

# Drug Policy News

A Publication of the Drug Policy Education Group, Inc.

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Working to Reduce the Harm Caused by Drugs and Failed Drug Policies

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## What's the Real Story About METHAMPHETAMINE?

No one could argue that there's a meth problem. It seems no matter where you turn, another home-brew meth kitchen is discovered by law enforcement, another batch of arrests are listed in the police report, and more hapless individuals are hauled back into court for violating parole or probation on prior meth convictions.

What is this drug called methamphetamine and where did it come from? Why do people use it? Why can't all the Kings horses and all the Kings men stop this human disaster?

Meth is one of a group of drugs called "uppers" in street vernacular. Caffeine is the mostly widely known and commonly used "upper," derived from a variety of sources including tea leaves and coffee beans. Cocaine and its offspring "crack" are extracts of coca leaves, revered by South American cultures for spiritual and medical uses. The pharmaceutical amphetamines are a large group of synthetic "uppers" longer lasting than cocaine, including dextroamphetamine (Dexedrine), methamphetamine (Methedrine, Desoxyn), and amphetamine (Benzedrine).

(Continued on Page 5)



## Doctors at Risk

Doctors working with patients in chronic pain continue to risk arrest and ruin as zealous DEA agents second-guess medical practice. Several Arkansas doctors have experienced SWAT team break-ins to their homes and offices, followed by months of struggle to retain their licenses. Doctors prescribing pain medications are 'profiled' for certain activities which trigger DEA action. Visit [www.drcnet.org/wol/197.html#drweitzel](http://www.drcnet.org/wol/197.html#drweitzel) for one such story. For physician support, contact the Association of American Physicians and Surgeons, 1-800-635-1196, or [www.aapsonline.org](http://www.aapsonline.org)

## AR Med-MJ Campaign Forges Ahead

Gathering more support every day, the Arkansas Alliance for Medical Marijuana expects committee hearings in late summer in spite of the loss in the primary election by Sen. John Riggs IV, who had planned to introduce a bill in the January 2003 session.

"We were very sorry to lose Sen. Riggs," stated Jerry Citti, Alliance Board President. "He's a skilled legislator and has the courage to work for difficult issues. It was a tough situation, with an experienced and popular opponent like Ms.- Brown. We look forward to working with Sen. Riggs through the rest of 2002, and we expect to gain new legislative supporters, too."

The Alliance has recently completed a short video that will be used in education efforts statewide. Entitled "Illegal Healthcare: Medical Marijuana and Arkansas," the video features Arkansas patients who depend on marijuana for critical health conditions.

"The video will be distributed to libraries, legislative candidates, media, community leaders, and others who are interested in learning about this issue," stated Denele Campbell, Executive Director of DPEG.



Also underway by Alliance workers is a tabloid-size newspaper that will contain groups of patient stories alongside summaries of all the research and human studies that have been done showing the scientific background for medical use. Also in the newspaper are updates on federal law, a comparison of marijuana and a synthetic drug Marinol, charts showing relative effects of various drugs, and much more, all formatted with lots of photographs and other items of visual interest. The papers will be distributed statewide free of charge.

For more information about the Arkansas Alliance for Medical Marijuana, contact Ms. Campbell at 479-839-2475 or Jerry Citti at 501-227-5161; email the [alliance@ardpark.org](mailto:alliance@ardpark.org) --website at [www.ardpark.org](http://www.ardpark.org)

## Drug Education – Is It Working?

The Winter 2002 edition of ReconsiDer Quarterly, a New York based reform organization, takes a comprehensive look at D.A.R.E., or Drug Abuse Resistance Education, our nation's premier drug education program. With articles by experts from a variety of professions, "The Education Issue" raises tough questions about what we have come to depend on to keep our kids off drugs.

"Are We Doing Enough," asks an expert advisor working on an overhaul of D.A.R.E. after studies revealed it was ineffective.

"A Guide to Shopping for Drug Education Programs" says it's "Buyer Beware."

