✪ Drug Policy News

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

Arkansas Legislature Convenes

Inevitable Drug Crazed Bills Introduced

Along with some hopeful measures that would give judges appropriate discretion in sentencing offenders, legislators meeting in the current session of the Arkansas General Assembly are also seeing a few over-the-top proposals.

Rep. Tim Hutchinson leads the pack so far by introducing two bills that would provide criminal penalties against a woman who exposes a fetus to illegal drugs, HB 1079 and HB 1265.

House Bill 1079 is "An Act to create the offense of child abuse by prenatal exposure to a controlled substance." If the child is "born addicted" or "has a significant presence of a controlled substance" in his or her system at birth, then the mother would be considered guilty of a Class D felony. A Class C felony would apply if the child "suffers serious physical injury because of this violation."

HB 1265 is "An Act to provide enhanced penalties for possession of a controlled substance by a pregnant person." If a woman found in possession of a controlled substance "knew or should have known" that she was pregnant, she would be subject to more stringent penalties. For example, possession of less than an ounce of marijuana would become a felony instead of a misdemeanor if a woman should have known she was pregnant.

HB 1079 does not describe how it will be determined that a child has been born addicted. While it may be assumed that heroin addiction would produce a set of withdrawal symptoms in a newborn, there are few clear addiction markers in such situations. About 70% of illegal drug use involves marijuana, which while not addictive, its presence shows up in drug tests three weeks after use. Especially problematic is the provision that "significant presence" of an illegal drug would constitute child abuse. What is "significant presence"? Who determines what newborn should be tested for such presence? Are mothers in labor to be profiled according to whether they smell of patchouli oil? Once the newborn is tested and found to carry a "significant"

▸ *(Continued on Page 7)*

DPEG Goals

with Action Plan for 2004-05 Fiscal Year

1. The State of Arkansas must ensure that current drug laws are not used as a tool of racial, cultural, or class discrimination. The state should:

a. Institute a data collection requirement for all police stops to track the use of profiling. Data elements would include race, length of hair (for males), and any remarkable features of the vehicle (if a traffic stop) including age, condition, decals if any. Periodic analysis of this data will reveal whether particular demographics are being used to trigger police stops rather than probable cause.

b. Provide for appropriate training of police to eliminate the use of profiling

c. Create a regulatory framework which discourages and penalizes profiling

DPEG's action plan: Monitor meetings of Governor's Task Force on Racial Profiling, make recommendations to task force, review task force recommendations to Governor, develop a plan of action to address profiling. Identify and contact other entities interested in this issue to build a coalition.

2. The State of Arkansas should provide for the least harmful outcome to persons arrested under existing drug laws, including to:

a. Provide equal opportunity to a vigorous defense for impoverished offenders. Improve public defender salaries and reduce caseload

b. Provide appropriate punishment for the offense
- Not incarcerate nonviolent drug offenders
- Offer drug court programs as an option for persons whose criminal activity stems from addiction
- Eliminate mandatory minimum sentencing and allow for judicial discretion
- Restrict asset seizure to cases in which an offender is found guilty of an offense and in which the seized item is shown to be directly connected to that offense
- Send proceeds of forfeited assets directly to a general state fund, not to the arresting jurisdiction
- Send proceeds derived from forfeited assets from drug offenses to substance abuse treatment programs after administrative costs are met.

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In the News

Meth Effects

The secret is out. Meth users become addicted because of the drug's aphrodisiac effect. Tennessee task force members reportedly 'winced' at a public hearing in early December, when a federal prosecutor made this revelation. As reported by the Associated Press, Assistant U. S. Attorney Paul Laymon stated sarcastically, "Who wouldn't want to use it? You lose weight and you have great sex."

Mr. Laymon's remarks were based on research by Dr. Mary Holley, an obstetrician who collects data about mothers in her treatment ministry. She describes meth's sexual effect as "the equivalent of 10 orgasms all on top of each other lasting for 30 minutes to an hour, with a feeling of arousal that lasts for another day and a half." Dr. Holley goes on to report that after six months of use, meth no longer creates a sexual high and in fact, prevents sexual experience.

