mrs. Hale for raising 43 disadvantaged youngsters, all of whom became college graduates.

Mrs. Hale was given a city proclamation and declared a Clara Hale Day.


BLACK CONTRADICTION

Black Afro-Shops which display the posters of The Honorable Elijah Muhammad, Amilcar Cabral, Marcus Garvey, Kwame Nkrumah, Patrice Lumumba, Malcolm X, Martin Luther King and other Black leaders along with hashish pipes, roller paper and machines, snorting spoons, roach clips, should examine the implied contradiction.
REPRESENTATIVE CHARLES RANGEL (DEMO, N.Y.) CHARGES FEDERAL DRUG AGENCIES WITH NEGLECT

Fifty-two percent of the nation’s drug addicts are members of minority groups, and as always, most federal agencies which administer drug-abuse programs have few Blacks or other minority-group members in top decision making positions.

Specifically, the Special Action Office for Drug Abuse Prevention (SAODAP), the most important policy-making agency for federal drug programs, lacks minority representation in its top 15 policy making positions.

Only eight Blacks and two Spanish Americans, out of a total staff of 149 persons, are employed by the Division of Narcotic Addiction and Drug Abuse of a broad range of drug abuse programs.

In the United States Justice Dept’s Bureau of Narcotics and Dangerous Drugs the deficient representation is of 2,299 persons employed, only 196 (8.5) percent are Black.

(Jet Magazine, February, 1973)

POLITICAL USE OF DOPE DURING WORLD WAR II

In a book published about the Office of Strategic Services, predecessor of the CIA, “The OSS in W.W.II,” author Edward Haymott writes that “OSS agents parachuted into Burma with silver coins and opium to pay anti-Japanese Kachin irregulars.” If there were any moral considerations, they were overcome by the realities of war and military operations.

(Jack Anderson, N.Y. Post, 11-2-72)

NATE ARCHIBALD - SCORING AND ASSIST LEADER IN THE NATIONAL BASKETBALL ASSOCIATION (NBA)

Nat (Tiny) Archibald led the NBA in scoring with a 34-point average and in assists with an average of more than 11 a game. In the programs, he is listed at 6 feet 1 and 160 pounds, but he appears smaller.

He grew up in the Bronx, on 143rd Street off Morris Avenue, and in the off-season he returns there. But he’s not there to flash his money and his fame. He’s there to work with the kids, to save them from the streets that he was saved from by basketball.

“In the streets, everybody is offering a high to you,” he was saying the other night at Madison Square Garden after a game. “The cat’ll say, ‘You my man,’ and he wants you to get high for old times’ sake.”

Too many kids went along for old times’ sake. He remembers one who was on the Clinton High School basketball team, a 6-7 leaper with about 75 scholarship offers, who hung around with the wrong people. It not only ended his basketball career; it killed him.

“He overdosed right there on the court, man,” Archibald remembered. “He died right there on the court.” With that memory, Nate Archibald coaches four playground teams in the summer basketball leagues.

“I give ‘em hell. I was raised on strict coaches,” he said. “But you can’t jive the kids. You can’t tell ‘em one thing and do another. Some guys try that. They tell the kids to be straight, but later the kids see him outside, drinking wine and smoking a joint. And the next time that man comes around, you can hear the kids saying, “Wish he would hurry up and cut this, because I see him do it.” There’s a demand for athletes to do all they can for the kids because the kids will listen to them if they don’t jive ‘em. But not enough athletes do anything. Most of them just don’t give a damn. Drugs are everywhere. It’s not just New York. I see ‘em in every city we go to. You go to the bottom, it’s there.” Six of his players now are in college on basketball scholarships.

(Washington Star, 12-9-72)
INTERVIEW WITH
DONALD BYRD,
BLACK MUSIC MASTER,
FOUNDER AND CHAIRMAN,
INSTITUTE ON JAZZ STUDIES, HOWARD UNIVERSITY

“I DIDN’T WANT NOTHING THAT WAS SO GOOD IT WOULD MAKE YOU KILL YOUR MAMA.”

Q. Were drugs prevalent during the early phases of your musical career?

A. Yes, there used to be a Big Band bus where alcohol users sat up front, moderate drug users sat in the middle, and heavy using cats shot-up in the back. Using dope was considered “hip”; a very good friend of mine was fond of the expression, “I did my bit.” If you hadn’t used s . . . t, or gone to jail or been to the crazy house you weren’t considered “hip”. At one time everybody was in Lexington (a major Federal drug rehabilitation prison); it was considered “hip” to be there. You could have given out all the Downbeat Awards in Lexington.

