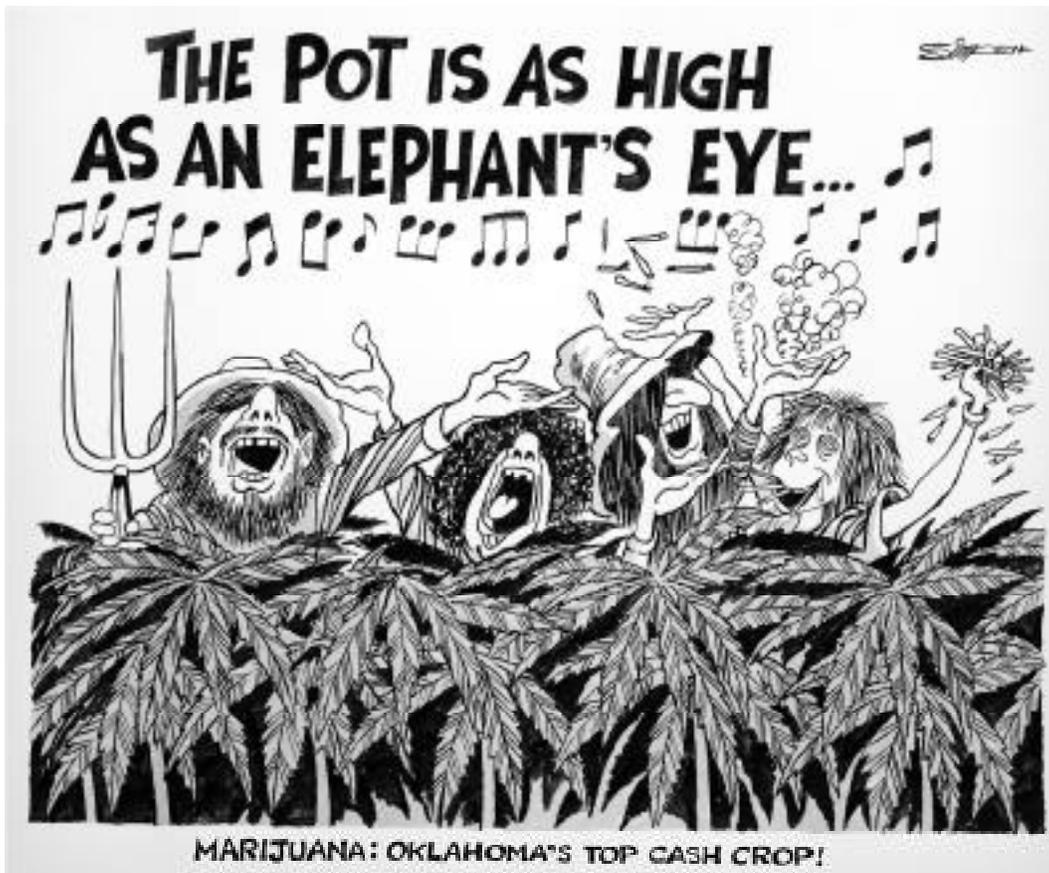


Drugs

“Legal ... Illegal ... and Otherwise”



*2005 Town Hall
October 23-26 in Norman*



Created for the Oklahoma Academy by David Simpson

OUR 2005 TOWN HALL

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Our 2005 Town Hall

Julie Knutson, President and CEO, Oklahoma Academy; Howard Barnett, Jr., TSF Capital; Michael Lapolla, University of Oklahoma; & Craig Knutson, e-conographic Consulting Services

The 2005 Town Hall recognizes that the term "drugs" has both a positive and negative tone. And that governments and businessesees are increasingly dealing with issues related to both. It is also recognized that these "drugs" are causing a myriad of debates concerning their use, abuse and social costs. Miracle drugs cure - at a price. Illegal drugs destroy - at a price. Government, business and our commonwealth must sort out the good, the bad and the in-between.

The topic originally considered was "substance abuse". Executive Committee discussions revealed that there is more to "drugs" than just the illegal abuse. It was realized that legal drugs - pharmaceuticals - are an emerging force in the health care arsenal of therapies; that businesses cope with the costs of health care and prescription drug benefits as much as they do with absenteeism caused by the use of illegal drugs. It is time to take a good look at both and determine the public policies that advance the positive outcomes of legal drugs and minimize the negative consequences of the abuse of illegal (and legal) drugs ... and alcohol. Oklahoma is **THE** national leader in three important public policies – one concerning prescription medicine – one concerning illegal drugs - and one providing drug court alternatives alternatives to incarceration. It is likely that Oklahoma is emerging as an important state for the development of effective policy. We need to continue.

- Oklahoma is the **FIRST** state in the nation to allow the responsible and transparent transfers of unused prescription medicine from nursing homes to charity clinics.
- Oklahoma is the **FIRST** state in the nation to restrict the access to Sudafed (pseudoephedrine), the key ingredient for making "meth".
- Oklahoma provides the **MOST** "drug court" funding per capita of any state.