Some meth users may argue that 'functional' levels of meth use simply allow users to work long hours, focus more closely on projects at hand, or gain a certain sense of well-being. Overall, however, a traditional appeal of most intoxicants is sexual stimulation.

Send in the Marines
UN Integrated Regional Information Networks, Dec. 13, 2004

Small landholders in Swaziland are growing patches of marijuana to generate cash and to provide an important medical treatment for their countrymen suffering from AIDS. Under pressure from global drug warriors, Swazi police continue an aggressive eradication campaign. Aerial defoliation stopped in 2002 after funding dried up, so police are conducting foot patrols in the mountainous regions where the crops thrive on fertile soils.

"My father and his father grew dagga here; my son now knows how. We are far from markets, and the trucks from the marketing board (the National Agricultural Marketing Board) are unreliable. The marketing board tells us to grow tomatoes and such for sale, but our harvests can rot in the sun waiting for them," said a farmer near the provincial capital, Pigg's Peak.

Farmers admit to supplying marijuana to the growing number of people living locally with HIV/AIDS. Although growing dagga is illegal in Swaziland, there seems to have been a system in the past whereby some individuals obtained approval from the late King Sobhuza II to grow it for medicinal purposes.

Some support groups for people living with HIV/AIDS encourage their members to smoke marijuana to stimulate their appetites.

"Particularly when you are starting with the anti-retroviral drugs, your body can feel bad and you don't want to eat anything - that is when people become thin," Eunice Simelane of Swazis for Positive Living told IRIN.

Nearly 40 percent of adult Swazis are living with HIV, according to UNAIDS. According to a study by Swaziland's Council on Alcohol, Drug and Tobacco Abuse, an estimated 70 percent of smallholder farmers in the Hhohho region grow marijuana to some extent, as a cash crop.

Despite 25 Years of Drug War, US Prices are Down
Thursday, December 2, 2004 Agence France Presse
http://www.afp.com/

Cocaine and heroin are cheaper today on US streets, despite a multi-billion- dollar, 25-year drug war, according to the Washington Office on Latin America (http://www.wola.org/), citing data from the US drug czar.

"The demand for cocaine, crack and heroin is at least stable, if not rising," said John Walsh, an expert on the matter at WOLA, a Washington think-tank on Latin America. The price of two grams of cocaine dropped nearly 31 percent, from 161 dollars in 2000, when Washington launched Plan Colombia against drug traffickers and rebels, to 106 dollars between January and June 2003, the most recent data available, according to data delivered to WOLA by an unidentified member of Congress. The same data show that during the same period, the cost of a gram of heroin dropped 14 percent, from 414 to 362 dollars. In the first half of 2003 the prices of cocaine and heroin were one-fifth of their prices in the early 1980s, Walsh said.

"After 25 years and 25 billion dollars fighting drugs in Latin America, we are no closer to winning the drug war -- which is ultimately about reducing drug abuse," said Joy Olson, executive director of WOLA, in a presentation of the 400-page report. "We've spent billions on anti-drug efforts in Latin America and have nothing to show for it but collateral damage," Olson added. "We can do better. We've been tough on drugs; now it's time to get smarter."

WOLA, which seeks an alternative US drug policy, said that the data was prepared by the Rand Corporation for the Office of National Drug Control Policy, headed by White House "drug czar" John Walters. Rand is a private analysis firm. An anti-drug official confirmed the Rand statistics, but told AFP that WOLA's report was "sort of a half truth." He said that because the most recent statistics were not available, a 33 percent drop in Colombia's coca cultivation had not had a chance to be felt in the United States. "The impact of Plan Colombia is something that's going to be felt in the future, not in the past," the source said on condition of anonymity.

Walters said in October 2003 that the eradication of drug-producing crops in Latin America would cause substantial change in the availability of cocaine in the world in the next six to 12 months. In August 2004, he repeated that in 12 months there would be results. The United States has spent 3.3 billion dollars on Plan Colombia since 2000 and President George W. Bush said stated that he would push Congress for more money in 2005.

Drug Policy Education Group Inc. is a nonprofit 501(c)(3) Arkansas corporation dedicated to reducing the harm caused by drugs and by failed drug policy.

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How Many Use Drugs?