"We Wasted Billions on D.A.R.E." says Edward Shepard, Ph.D., an economics professor who has researched the effectiveness of the program.

"What It's Like to Drop the D.A.R.E. Program," by Salt Lake City's Mayor Rocky Anderson.

"Reinventing Drug Education, Especially for Adolescents," by Rodney Skager, Ph.D, a respected veteran of education and substance abuse research.

"Ignorance Hurts Both Drug Users and Their Families, by Susan P. Koning, creator of a 12-week recovery program for families.

"Notes on Drug Education for College Students," by Craig Reinerman, PhD, a professor of sociology and visiting scholar at the Center for Drug Research at the University of Amsterdam.

"A Focus on Safety First Strikes a Universal Chord," by Marsha Rosenbaum, PhD, medical sociologist.

And more, in a 29 page booklet edition available free in a special summer press run. View the full text online at

<http://www.reconsider.org/quarterly/default.htm>

Contact ReconsiDer immediately with your requests and they will ship copies to your school principal, school nurse, counselors, education writer/editor at your community newspaper, or anyone else you believe needs access to this information, free of charge. Call Nicolas Eyle at (315) 422-6231 or email [eyle@reconsider.org](mailto:eyle@reconsider.org)

Copies of this publication have been sent to 52 libraries in Arkansas, part of DPEGs Delbert O. Lewis Memorial Library Project, funded in part by a generous grant from the Tides Foundation and by donations from Arkansas people.

### National Briefs

## Protest Mounts on Student Aid Denial

In late May, lawmakers, educators, and student, religious, and civil rights organizations gathered together at the US Capitol in Washington, DC to urge repeal of a law that has denied financial aid to nearly 80,000 would-be students because they had drug convictions, no matter how minor.

Ten members of Congress joined with the Coalition for HEA Reform (CHEAR) as it submitted a letter to Congress calling for repeal of the Higher Education Act's anti-drug provision. The letter was endorsed by 41 national educational, civil rights, religious, and other advocacy groups, including the NAACP, American Federation of Teachers, Leadership Conference on Civil Rights, American Civil Liberties Union, National Association of Student Financial Aid Administrators, General Board of Church and Society of the United Methodist Church, and others.



The current provisions prevent students from obtaining student aid if they have had a conviction for even minor drug possession charges.

In a recent interview for an article on this issue in the Morning News of Northwest Arkansas, DPEG's Denele Campbell stated that these restrictions are the worst example of drug policies that cause more harm than the drugs themselves. "This policy marginalizes kids who are already marginalized," she stated. "It doesn't take much to push them over the edge. If they can't go to college, what are they supposed to do – hang out with addicts?"

Campbell pointed out that the majority of Arkansas families can't pay college tuition, so for a poor state like Arkansas, this law is disproportionately unfair. Kids from rich families can go to college no matter how many drug arrests they might have. Kids who commit other crimes, even violent crimes, can still get student aid.

"Kids who are using drugs should be encouraged to explore the excitement of learning, to look for more profound adventures than intoxication. College is a place where kids can discover a positive future," she said. "For people this age, such policies can be a death sentence."

Under the law, students convicted of drug possession lose their student financial aid eligibility for one year for the first offense, two years for the second offense, and indefinitely for a third offense. Drug sellers lose eligibility for two years and indefinitely for the second.

The NAACP's Washington DC bureau chief Hilary Shelton elaborated on the racial disparities at work in the drug war and in the anti-drug provision. "African Americans are disproportionately more likely to use financial aid, Pell grants, and the like," he said, "and they are also disproportionately more likely to be convicted of drug related offenses."

To learn more about the HEA provisions or to take action, visit <http://www.RaiseYourVoice.com>

### Drug Ads Fail, but Let's Do It Some More

The Office of National Drug Control Policy (ONDCP), which operates directly under the President, has spent nearly a billion dollars in the last five years on paid anti-drug advertising. June 1, the ONDCP director John Walters admitted that the program was a bust.