Q. Who supplied the musicians with dope?

A. A variety of sources like other musicians and certain white hangers-on, booking agents (white and Black) and record companies. When the record companies started supplying musicians with dope some white owners of companies got strung out, they were in turn influenced by certain musicians. Club owners also supplied and reinforced experiences with dope. This has happened in a very recent example. When musicians bought dope from club owners they wouldn’t have any money at the end of the week.

Q. What were the trends concerning drug use among Black musicians in the ’50’s and the ’60’s?

A. In the mid ’50’s everybody started cleaning up with the Brooks Brothers looks and the Ivy League hair cut. The MJQ (Modern Jazz Quartet) style was in vogue. Our group, the Jazz Messengers, wore similar suits; it was the thing. Anybody using drugs was looked down on. Miles Davis was the style setter, with his four button suits, the olive drab suit, etc. The look of business people, that was the thing. For a long time hardly anybody was using drugs except for one band. It stayed like that until a few years ago, 1968-1969. In 1958, “cats” went into a health bag. and spiritually the Islamic thing and an African thing. Trane was using nuts, birdseed and sunflower seed. Eric Dolphy died from an overdose of honey. All of this was incompatible with drug use. Trane (John Coltrane) is an example of a musician who kicked drugs and went into his most creative periods; Sonny Rollins and Miles Davis also. Rollins came out of jail in 1955 and joined with Clifford Brown and Max Roach.

Q. When did you first encounter the drug scene?

A. My first contact with drugs was in high school in 1947. All my peers emulated “Bird” and “Be-bop” figures of the ’40’s.

Q. How did you manage to stay free of drugs among fellow musicians who were users?
A. They knew I never messed around. I was one of the few in the crowd who never used. It was hard to get along unless you used stuff. "Cats" didn’t accept people if you didn’t. You wouldn’t be a part of the thing, it was a social thing. Yet, I was able to get along. They respected my ability to play. As a leader, I could hold some musical groups together. One time a group of “cats” overpowered me and held me down on the floor while trying to force me to use drugs. I talked them out of it.

Q. What stopped you from using dope?

A. I didn’t dig needles, didn’t want to get sick, scared of getting caught, didn’t want to go through the hassle. If it was legal I might have gotten into it, but didn’t like the idea of hustling to cop and hanging out in filthy places. I DIDN’T LIKE THE IDEA OF O.D.-ING. I DIDN’T WANT NOTHING THAT WAS SO GOOD IT WOULD MAKE YOU KILL YOUR MAMA.

Q. DOMIABRA discourages marijuana use, what is your feeling about reefer smoking?

A. Reefer. Somebody, one of these days, will publicize the truth. They say the drug is addictive. Ain’t nothing wrong with smoking reefer outside of getting caught. I don’t dig alcohol. If I had my choice, I rather smoke than drink. Drinking is out. It damages brain cells, messes with kidneys and liver, etc. Alcohol went out in the ’30’s among Jazz Musicians. Alcoholism and homosexuality are two things you don’t find among Black jazz musicians. I don’t dig playing and being high. Frankly, I been so busy that I don’t have time to relax. All drugs tend to make you relax. When the man relaxes, then I’ll relax.

Q. What’s going on at present with drugs and Black music?

A. Right now, dope use in Black music is at an all time low. Times are hard. Musicians ain’t got no money to do nothing, probably not enough money to get involved to become strung out. “Cats” are moving into academia and business like attitudes, rewards on a high level. The leaders of the music are not into dope. Those who are out there are too busy making money. Among musicians, the thing is to make as much money as you can. They’re at a survival level. That’s the reason cats are playing rock music. Its economics. The number of clubs, record companies, concerts, and gigs have diminished where booking agents and Black Jazz music is concerned. Those who are making it, are making all the money; those who ain’t making it, ain’t making nothing. Musicians don’t work for scale anymore. Everybody wants more money up front. not like the ’40’s and ’50’s and early ’60’s. Let me say too that economic consideration is a form of control.

There is like a little light boxer rebellion going on among Black people. I don’t know if drugs are like a fraud perpetrated on the people, like birth control pills. Why are drugs so easily attainable in the Black neighborhoods and can’t be copped in the white neighborhoods? The difference is that in the white neighborhoods it’s protected by physicians and prescriptions. Also, in the white community it’s legal; in the Black community it’s not. In general, students don’t dig drugs. LSD never did catch on with Black people nor with musicians. Black people are not hallucinogenic or psychedelic. They can’t afford to be laid out drugged. Somebody might rip you off. It’s not their nature. Drugs are being forced on people. Black people don’t need drugs to create an illusion or a vision: “TOMORROW’S GONNA BE A BETTER DAY, SO DON’T YOU COMMIT SUICIDE, that’s the Black Temperment.”