In the most recent federal study of mental illness and substance use/abuse, Arkansas ranked among the top tier of states with serious mental illness among adults 18 and older (9.8 to 11.35% of the adult population, up to 226,209 people). Not surprisingly, the study notes a positive correlation between per capita income and mental illness: the higher the percentage with serious mental illness (SMI), the lower the income. SMI is defined as a condition where the person sometime in the past year has suffered a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that interfered with a major life activity. (State Estimates of Substance Use 2002 by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA), U S Dept of Health and Human Services (http://oas.samhsa.gov/2k2State/html/toc.htm)

The study showed a variety of results for Arkansans using or abusing tobacco, alcohol, or illegal drugs. Arkansas showed the highest prevalence in the nation for persons aged 12 or older using some form of tobacco, at 39.9 percent, or over one third of the population.

Among Arkansans 26 and older, an estimated 64,670 used marijuana in the past month, while 44,483 used an illicit drug other than marijuana.

About 54,659 used marijuana in the past month, while about 46,898 used illicit drugs other than marijuana. Among persons 26 and older, an estimated 64,670 used marijuana in the past month, while 44,483 used an illicit drug other than marijuana. Over 975,000 Arkansans aged 12 and up used alcohol in the past month, with usage among persons age 18 and older around the 50% mark.

Arkansans needing but not receiving treatment for illicit drug or alcohol dependence or abuse among persons 18-25 was estimated at over 58,000, while for those 26 and up over 105,000 were unable to receive needed services. There was no estimate of how many Arkansans needed but failed to receive mental health services.

The 2002 survey is based on interviews with 68,126 respondents who were interviewed in their homes. This includes persons residing in dormitories or homeless shelters. The interviews represent 98 percent of the population ages 12 and older. Not included in the survey are persons in the active military, in prisons or other institutionalized populations or who are homeless.The new report presents state estimates for 20 measures of substance use or mental disorders.

Critics of the survey point out that the federal data is hopelessly out of touch with reality. Paul Armamento, Senior Policy Analyst for the NORML Foundation, noted: “Disregarding that many of America’s more egregious drug users do not possess consistent, long-term "places of residence" (some are homeless or enrolled in substance abuse treatment programs, and many are incarcerated on drug-related or other criminal charges) and, thus, are never polled by SAMHSA’s researchers, the larger problem still remains. How likely is it that the average American drug consumer is going to truthfully admit to a representative of the federal government — one who is standing in their living room, no less — that they engage in illicit activity punishable by a lengthy prison term? Judging by the fact that of the 130,605 addresses screened by SAMHSA, more than half refused to answer their questions, the answer is: not likely.

“Additionally, among those who did respond, it’s arguable that a sizable percentage significantly under-reported their illicit drug use. In fact, it would be hard to believe that they wouldn’t. According to a White House briefing paper analyzing SAMHSA’s figures regarding Americans alcohol and tobacco use, respondents have historically under-reported their usage of these two legal substances by as much as 30 to 50 percent. (Revenues from alcohol and tobacco taxes allow researchers to cross check respondents admitted usage patterns with actual annual consumption rates; naturally the prohibited status of controlled substances prevents researchers from conducting a similar comparative analysis on illicit drugs.) Based on this fact, one can only assume that respondents underreport their illicit drug consumption by similar or even greater margins.

“Annual arrest figures from the FBI cast further doubt on the Feds’ dubious figures. For example, of the nearly 1.6 million drug abuse violations reported annually, roughly 725,000 are for heroin and cocaine violations. (Federal statistics lump the two drugs together.) Put another way, if one is to accept SAMHSA’s survey data at face value, then approximately one-third of the nation¹s total population of cocaine users and perhaps even a greater percentage of America¹s heroin users have been arrested within the past year, and virtually every US cocaine and heroin user could theoretically be behind bars by 2005. Given that Americans’ illicit drug use has continued virtually unabated despite decades of ever-increasing anti-drug enforcement and prosecutions (more than 4.5 million Americans have been arrested for drug-related charges since 2000 and approximately 450,000 are now incarcerated on drug-related charges) one would have to assume that there exists a far larger pool of Americans engaging in the use of these substances than SAMHSA would like to admit.