Each public policy has been effective, but none is perfect and each require adjustments. States from all over the country are contacting Oklahomans in order to replicate these policies where they live. Each public policy is elegant in its simplicity. The first two require no public funds, and drug courts save money; none of the policies are intrusive or onerous; none requires new employees or new agencies. These are the types of effective "out-of-the-box" ideas we need. Are you up to the challenge?



*Howard Barnett
Chairman
2005 Town Hall*



*Julie Knutson
President & CEO
Oklahoma Academy*



*Michael Lapolla
Research Co-Coordinator
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*Craig Knutson
Research Co-Coordinator
2005 Town Hall*

Pre-Town Hall Thoughts

Ross U. Robinson, Norman Economic Development Coalition

Editor's Comment:

As we were planning our Town Hall research, we approached Mr. Robinson and sought his perspective of the impacts of drugs - both legal and illegal - on economic development. Listed below are his initial free-association thoughts. We think they are on the mark. We think you will agree.

Regarding "Drugs", I am jotting down a few thoughts which might be of some value to your planning group. Undoubtedly, many (or most) are probably already in your thinking.

- I think of drugs as but one of a wide variety of forms of therapy. We can cause medical improvement by radiation treatment, electrostimulation (pacemakers is an example), physical devices (stents, hip joints). I also include diagnostics as a critical component in the therapeutic process. Should we allow tests that tell of a disease for which we do not have a cure?
- There are many problems with the therapeutic delivery system. Specialty hospitals, home treatment, for example. Where is the best place to perform or deliver therapy.
- The cost of therapy is a major problem, with pharmaceutical formulations only one of the more visible issues.
- There are number of alternatives to Western medicine that raise issues, such as acupuncture, natural products, nutraceuticals. How do you regulate these?
- Our system is built to respond to medical problems but there is a growing interest, market and industry to think about prevention.
- In Oklahoma, we tend to focus on the "companies that might be" while we ignore those we have had for some time such as Astellas (new name for Yamanuchi), Scott Sabolich, Smith and Nephew. And we ignore the losses such as Shaklee. Contract manufacturing can grow again and I think diagnostic and devices are likely to be important to the Oklahoma economy.
- Drugs are the most highly regulated of all industries, including the other components of the therapeutic spectrum. For the most part, this is federal and international regulation, not something that the states do.
- There are increasing issues related to moral issues. Pharmacists are now resisting selling "morning-after pills." Medical research is being seriously hampered by resistance to stem-cell research. Some states are now moving to get around the federal ban on embryo use. Contention now exists with regard to handling genetic diseases and the information that becomes available.
- Therapeutic research is getting both tougher and more interesting. Small molecules, which can be delivered orally, will always have difficulty with the benefit/toxicity ratio. We can see and even predict side effects more easily. We can now synthesize large drug molecules such as peptides and proteins which have a sharper focus but which are very difficult to deliver.
- Brain research leads to the possibilities of better understanding your thoughts and to therapies that can "improve" them. Psychophysiology research (little in Oklahoma) will become an arguable research area.
- Drug research in Oklahoma has consistently exported the results to other places where companies benefit economically. We do better at the devices and diagnostics possibilities which are growing in the state.
- A few other issues which might be of interest - Drug advertising, risk aversion in Oklahoma, drug interactions, clinical trials, role of charity in therapeutic delivery etc.

The Big Picture in Oklahoma

Terry Cline, PhD, Oklahoma Secretary of Health

Introduction

The abuse of illicit and prescription drugs is a problem that not only plagues our nation, but is destroying the infrastructure upon which our state's future is built. While we have made significant advances, we have yet to reach the point where we must be to sufficiently address this priority health issue.



State's response to the problem

The state commits approximately 10.5 percent of the public budget toward substance abuse, or about \$213 per household, with 99.5 percent of those funds used for criminal justice activities. One-half a percent of these funds, or just over \$10 of the \$213 per household, are used to fund treatment and prevention.

Understanding the Problem: Public Policy has Traditionally Viewed Substance Abuse as a Criminal Issue.

Speak of drug abuse, and many immediately think of the term “war on drugs” and the myriad of law enforcement programs and crime prevention efforts that receive so much public attention.

Billions of dollars are annually earmarked for these programs. Yet, very little funding, a miniscule amount in comparison, is set aside to focus on the primary means to immediately impact criminal and other negative societal consequences resulting from drug activities – an individual's abuse and addiction to these substances.

Costs of Untreated Substance Abuse in Oklahoma

The economic impact of untreated substance abuse in Oklahoma is \$5.5 billion annually. Indirect costs related to premature death and lost productivity account for more than \$4 billion. Direct expenditures, actual costs incurred and paid for each year, are \$1.4 billion.

The majority of this expense is incurred within the criminal justice system – some \$788 million – for law enforcement programs, court costs and incarceration. Another \$398 million represents direct healthcare expenses, with a majority of that being absorbed by local hospitals for treatment of injury and disease resulting from substance abuse.