DOMIABRA recommends Professor Byrd’s latest album, “BLACK BYRD”
"SATCHMO" on Smoking "GAGE" (Marijuana)

"Through the years you try everything to an extent to see which one's best for you. And trying to get with the other cats I used to light up with them—and to me you'd have a better session with gage, as we called it, than getting full of whisky. But the judge started throwing all them years at us for just a roach. So, well, I didn't see nothing funny in that."

"Truth is, it's all in your mind and you play better without anything. I ain't seen nobody make a success out of it."

Louis "Satchmo" Armstrong

Autobiography: A Self Portrait—

PRAISES BROTHERS

DOMIABRA congratulates Dr. Fletcher Robinson, Director of Howard University Urban Health Project, for his intervention in the attempt by a Canadian physician to "inject two thousand (2000) college students at Makerere University in Kampala with killed gonococcal bacteria vaccine." This proposed Kampala experiment was reminiscent of the "Tuskegee Experiment" wherein 400 Black Males were denied treatment for syphilis for experimental purposes. It was conservatively estimated that some one hundred (100) men died from the Tuskegee project.

Because of Dr. Robinson's efforts, The Minister of Health in Uganda decided to stop the experiment. Logic implies that in order to test the vaccine's effectiveness, the African student would have had to undergo injections of the gonorrhea disease. Consider the IMPLICATIONS of two thousand (2000) Africans walking around with "experimental gonorrhea" in terms of the potential contamination, incidence of sterility and other complications.

Advice From Oscar Brown, Jr.

"Super-fly ultimately gets caught on the Super-fly paper." "It takes just as much energy to be mediocre as it does to be excellent."

(Interview WHUR Radio Washington, D.C., April, 1973)

RECOMMENDED READING LIST

Edward M. Brecher and the Editors of Consumer Reports, LICIT AND ILLICIT DRUGS.


Dr. Charles F. Terry and Mildred Pellens, THE OPIUM PROBLEM

RECOMMENDED READINGS ON SCIENCE

Sister Helen 3X (Science Teacher, Muhammad University of Islam No. 4 Washington, D.C.)

Maurice Biefield, Modern Biology at a Glance
William Metcalfe, Modern Chemistry
Donald Ordway, Physical Science
Michell Sienko and Robert Plain, Chemistry
Jerome Sparks, Earth Sea and Air
Claude A. Ville, Biology
The Honorable Elijah Muhammad, How to Eat to Live, Books One and Two

DO BLACKS HAVE ANY MONEY FOR HOSPITALS, SCHOLARSHIPS, OR SCHOOLS?

Executive Producer, Tony Brown, of T.V.'s Black Journal states, "Before the last ticket is sold 'Super Fly' will gross over $30 million dollars for white people. The Negro investors of 'Super Fly' have not been allowed to invest in the sequel—the exploiters have been exploited."

(Muhammad Speaks, January 19, 1973)
INTERVIEW ON PSYCHO-SURGERY  
- JESSE BARBER M.D.  

(Chief, Division of Neurosurgery, President, Medical - Dental Staff, Freedmen's Hospital)  

Note  

DOMIABRA plans to interview several physicians from the Howard University medical Complex on a variety of topics related to drug abuse. The views and opinions expressed in such interviews are not necessarily those of DOMIABRA, Freedmen's Hospital, or Howard University. We welcome comments on all interviews.  

Q. Has psychiatry been effective in treating patients with drug problems?  
A. Well the overall success rate in terms of the patients whom I see in relationship to alcohol, which is the only thing I can speak of statistically, is that the effectiveness of present day modalities of treatment including Alcoholics Anonymous, psychiatric treatment and the like is low. Nonetheless, as far as I'm concerned, at the moment it's the best thing that we've got and should still be utilized. There are people who I think we see that have a record of failures with every known and accepted method of treatment and it seems to me to be enough of these people to justify innovative kinds of approaches, possibly including psycho-surgery.  

The performance of psycho-surgical procedures on prison inmates is a complex problem. Generally speaking, the medical care of these prisoners is poor and seldom do they receive adequate medical care for any condition. They do, then, often represent "treatment failures" but from the point of view of not being given treatment. I do not feel that psycho-surgery should be used, at the present time, on persons who have not received the usual and customary medical therapy.  