“Interestingly, the lone figured touted by SAMHSA that appears to be based somewhat in reality is that 97 million Americans — more than 40 percent of the US population age 12 or older — have used marijuana during their lifetimes. (SAMHSA estimates the number of current marijuana users to be 14.6 million — a figure that appears low, but not absurdly low when checked against annual marijuana arrest data and interdiction data.) Perhaps this is because

most respondents, like many politicians, have fewer misgivings about admitting to past transgressions than they do divulging recent or current behavior. Or perhaps it's because marijuana consumption – particularly past use of the drug – carries far less of a social stigma than the use of other illicit substances."

DPEG's Goals *(continued from Page 1)*

DPEG's action plan:

- Investigate public defender salary and caseload status and compare to other states; Identify and contact other entities interested in this issue to build a coalition.
- Develop and distribute data regarding the dollars spent by Arkansas for drug law enforcement.
- Develop and distribute data regarding sentencing options used in other states.
- Develop and distribute information regarding the availability and adequacy of drug courts in Arkansas
- Communicate with and provide assistance to legislators who are working on reforms
- Make available through DPEG's Speaker's Bureau innovative speakers who have specific expertise on some aspect of drug policy; promote speaking tours to civic and community groups

3. The State of Arkansas must ensure the availability of adequate and accessible substance abuse treatment (Adopted from Wash. Co League of Women Voters 2003 study)**:**

a. Regarding accessibility, treatment programs should:

- have easily accessible locations
- be served by public transportation
- be affordable
- be advertised in a way that adequately informs the public and target populations of treatment availability
- be structured to encourage voluntary participation

b. Regarding adequacy, treatment programs should:

- provide immediate access to professional therapeutic services
- meet the "Principles of Effective Treatment" listed by the National Institute of Drug Abuse
- 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
- 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
- offer therapeutic programs tailored to individual need for both adolescents and adults, administered by professional, certified staff
- provide residential programs offering suitable, clean, orderly environments conducive to healing and allowing for outdoor exercise
- 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
- encourage the proliferation of diverse self-help groups including 12-step programs
- be evaluated by appropriate quality and accountability guidelines and licensing criteria, including long-term follow-up contacts with clients to the greatest extent possible.

DPEG's action plan: educate about optimum treatment.

4. The State of Arkansas should encourage schools to provide appropriate, adequate, and reality-based drug education for young people to include and otherwise reduce the harm of current policies:

- discussion of all drugs, legal and illegal, and their potential danger
- discussion of how and why people use and abuse substances
- discussion of the difference between use and abuse
- removal of law enforcement officers from drug education programs
- use of medical context for substance abuse discussion rather than criminal model
- elimination of zero-tolerance drug policies in schools

DPEG's action plan: Provide literature about reality based drug education to 50 libraries statewide; provide information about the failure of DARE programs and about the benefits of reality-based drug education to principals of the state's 50 largest secondary school districts; make available through DPEG's Speaker's Bureau innovative, recognized leaders in drug education.

5. The State of Arkansas should establish regulations governing the use of drug testing to include:

- protections for job applicants and workers (right of appeal, disclosure, confirming second test)
- promotion of performance testing instead of drug testing to ensure workplace safety
- regulations setting forth appropriate procedures governing drug testing in divorce/custody proceedings, in childbirth settings, and other

DPEG's action plan: Obtain model legislation for drug testing regulation, obtain information about such legislation in other states, provide these materials to key legislators, interest groups, labor unions and other stakeholders; gather documentation of testing abuses in Arkansas

6. The State of Arkansas should reform marijuana laws to allow for:

- medical use under a regulated program
- non-criminal penalties for adult possession of one ounce or less

DPEG's action plan: Provide education on the issue of medical use, to include the donation of literature to 50 libraries across the state; gather and disseminate information about non-criminal penalties as enforced in other states; gather and disseminate information about the cost of marijuana prohibition in Arkansas.