"This campaign isn't reducing drug use," Walters told the Wall Street Journal. In remarks calculated to put the best possible spin on the dismal results of this expensive government boondoggle, Walters revealed that recent statistics have shown a 5% increase in drug use by teens. Walters went on to explain that future efforts would surely be more successful, and so he was asking the Congress for an additional \$180 million for 2002 alone.

"The new ad campaign is going to provide more direct messages about the real threats," he promised. "We are going to turn and more directly look at marijuana."

More National Briefs on Pg. 7

Each time a person stands up for an ideal, or acts to improve the lot of others... he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy and daring, those ripples build a current that sweeps down the mightiest walls of oppression and resistance.

Robert F. Kennedy

## League of Women Voters Studies Treatment

The Washington Co (AR) League of Women Voters has recently concluded a year-long study on substance abuse treatment programs in Washington County. The purpose of the study was to evaluate available programs and to develop a concept of ideal treatment.

Study group members interviewed program directors of all Washington County substance abuse treatment programs, learning about phases of operations, program goals, and resources. Five programs exist in the county:

Decision Point of Springdale, the only program accepting Medicaid and the only residential program available to the general public. Residential programs are limited to three weeks. A separate program conducted by Decision Point for drug court participants adjudicated by Judge Mary Ann Gunn allows longer residential stays and expanded treatment.

Veterans Administration Hospital offers indefinite residential treatment, along with a comprehensive approach to treatment assessing medical, mental, educational, and vocational needs of the patients. The VA program is restricted to veterans of military service.

Vista Health, a cash or insurance-paid mental health facility, does not offer substance abuse treatment per se, but will address minimal addiction/withdrawal needs in patients admitted under other diagnoses. Patients in need of continuing treatment of substance abuse are sent to other facilities for treatment.

Ozark Guidance Center, a facility with sliding fee scales accepting public and private funding, provides outpatient substance abuse counseling in two tracks defined in intake interviews. Patients in need of immediate and intense intervention are referred to appropriate facilities in the region (Decision Point). Other clients, a majority of those seen at Ozark Guidance, are participating as required under court order for DWI. Program includes weekly group meetings.

Youth Bridge, a facility for troubled teens up to age 18, provides out-patient counseling sessions and group for teens with substance abuse problems.

In order to take a meaningful look at substance abuse, the study group first had to develop an understanding of substance abuse. For this purpose, the group delineated a

difference between substance “use” and substance “abuse,” as follows:

“Where ‘substance’ is defined as a consumable material with mind-altering and/or intoxicating properties, ‘substance use’ is the medical, recreational, or spiritual and controlled utilization of the material, while ‘substance abuse’ would be utilization that is out-of-control to the point that key aspects of the person’s life have become neglected, damaged, or otherwise harmed. It is certainly ‘substance abuse’ if the person’s actions have become harmful to others or the property of others. Substance abuse is usually characterized by escalating or excessive dosage levels.

“‘Substances’ meeting this definition include legal drugs such as caffeine, tobacco, alcohol, and pharmaceuticals taken as prescribed, and illegal drugs such as marijuana (and derivatives including hashish), cocaine (and derivatives including crack), opium (and derivatives including heroin), methamphetamine, peyote (and derivatives including mescaline), LSD (and similar “psychedelics”), and pharmaceuticals not taken as prescribed or not prescribed.”

The study group also sought to develop a greater understanding of why substance use and abuse might occur. The report states:

“Among the young, substance use may be in part a compensation for Western culture’s lack of a rite of passage. Substance use may also be part of a person’s desire to be glamorous, to meet the challenge (similar to extreme sport), to loosen inhibitions, to rebel from perceived expectations, to fit into a perceived norm (peer group), to seek spiritual/mystical enlightenment, for recreation/pleasure, to self-medicate mental or physical problems or illness, and/or for stress relief.

Substance use has always been part of human existence.