The problem of "informed consent" in prisoners to any diagnostic or treatment technique encompasses all their medical care and should be solved from an overall point of view. If one assumes that the inmate of a penal institution has the human, moral and constitutional right to the same medical care that all the persons in our community may receive—then one must agree that established medical procedures can be administered to them.  

Personally, I would welcome the rehabilitation of Black prisoners and the relief of the Black Community from the burden of the crimes of Black prisoners afforded by psycho-surgery. The recent trend toward the delay and possible prevention by our courts, of psychosurgical procedures on members of the community who have, along with their families and physicians, agreed to such procedures is deplorable and a dangerous precedent. The legal determination of the nature and type of medical treatment is preposterous. As long as patients continue to suffer from disorders of the body and mind we must continue unceasingly to attempt to alleviate these disorders by any available means including psycho-surgery.  

The utilization of psycho-surgery should not and does not preclude the study and use of other forms of treatment. My own professional experience with the results and the treatment of those addicted to heroin is limited.  

Q. Do you favor the University and the Hospital seeking grants to foster research in psychosurgery?  
A. Unequivocally, as a matter of fact, I think that not only am I in favor of it, I think we have an obligation to do it. I think so many of these problems we are discussing are our patients and also because of the fact we would hope in our approach to them that it would be more humane, non-racist approach, which may not be the case when approached in other institutions.  

Q. What has been your observations of the effects of so-called soft-drugs, like marijuana, on the brain?  
A. As far as I'm concerned, the information I have of course would be purely clinical rather than experimental, and it does not appear to me that any of the soft drugs to my knowledge have any recognizable deleterious effects on brain function. Let me hasten to add that there are a number of social and behavioral problems that causes medical problems in people who are on these drugs that is to say in terms of association with head injuries or falls and the like which do cause secondary brain problems. But in doing frequent
examinations on known marijuana users who are not under the influence of drugs at the time of examination, a routine neurological examination and fairly cursory evaluation of their mental status and psychological abnormalities of an organic nature do not show any gross abnormalities in my experience.

Q. What about hard drugs like Heroin?
A. I think the body of evidence certainly indicates that particularly those administered intravenously may be associated with definite brain or nervous system injuries and problems. Whether or not these are due purely to the drugs themselves or vehicles which they use with them is not entirely clear.

Q. Do you think that psycho-surgery has a positive function in the treatment of so-called “deviant behavior?”
A. Medically speaking, psycho-surgery deserves to be utilized and studied, particularly in view of the newer techniques of operation with the days of ice-pick kind of surgery that many of us are familiar with and pre-frontal lobotomy kind of operative procedures by and large having been abandoned. The more sophisticated neurosurgical techniques for psycho-surgery, I think, have a good deal to offer. Certainly, they deserve to be thoroughly studied and evaluated. On the other hand, as a Black neurosurgeon, I have some problems with the fact that if the practice of psycho-surgery, for example, were to be utilized, particularly in terms of aggressive and criminal behavior and in other socially unacceptable forms of behavior, a high percentage of these people that would be subjected to this would very likely be Black people. So despite the fact that I feel that psycho-surgery ought to be utilized, there ought to be some type of fairly rigid criteria to make certain that the surgical techniques are not used from a racially motivated basis for selectivity. And I really feel that some type of community or lay advisory group ought to be utilized to make absolutely certain that this does not occur.

Q. Do you view narcotic addiction as a major health problem among Black people?
A. Well, let me put it this way. I think narcotics and drugs if in speaking of narcotics and drugs you are including alcohol. I think that these problems are certainly major health problems. In terms of numbers of people that are involved, and my own personal feelings is that alcoholism is probably a more significant problem statistically. On the other hand, when one looks at the fact that perhaps hard drugs are much more destructive in the earlier period in life than is alcoholism, I certainly think that it deserves our attention. I feel very strongly, however, that although we have problems in narcotics and drugs, to fully direct our attention to narcotics and ignore alcohol is misguided and incorrect as far as the greatest good for the greatest number of people that we have to deal with. I further feel that some of the suggested testing in terms of routine screening of urine for evidence of narcotics are in my opinion very superficial and are not well thought out. My own feeling is if one is to do screening that one ought to screen as a part of a total screening process and not just direct attention toward the restrictive kinds that will likely develop if one screens purely for narcotics. Moreover, it is my opinion that it is an infringement on the personal right of individuals to screen them purely for drugs as a criteria for continued employment and other similar reasons.