7. The State of Arkansas should eliminate laws against paraphernalia

Other Important Projects Underway at Drug Policy Education Group

1. **Delbert O. Lewis Memorial Library Project**
   Each year DPEG donates valuable books, articles, and other educational materials to 50 college and community libraries statewide. In 2002-03, DPEG's first donation included seven books, a video, five booklets, and four article reprints, a donation value over $6800. In 2003-04, the project donated three new publications including *Prescription Pot: A Leading Advocate's Heroic Battle to Legalize Medical Marijuana*, by George McMahon and Christopher Largen,; "Going to Pot: The growing movement toward ending America's irrational marijuana prohibition," by Ethan Nadelmann, which appeared in the July 12, 2004, issue of *National Review*;and *Drug War Facts* 4th Edition, a compendium of statistics and research from government agencies on topics as wide-ranging as methamphetamine to the addictive qualities of popular drugs such as alcohol and tobacco, Editor Doug McVay, Common Sense for Drug Policy. For a complete list of the previous donations: www.dpeg.org/resource/library.htm. The 2004 donations are valued at $1335. DPEG is currently accepting nominations and contributions toward the 2004-05 library donation.

2. **www.dpeg.org**
Website including Patient Forum
   DPEG's website features a community plan of action, a discussion of many issues involved in drug policy including types and effects of drugs, drug education, drug treatment, economics, and a review of DPEG's Speaker's Bureau panel with contact information,

3. **Five Year Plan for Reform Work in Arkansas**
   Early in 2005 DPEG's board of directors will work in a facilitated one day retreat to review its vision statement, mission statement, and operating guidelines. A five-year plan will be developed.

ONGOING WORK AT DPEG

1. Produce and Distribute Quarterly Newsletter
2. Produce and Distribute AAMM Report 2nd Edition
3. Maintain ongoing communication with scientists, business leaders, community activists, educators, medical professionals, and others who are interested in drug policy reform in America and around the world
4. Engage in effective communications and interactions with members of DPEG's Advisory Committee
5. Seek improved methods of educating and motivating at the grassroots level; plan and implement projects; recruit volunteers; raise funds; write grants, and carry out administrative responsibilities.
6. Schedule board meetings and online board discussions about the work of the corporation.

Your financial contribution supports our work and is tax deductible.

Drug Courts – A Contrary View

"The sheer irrationality of continuing to expand a policy doomed to failure begs an explanation. A Jihad comes to mind-a holy war that must be fought regardless of the resulting human horrors. Thus, some scholars who can no longer ignore the inevitable failure of past practices now proclaim a new solution, which the government is eagerly embracing. The phrase "coerced abstinence" is the practice of continuously drug-testing convicted criminals (and eventually, in all probability, many others) through special drug courts, to detect the presence of illegal drugs in their bodies. Judges, traditionally functioning as impartial legal experts during trials to guarantee due process of law, will now become shamans taking on the responsibilities of judging who is falling under evil spells. We will have legions of real-life television "Judge Judys" routinely denouncing and incarcerating people not on the basis of what they did, but because certain chemicals are present in their urine."

Former police chief Joseph D. McNamara,
Psychiatric Times September 2000 Vol. XVII Issue 9

Robert Field of Common Sense for Drug Policy (CSDP) makes the following points in support of such opinion:

1) People who are forced into treatment may not actually need it. They may just be people who use drugs in a non-problematic way who happened to get arrested.

2) Providing coerced treatment, at a time when the needs for voluntary treatments are not being met, creates the strange circumstance of someone needing to get arrested to get treatment.

3) Some Drug Courts rely on abstinence-based treatment. For example, methadone may not be allowed to heroin addicts. In addition, some may rely heavily on urine testing rather than focus on whether the person is succeeding in employment, education or family relationships.

4) Drug Courts often mandate twelve-step treatment programs that some believe to be an infringement on religious freedom.

5) Drug Courts invade the confidentiality of patient and health care provider. The health care provider's client is really the court, prosecutor and probation officer, rather than the person who is receiving drug treatment.

6) Drug Courts are creating a separate system of justice for drug offenders not based on the time honored adversarial roles of defense attorney, prosecutor and judge. Therefore, a relapsed patient may end up with much harsher penalties than from a regular court.

7) Drug Courts could result in more people being prosecuted than ever, thus expanding the harm caused by the drug laws."

Visit CSDP's website at www.csdp.org

At the least, public policy makers in Arkansas must determine that tax dollars spent on drug court are supporting a workable, just system. Anything less is a step in the wrong direction.