Traditionally, use of mind-altering substances has been in spiritual, medical, or social ritual contexts.

Some argue that the pace and materialism of modern society create an unnatural and harmful human condition from which

many seek relief through substance use or abuse.

1. “Substance abuse may result from substance use when the individual depends on the substance in daily life and the desired result of such use requires increasingly larger doses (habituation).

2. “Substance abuse may result when the individual uses intoxicants in an effort to mitigate a problem which in fact cannot be mitigated by substance use, and ever increasing doses merely mask the symptoms of the underlying problem.
3. “In some cases, substance abuse may result when a person’s physiology is genetically or environmentally predisposed to become dependent upon the substance and demands increasingly larger doses even though in many cases, physical harm is produced by this level of use (addiction).

The League study also reviewed guidelines provided by federal agencies which offer a checklist of considerations for people interested in understanding more about substance abuse. Based on this checklist, the League study group envisioned an “ideal” treatment approach.

Finally, the full chapter of the Washington Co. League adopted a consensus statement, as follows:

“Public policy in Washington County which governs illegal substances should:

1. reflect an understanding of substance use, substance abuse, and addiction
2. frame substance use/abuse as an issue of public health rather than criminality
3. focus public resources on the prevention and treatment of substance abuse
4. require evaluation assessments of treatment programs to be made public
5. support the development of resources which provide one-stop, whole-life guidance for people in need; and
6. include permanent funding for the pre-adjudication Washington County Drug Court program through the AR Dept of Health.

Substance abuse treatment in Washington County should:

1. have easily accessible locations
2. be served by public transportation
3. be structured to encourage voluntary participation
4. be affordable
5. be advertised in a way that adequately informs the public and target populations of treatment availability
6. provide immediate access to professional therapeutic services
7. meet the “Principles of Effective Treatment” listed by



- the National Institute of Drug Abuse
8. include a full intake assessment that immediately determines the level of urgency for treatment, as well as determining needs and providing for programs that address mental and physical health, nutritional education, educational/vocational skills, life skills, domestic/family issues, and other important life components
  9. provide immediate attention to detoxification and other physical needs, including a program of nutritional/herbal/vitamin therapy, relaxation/massage, and any other techniques which speed the detoxification and healing process
  10. offer therapeutic programs tailored to individual need for both adolescents and adults, administered by professional, certified staff
  11. provide residential programs offering suitable, clean, orderly environments conducive to healing and allowing for outdoor exercise
  12. provide treatment options to meet all levels of need, including regular outpatient, Intensive Outpatient Therapy, partial day residence, residential, and long-term residential up to one year, with transitional housing available in a therapeutic “community” setting
  13. encourage the proliferation of diverse self-help groups including 12-step programs
  14. be evaluated by appropriate quality and accountability guidelines and licensing criteria, including long-term follow-up contacts with clients to the greatest extent possible.”

The study group plans to produce a brochure offering basic contact information about treatment in the county and to provide these resources to a wide range of professionals, institutions, and other publicly accessible locations. Ideally, another such study and results should be accomplished statewide, but currently there is no plan to pursue such a study.

The complete study is available through DPEG’s website at [www.dpeg.org/treatment](http://www.dpeg.org/treatment) For more information, contact the LWVWC President, Valerie McMullen at 479-582-0316.

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(Methamphetamine – Continued from Pg 1)  
 Amphetamines, first synthesized in 1887, were not recognized for clinical application until 1927. Early uses included raising blood pressure, dilating nasal and bronchial passages, and stimulating the central nervous

system. Bensedrine was first marketed in 1932 and was most often prescribed for narcolepsy, a rare disorder in which persons fall asleep unexpectedly.



In 1937, it was discovered that amphetamines were effective in controlling hyperactive children. Variations of this chemical family include Ritalin and other drugs commonly prescribed for children; diet pills; and anti-depressants.