In summary there is a considerable number of people in whom the type of brain operations we call “psycho-surgery” should be used at the present time. For example, people with intractable pain which is unresponsive to other treatment modalities, or people with repetitive acts of violent, senseless behavior in whom there is evidence of organic brain disease, the chronic alcoholic or hardcore psychotic patients who have failed to respond to other treatment modalities just to mention a few. The results clearly demonstrate the effectiveness of these newer techniques without significant impairment of the patient’s personality or function in most patients. At the present stage of our knowledge psycho-surgical procedures for less well established indications should probably be limited to institutions which have the capacity to thoroughly study these persons by a team approach. Psychological, neurological and social factors should be carried out. Depth electrode recordings and careful evaluation of the results should be done. The evaluation and decision to operate should be reviewed preoperatively by some type of committee including representation from varied medical, psychological, social, legal and community disciplines.

There is, in my opinion, no justifiable objection to the use of these effective psycho-surgical techniques on those patients who are “treatment failures” from present therapeutic regimes provided careful selection is carried out.

A COMMENT BY DR. SWEET

“We’re talking about senseless behavior individuals who bring discredit on their movement by excesses of one sort or another. The proponents of urban disorders seem to be the people who are most likely to suffer from organic brain diseases.”

(Dr. William II. Sweet, Chief of Neurosurgery, Massachusetts General Hospital is an applicant for a Federal grant in PSYCHOSURGERY.

(Ebony Magazine, February, 1973)
ENGLAND SWITCHING FROM HEROIN MAINTENANCE TO METHADONE

Doubt has been cast on the contention that medically prescribed heroin is used successfully in the British System of drug treatment.

Morris J. Bernstein, supervisor of 36 methadone clinics of New York says, “In England, where they’re not running a maintenance program as we know it, they’re switching more and more to methadone. I visited their clinics and found more methadone used than heroin.” The same point was made at the Fifth World Congress of Psychiatry in Mexico City last December. Dr. Bewley, consultant psychiatrist to three of Great Britain’s 16 drug dependence treatment units, states: “More methadone is prescribed now and less heroin. The total monthly amount of heroin dispensed in the British clinics declined steadily from 2,690 gm. in July, 1968 to 1,358 gm. in December, 1970. Meanwhile, total methadone prescribed rose from 918 gm. in August, 1969 to 1,330 gm. by December, 1970. In 1970 methadone moved ahead of heroin.”

(Medical World News, March 17, 1972)

DRUG SUPERSTITION

“People believe that getting high will solve the problems of life or they take refuge in superstitions. They get high to escape the hassles, but they wake up and find out they’re just back where they started. That’s what a song like Superstition is about: Would you believe in things you don’t understand. Then you suffer. Superstition ain’t the way.”

(Brother Stevie Wonder, Interviewed in THIRD WORLD NEWSPAPER, March, 1973.)

73 MILLION DOLLARS STOLEN FROM NEW YORK CITY POLICE DEPARTMENT

The New York City Police Department discovered at least as early as August, 1972 that a sizable quantity of drug, name 169 pounds of heroin and 131 pounds of cocaine were missing from the offices of its property clerk. Some of the heroin was initially seized in the celebrated “French Connection” case of 1962. The street value of the missing drugs is estimated to be about $73 million dollars.

Baltimore and other cities have been struck by scandals involving corruption by police officials and the theft of seized contraband.

(New York Times, December, 1972)

THE MYTH OF THE HEROIN OVERDOSE

(Excerpt from an article in LICIT AND ILLICIT DRUGS)

Death from an overdose of opiates is ordinarily a slow process. The first signs are lethargy, and stupor followed by prolonged coma. If after a few hours, death does occur, it is most often from respiratory failure. Within minutes or sometimes hours following the injection of a so-called fatal overdose, administration of the narcotic antagonist-nalorphine (Nalline) death can be avoided.

However, THE THOUSANDS OF DEATHS ATTRIBUTED TO HEROIN OVERDOSE ARE NOT DUE TO HEROIN OVERDOSE AT ALL. “The amount of morphine or heroin required to kill a human who is not addicted to opiates remains in doubt, but it is certainly many times the usual 10 milligrams found in a New York City bag.” Between 120 milligrams (oral) to 350 milligrams is estimated to kill a human but even non-addicts have survived larger doses. “Virtually, all of the victims whose deaths are falsely labeled as due to heroin overdose are addicts who have already developed a tolerance for opiates—and even enormous amounts of morphine or heroin do not kill addicts.” In the 1920’s a Philadelphia study reported some addicts as using 28 grains (1,680 milligrams) of morphine or heroin per day—40 times the New York City daily dose. Also the study stated that 1,800 milligrams of morphine were injected into an addict over a 2 and ½ hour period. He didn’t even get sick. A sudden increase in dosage doesn’t even produce striking side effects or death among addicts. Three addicts were mainlined between six to nine times their usual dosage. Results were “insignificant changes in pulse, respiration rates,
electrocardiogram, chemical studies of the blood and behavior of the addict.”