Pain versus Morality

EDITORIAL

Over the last several months, the drama has intensified between physicians and the U. S. Drug Enforcement Agency (DEA) on the issue of pain medication. Increasingly, DEA is prosecuting doctors for allegedly over-prescribing pain medicine. Doctors have become hesitant to prescribe even for patients in obvious pain. Patients are left to suffer. Behind it lurks the relic ethic that pain is somehow a necessary burden and that there is something wrong with “feeling good.”

DEA uses a set of criteria to determine whether prescriptions are needed. These so-called “red flags” include “targeting,” which is simply looking to see how many pain medication prescriptions a physician may issue. In the surveillance phase, DEA agents hang out in the doctor’s parking lot to observe whether large numbers of patients are coming and going. License plates may be traced to see if patients are coming a long distance. If patients have a shabby appearance, this is considered a red flag.

A “sting operation” sends in wired undercover agents posing as patients. Yet even in cases where such agents are refused the requested prescriptions, doctors often are still prosecuted. DEA typically uses full force in their search and arrest methods. Doctors are humiliated in the media, turned over to their state medical boards, and become unable to practice medicine before a trial is ever convened.

Frank B. Fisher, M.D., is a Harvard-trained general practitioner who has joined the growing number of physicians speaking out against these abuses. In a recent article for the *Journal of American Physicians and Surgeons* (V 9, No.4 Winter 2004) he summarizes:
“Opioid prohibition is a social experiment, accompanied by the unintended but apparently inevitable consequence of transferring responsibility for the regulation of pain management from the medical profession to law enforcement.... This results in a regulatory environment in which the well-intentioned conduct of conscientious physicians may later be second-guessed by law enforcement as criminal.”

Laws don’t appear in a vacuum, and in spite of our nation’s assumed role as leader in caring about the ills of the world, the DEA’s power over medical options stems from a drug war hysteria accepted seemingly without question by the religious right. In “Life Everlasting,” in the February 2005 issue of *Harper’s Magazine*, author Garret Keizer discusses this point. “Assuming that one’s life might be taken as the most private of all forms of property, one might also assume that the option for assisted suicide would resonate most powerfully with conservatives. But to make that assumption would give too much weight to ideology and too little to the psychology that informs it. The right talks about protecting life and tradition, but on some level ... it is mostly interested in protecting pain. For two reasons.

“The first is theological: the belief that pain holds the meaning of life. Supposedly, and demonstrably, this is a Christian idea, though if Jesus himself had believed it, he would have told the lepers to find meaning in their sores. The fact is, with even a little encouragement, most lepers do. This explains the conundrum so perplexing to the liberal mind: why hard-pressed people can vote against their own interests in support of someone like George W. Bush. How can they not see? In fact, they do see; they see from the same point of view that has led them to believe that the misery of their lives is the foundation of their integrity.

“The second reason, which can always be counted on to exploit the first, is political: the belief that pain is fundamental to justice, which makes perfect sense if justice is conceived as nothing more than a system of punishments and rewards. The essence of punishment is pain. Whoever owns pain owns power.”

Mr. Keizer’s point – that pain wins salvation – undergirds the thinking of those who oppose a “feel-good” approach to pain management (and those who oppose recreational intoxication in general). But to the physician, who is scientifically trained and philosophically motivated to relieve pain, there is no comfort in a theological or political justification for pain.

“The U.S. government has adopted a policy that will result in subjecting human beings to torture, without limit as to degree or duration, and without the necessity of proving them guilty (or even suspecting them) of any crime,” states Dr. Jane Orient in a recent guest editorial (1/5/2005 UPI “Jailed doc, tortured patient.”) Dr. Jane M. Orient is an internist who no longer treats chronic pain. She is executive director of the Association of American Physicians and Surgeons. Dr. Orient points out that in spite of elaborate precautions in the penal code and international relations against torture, torture is routine for patients in pain.

The routine acceptance of torture for patients suffering chronic pain results from the DEA’s determination to be in control of medical decisions, rather than allowing doctors to practice medicine as they see fit. DEA’s ongoing crusade to intimidate and prosecute physicians has shown the medical profession that no matter what the doctor’s intent, the government will not hesitate to send him to prison where he may die of old age. But DEA only enforces laws set down by elected representatives of the nation’s families and communities, legislators who don’t want to appear “soft” on drugs.