In the same pattern that led to cocaine’s widespread use following the German army issuance of that drug to soldiers in World War I, amphetamines were popularized by military use during World War II. American armed forces used it to “counteract fatigue, elevate mood, and heighten endurance.”<sup>1</sup> After the war, doctors prescribed amphetamines for various ailments; a combination of “uppers” and “downers” – barbiturates and opiates – proved effective in treating clinical depression.

This practice has not ended. As police and the U. S. Drug Enforcement Agency procure billions of dollars to make America a “drug free” nation, military commanders issue amphetamines to pilots to keep them flying. A recent news story reveals that “pilots from the U. S. fighter squadron that mistakenly bombed Canadian troops in Afghanistan had told their commanders shortly before the fatal incident that they were exhausted and needed more rest between missions. ...Instead, pilots were advised to speak to a flight surgeon about so-called ‘go/no pills’ – amphetamines used to help stay awake on long missions and sedatives to help sleep.”<sup>2</sup> The story also notes that “two-thirds of all pilots in Desert Storm used dexedrine at least once.”



The amphetamine drugs, like cocaine, are not physiologically addictive. Addictive drugs such as alcohol and the opiates cause the body to become physically dependent; sudden cessation of use can cause death. At worst, withdrawal from amphetamines may include depression and exhaustion. Some but not all amphetamine users build up tolerance. While persons on a steady dose of Ritalin or antidepressants may never need to increase the dosage amount, persons abusing amphetamines can find themselves ingesting increasingly larger amounts. However, even in cases of huge doses, death from amphetamine abuse is rare. “Long term users have reportedly injected as much as 15,000 mg ... in 24 hours without observable acute illness.”<sup>3</sup>

Abuse of amphetamines was reported as early as the 1940s and included businessmen, athletes, truck drivers,

and students staying up to study for exams. While early use of “uppers” was generally by oral ingestion, thrill seekers and “speed freaks” began injecting the drug for a bigger “rush” and stronger effects. By the mid-60s, doctors realized that injection posed a new risk.

“The first use of intravenous amphetamine is ‘an ecstatic experience,’” writes Dr. John Kramer in a 1969 report. “The user’s first thought is ‘where has this been all my life?’”<sup>4</sup>

Dr. Kramer cautioned against a simplistic view that anyone who once uses amphetamine intravenously will automatically become addicted. “There are individuals who have tried it once or several times and have chosen not to continue.”

Dr. Roger C. Smith, in his study of amphetamine abuse, addressed a question quite familiar today among those who face the methamphetamine crisis plaguing our cities and rural areas. He wondered why people would take such a drug, why some could take it and quit while others became hopelessly dependent even to the point of making it the center of their lives.

“Many young people in our culture are brought up with a seriously damaged self-image. The methods of discipline imposed upon them as children, or other factors, convince them of their own inherent worthlessness, though they may mask this sense of worthlessness with bravado.

“Many of the young people who are currently involved in the speed scene,” Dr. Smith wrote, “report that they were initially attracted to the drug because of the instant improvement noted in self-image. Many suffered from feelings of inferiority and lack of self-worth, which manifested itself in chronic, and often debilitating, depression.

Dr. Smith goes on to describe a common scenario, no less true today than at the time of his writing, in which a person struggling to overcome self-image problems will self-medicate with various mind altering substances. Alcohol is the most widely used of these popular drugs, and alcohol is a depressant. Increasingly depressed by the fundamental psychological crisis now exacerbated by alcohol, the person is set up for the relief they will experience in the first methamphetamine dosage.

Once the brain experiences the euphoria, empowerment,

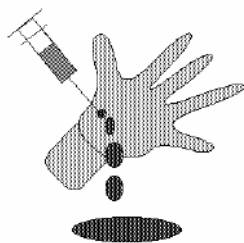
and sense of control that comes with amphetamines, it never forgets. Every time the person considers whether to use, even facing jail time, the brain quickly remembers that this was the one thing that solved all the problems. The urge to use is almost overwhelming.