THERE IS NOT A SINGLE SCIENTIFIC PAPER IN THE UNITED STATES MEDICAL LITERATURE STATING OVERDOSE IS IN FACT A CAUSE OF DEATH AMONG HEROIN ADDICTS. THERE IS NO EXISTING EVIDENCE ON ADDICTS DYING FROM HEROIN OVERDOSE.

Why is this overdose myth accepted universally if there is no evidence to indicate addicts are dying from overdose and even huge doses of heroin will not kill an addict?

The answer lies in the practices of the U.S. coroner-medical examiner system. The practice rose among coroners and medical examiners to label all deaths among heroin addicts as heroin overdose because the true cause could not be determined or was not determined.

“Overdose” determinations rested on:
- the victim was a heroin addict who “shot-up” prior to his death.
- there was no evidence of suicide, violence, infection, or other natural cause.

Thus, death from heroin overdose is synonymous with “death from unknown causes after injecting heroin.

In 1943, a strange new kind of death began to make its appearance among heroin addicts. The cause of this new kind of death remains unknown today and is quite common. This mysterious new way of dying is extremely sudden. Death occurs a few minutes or less perhaps only seconds after the drug is injected. It has been shown that a high proportion of all so-called “overdose” deaths share these two characteristics.

Dr. Milton Helpern, Chief Medical Examiner of New York City explained that pulmonary edema—massive flooding of the lungs with fluid is the most conspicuous feature of so-called “overdose” deaths.

The cause of pulmonary edema is not known. This reaction sometimes occurs with the intravenous injections of mixtures, which as far as is known do not contain heroin.

Dr. Michael M. Baden, Deputy Chief Medical Examiner says, “The majority of deaths are due to an acute reaction to the intravenous injection of the heroin-quinine sugar mixture. This type of death is often referred to as an ‘overdose,’ which is a misnomer. Death is not due to a pharmacological overdose in the majority of cases.

Neophytes (new converts) unaccustomed to heroin would be expected to be susceptible to death from overdose. But, those dying of so-called overdose are reported to be long term users. Also, according to Dr. Baden “addicts often shoot in a group, all using the same heroin supply, and rarely does more than one addict die at such a time.”

Syndrome X is the name given to this “acute fatal reaction to the intravenous injection of crude mixtures of heroin and other substances. One theory is that Syndrome X deaths are caused by quinine in the bag. Quinine was introduced as an adulterant of heroin after 1939, when an epidemic of malaria spread by contaminated injection needles hit New York City addicts. The first suggestion that quinine might be causing New York City’s Syndrome X deaths came from Dr. F.E. Camps, the United Kingdom Home Office pathologist in charge of investigating opiate deaths in England. At the meeting in London in 1966, Dr. Camps stated, “The only comparable drug to heroin which causes rapid death with pulmonary edema is quinine.”

(Edward M. Brecher and the Editors of Consumer Reports LICIT & ILLICIT DRUGS, 1972)

DEAN PERCY PIERRE,
SCHOOL OF ENGINEERING -
COMMENTS ON DRUGS

Q. Do you think drug addiction and abuse is a major problem in the Black community? If yes, why?
A. Yes. It diverts the energies of the Black community from the tasks of Black development.

Q. If your child or friend or relative was using drugs, what advice or alternative would you attempt to offer to him?
A. I would try to help develop meaningful life goals.

Q. What merits or demerits do you see in the legalization of marijuana and/or other drugs?
A. I see very little harm in legalizing it. One benefit would be to separate users from the traffickers in hard stuff.
Staff Of The Institute

The Institute on Drug Abuse and Addiction has been in operation for the past fourteen months. Staff members pictured above are (from left to right) Wilbur Atwell, Research Associate, Reginald Locke, and Ed White, Senior Counselor.

The services and programs conducted by the Institute embrace treatment, education, and prevention and research. Education and prevention are addressed through workshops and seminars conducted in a number of areas aimed at augmenting the body of knowledge about drug use.

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