Most doctors won’t take the risk to address pain suffered by their patients when the weight of the government might soon fall upon their shoulders. They would rather under-medicate pain than risk DEA scrutiny. Aware that doctors and patients were struggling with this problem, and after years of holding out, DEA last year agreed to work with a panel of physicians to establish a set of guidelines agreeable to both parties. However, within days of posting the guidelines to their website, the DEA withdrew the material without explanation.

Dr. Orient stated in her article that DEA’s unilateral action “makes it clear that it is law enforcement that will define what is legitimate...”

Doctors familiar with pain treatment, like Dr. Orient, point out that high-dose opioids are actually safer than over-the-counter medications like Tylenol, which can cause liver damage. “There is no upper limit to the safe dose of opioids in a tolerant patient.

Unlike the nonsteroidal antiinflammatory drugs (such as ibuprofen and naprosyn), they don't cause sudden fatal internal bleeding."

Dr. Orient concludes: "We won't know how many patients will suffer torture because of the deterrent effect on other doctors. But it's not the DEA's problem. It did its duty. A message has been sent, in the interest of protecting the public health from demon drugs. Shouldn't all patients be willing to be sacrificed for such a noble objective?"

Indeed, shouldn't we all be willing to suffer if the suffering somehow redeems us? Until we understand the dark need for human sacrifice that lurks behind our drug laws, we can have little hope that effectively treating pain will be tolerated.

Resources

"The Brain's Own Marijuana"
article in *Scientific American* Nov 22, 2002
also see Editorial in the same issue.
Visit their website at www.scientificamerican.com

Judges Against the Drug War: a new online database of legal opinions in which judges critique prohibition.
Visit www.judgesagainstthedrugwar.org

False Positive Drug Test

Experts advise that a drug screen which comes back positive for marijuana should not be accepted as a conclusive result. False positives can show up for many different reasons. A urine analysis on a chromatograph or mass spectrometer is required to authenticate an initial positive screen. Such analysis requires a "limit of detection", usually 50ng/ml as accepted by government and most employers. Some less than professional drug testing agencies may test for any level of detection, rather than using the 50ng/ml limit.

Drugs such as Protonix might cause a positive initial screen for marijuana and Ritalin may produce a positive result for methamphetamine. Some older tests also show positive marijuana results for ibuprofen.

For more information, visit www.canorml.org for drug testing tips.

YOU CAN HELP!
If you have experienced a drug testing abuse, please contact DPEG so we can document your experience.
No names required

Drug Crazed Legislature *(Continued from Page 1)*

amount of illegal drug in its system, does the infant then become a ward of the state? Is the drug testing of a newborn child an un-Constitutional search?

HB 1265 does not describe how a court will determine whether a woman charged with marijuana possession might be determined to be pregnant so that the enhanced penalties could be applied. Does the bill author anticipate that law enforcement officers will routinely require pregnancy tests for women arrested on drug charges?

Aside from clearly troubling Constitutional and procedural issues raised by these proposed bills, Rep. Hutchinson's apparent overwhelming concern for the welfare of unborn children seems wide of its intended mark. By far a greater risk to Arkansas fetuses is the widespread use of tobacco and alcohol.

Whether or not these drugs are legal, it is common knowledge that fetal alcohol syndrome is a real and present danger. "Fetal Alcohol Syndrome (FAS) is a pattern of mental and physical defects which develops in some unborn babies when the mother drinks too much alcohol during pregnancy. A baby born with FAS may be seriously handicapped and require a lifetime of special care. Some babies with alcohol-related birth defects, including smaller body size, lower birth weight, and other impairments, do not have all of the classic FAS symptoms." (Missouri Div. of Alcohol and Drug Abuse).

Tobacco is also known to have a negative impact on a fetus. According to medical fact sheets, "Pregnant women who smoke are more likely than nonsmokers to have low birthweight babies and babies who are at risk for developmental delays. Maternal smoking is a contributing factor in 14 percent of premature deliveries in the United States. Additionally, there is a direct correlation between the amount of smoking during pregnancy and the frequency of spontaneous abortion and fetal death."