Briefly then we might say that those most at risk of becoming methamphetamine abusers are those who grow up without learning to value themselves, who are abused or ignored, who are under-educated, who have no job skills -- or those at the other end of the scale whose expectations are set unachievably high. As they move from childhood through adolescence, they begin to understand that the American dream is not for them. The grade school failures in reading and discipline for acting out translate into a hardened attitude. Lack of family resources, inappropriate school responses, and other family and societal failure may leave the at-risk young adult perfectly set up for substance abuse.

In the intervening decades since the writings of Drs. Kramer and Smith, American society has become more competitive, creating a wider gulf than ever between the “haves” and the “have-nots.” As manufacturing jobs have been lost to Third World countries, fewer decent-paying jobs are available for middle and lower class Americans. Statistically, the lower socio-economic groups are most at risk for substance abuse. Working class people at the edge may need “uppers” to work two jobs to make enough money for a nicer house, a newer car, new shoes for the kids. If Mom and Dad both work, it leaves little nurturing for kids who suffer the brunt of their parents’ economic and psychological crises. All of this breeds a steadily increasing group of people who fit the definition of being at-risk for amphetamine abuse.

Like many aspects of present day American drug policy, a criminal justice approach to amphetamine abuse is the worst possible approach. Persons already struggling with self-esteem issues and self medicating with amphetamines are only damaged further by repeated humiliation in the process of arrest and prosecution.

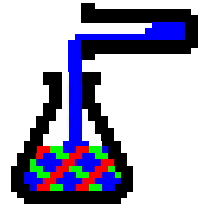
Suffering through deprivation from the only thing that made him/her feel normal”, the jailed meth user is further damaged by loss of children, loss of employment, (sometimes) loss of family support, and stigmatization in the eyes of the community. In fact, all the responses now  
(Continued on Pg 8)



(Methamphetamine — Continued from Pg 6) entrenched in our “get tough” approach to methamphetamine abuse essentially guarantee that the individuals and immediate families will become even more at risk for future problems.

A growing market for “uppers” has been officially addressed by tightened controls – less available supply and threat of criminality. This has done nothing to reduce demand. As cocaine and prescription amphetamines has become harder to obtain, home-brewed methamphetamine production has increased. As early as the 1960s, observers noted that “bathtub labs” were producing vast quantities of cheap amphetamine.

Over the subsequent decades, in spite of the growing alarm over the proliferation of meth labs, however, there have been no studies showing in what ways home-cooked methamphetamine is any more dangerous than prescription amphetamines. Common sense dictates that haphazard production and substitute ingredients would yield a less safe product than clean laboratories. Doctors continue to prescribe and patients continue to safely use legal amphetamines for a limited number of ailments, although these drugs are highly prized in the street trade.



In a current effort to address IV methamphetamine abuse in England, British physicians in a pilot study are giving addicts prescription amphetamine pills. Early results are promising. Addicts are able to reduce their dosage, avoid unsafe street injection practices, and benefit from other aspects of treatment.<sup>5</sup> In our nation, where children are conditioned to “uppers” through caffeinated drinks and are sociologically predisposed to amphetamine abuse, perhaps it is time to consider a similar approach. Obviously what we’ve been doing for 40 years is not working.

1. Licit and Illicit Drugs, Edward M. Brecher and the Editors of Consumer Reports, 1972. Little, Brown, & Company: Boston.
  2. “Fatigue Dogged U. S. Pilots,” Glen McGregor, Vancouver Sun, Ottawa CN; June 3, 2002.
  3. “Amphetamine Dependence,” The Merck Manual of Diagnosis and Therapy, Sect. 15, Chp 195.  
[www.merck.com/pubs/mmanual/section15/chapter195/195g.thm](http://www.merck.com/pubs/mmanual/section15/chapter195/195g.thm)
  4. Licit and Illicit Drugs, p 283
  5. Klee H, Wright S, Carnwath T, Merrill J. The role of substitute therapy in the treatment of problem amphetamine use. D&A Review (2001) 20: 417-429
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