Shall government single out pregnant women for selective enforcement of targeted laws in an effort to ensure optimum breeding conditions for future generations? Or shall humanity continue as it always has, guided by individual conscience which for itself must determine whether to eat right, exercise, avoid harmful chemicals, and otherwise responsibly provide for the well being of the next generation?

If government has a role in this ancient human activity, it should be to promote in every possible way enhanced opportunities which might help build a responsible consciousness. Self-esteem, access to health care, and a good early-childhood preparation for life are critical elements in the fostering of such a consciousness. A far greater number of Arkansas women expose their fetuses to alcohol and tobacco than to all illegal drugs combined. It is not the chemical that is the problem.

How Much Should Arkansas Spend to Punish Pot Smokers?

Decriminalization of marijuana has already occurred in most states, whether embodied in the language of the law or by default. In Ohio, for example, possession of less than 100 grams (about three ounces) brings a citation with a $100 fine. In Nebraska and Colorado, a ticket with a $100 fine is handed out to anyone caught with an ounce or less. In Alaska, a person may possess up to four ounces with no penalty.

Arkansas lists one ounce or less as a misdemeanor offense punishable by up to $1000 fine and one year in jail. Offenders go through a well-worn routine that costs both the offender and the state more than the "crime" merits. The offender must obtain legal counsel, usually from the public defender for their district. Months go by as the prosecutor, defender, and the court wrangle over the details of a plea bargain, which usually results in a fine and period of probation. During probation, offenders may be required to make regular monthly visits to a probation officer and to submit to random drug tests. Failed drug tests result in jail time.

Marijuana arrests account for 70% of drug arrests in the State of Arkansas. Taxpayers support a considerable cost EACH YEAR for involving marijuana users in the criminal process:

- $20 million – Estimates of police time spent in marijuana arrest, booking, and testimony[1]
- $3 million – The state pays over $15 million for public defender salaries, of which about 20% are marijuana cases. This cost does not include each county's expense in providing office space, support staff, and other operating expenses. [2]
- $1,017,000 – In Washington County, public defender support costs are roughly $300,000 for 2005.[3] Estimating on a per capita basis for the rest of the state and calculating only the percentage that applies to marijuana, taxpayers of Arkansas may spend more than $1,017,000 in county support of public defense for marijuana offenders.
- $4 million – Salaries and support for prosecution are at least as much as the public defense cost in marijuana offenses.
- $30,328,536 – Corrections expenditures in the State of Arkansas, based on 2001 statistics, include an estimated $86,652,960 for drug offenders. Marijuana offenders constitute 70% of drug arrests. We are estimating that half of marijuana offenders serve some jail time.[4]

TOTAL: $58,345,546 spent annually by the State of Arkansas to punish marijuana users

Not taken into account are indirect costs to the State:

- Loss of employment due to arrest – offender no longer earning wages, no longer paying taxes
- Loss of household support – offender dependants often require food stamps, rent assistance, and Medicaid.
- Loss of future earnings potential – criminal record impedes offender's ability to earn for the rest of his/her lifetime
- Loss of self-esteem – demeaning experience of criminal prosecution undermines offender's ability to lead a successful life
- Loss of respect for American legal system – offender views his/her arrest for marijuana as an unjust prosecution; frequently cites comparison to alcohol as equally strong intoxicant and/or tobacco as equally harmful

The original intent of draconian drug laws including criminal prosecutions for possession of small amounts of marijuana was to teach young people a lesson and/or scare them away from experimenting with drugs. But the majority of marijuana users are adults making personal choices about which intoxicant suits their needs and preferences. What an adult may choose to do in his or her own living room is hardly an activity that can be controlled by the state. $58 million per year is a price Arkansas can ill afford to pay in pursuit of this elusive and questionable objective.

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[1] Bauer, Lynn & Steven D. Owens, *"Justice Expenditure and Employment in the United States, 2001"* (Washington DC: US Dept of Justice, Bureau of Justice Statistics, May 2004), NCJ202792, p. 4.

[2] Public Defenders Commission, Little Rock December 2004

[3] Boyd Darling, Washington County Comptroller December 2004

[4] Bauer and Owens