Provision of other social services to address issues such as family violence and child neglect, property damage and employer costs make up the bulk of the remaining balance.

In effect, 10.5 percent of the budget is targeted to pick up the pieces and less than one percent to address the root causes. Still, we have not managed to lessen criminal activity associated with substance abuse, nor have we curbed the need for substance abuse treatment. In fact these numbers are on the rise.

The filing of criminal charges, court convictions and incarceration rates for substance abuse crimes have dramatically increased on an annual basis. The state's substance abuse treatment system is turning away hundreds of potential clients each month due to a limited ability to meet service demands. And, we have witnessed a rise in substance abuse among many population groups which signals a potential increase in future system stressors.

Incarceration versus appropriate treatment

We have focused on crime and punishment as the primary means to stop drug abuse. This is akin to treating the symptoms of a disease without healing the disease itself.

It is not a condemnation of the criminal justice system. Drug interdiction programs and the prosecution of criminal activity are vital components of our efforts to curb the societal impact of drug abuse. However, treatment has proven to be far less costly and much more successful in reducing the demand for drugs and alleviating their negative effects. Access to the appropriate treatment and programs such as drug courts, designed to help the individual maintain recovery and become productive members of

society, rather than becoming a public burden, are now seen as an effective means to offset what was once seen as impossible...a reversal of the ills of substance abuse.

Results show that Oklahoma drug court graduates are almost two times less likely to be re-arrested than successful standard probation drug offenders. Drug court graduates are four times less likely to be re-arrested than drug offenders who serve out their sentences and are then released from prison. Economic studies have proven the benefit of partnering healthcare services with the criminal justice system.

Arrest, prosecution and incarceration without treatment have a lessened impact on future system and economic demands. If an abuser entering the criminal justice system does not receive treatment for the abuse, that individual is much more likely to recommit a crime than someone who receives treatment. There are also many individuals who are arrested for lesser crimes or non-violent crimes who would benefit more from treatment than incarceration or other adjudication measures not mandating treatment.

Treatment markedly increases employment and decreases homelessness, results in substantially improved physical and mental health, and reduces other risky health behaviors. When tailored to the needs of the individual, addiction treatment is as effective as treatments for other illnesses, such as diabetes, hypertension, and asthma.

Prescription Drug and Over-the-Counter Medication Abuse: Significant Increases in Reported Cases of Abuse Raise Public Health Concern

Substance abuse involves more than the illicit trade and the criminal activity so readily associated with substance abuse. There is a very serious and ever growing public health concern related to the non-medical use of prescription and over-the-counter drugs. The abuse does not necessarily take place through any type of criminal action. Abuse of prescription drugs may occur accidentally when a patient fails to follow usage instructions. It also occurs when a person illegally obtains a legal prescription drug for non-medical use.

It very well may involve individuals who do not fit the common stereotype of a drug user. Most are law abiding citizens, gainfully employed and outstanding members of the community. And, while the drugs in question have legitimate medical use, and when used appropriately are very effective medical tools, there is the potential for abuse and addiction.

Who is the Abuser? There is an Erroneous Public Perception of Substance Abuse

The emphasis on substance abuse as a criminal issue has aided in creating an erroneous public perception that drug abuse affects only a small portion of society, plaguing disadvantaged socio-economic communities, criminal elements and individuals without a sense of self-worth. Typically, one thinks of street corner drug deals involving illicit substances. Substance abuse is in reality an indiscriminate disabler and killer. It is unconcerned with an individual's family background, economic situation, education or residency.

The Addict

SAMHSA reported there are an estimated 16.7 million adult users of illicit drugs in the United States. About 74 percent are employed either full time or part time.

Most people who commit prescription medication fraud are individuals without criminal records who otherwise would be considered law-abiding citizens. Their condition has most likely continued unnoticed by their physicians and they have turned to fraud as a means to feed their addiction.

These descriptions do not meet the stereotypical picture of a drug abuser. They are however an accurate depiction of addiction across our nation and state.

Addressing the Problem is the Responsibility of Us All:

The negative impact of substance abuse goes well beyond the individual. It affects the lives of families and loved-ones and has wreaked havoc on our state's economy, healthcare system and quality of life. The far reaching impact of substance abuse on all Oklahomans demands our immediate attention to the issue.

Who's Coming Into My ER?

Mark Brandenburg, MD, Saint Francis Hospital, Tulsa

Mark A. Brandenburg, M.D., FACEP is a Clinical Associate Professor and Director, Emergency Medicine Student Programs within the Section of Emergency Medicine/ Dept. Internal Medicine, University of Oklahoma College of Medicine-Tulsa. He is also a practicing physician at the Trauma Emergency Center, St. Francis Hospital in Tulsa, Oklahoma.

The general categories of patients and their abuse-related conditions and adverse events are as follows:

Prescription Drugs

- *Drug seeking behavior*
- *Withdrawal symptoms*
- *Injuries caused by the influence of prescription drugs*
- *Unintentional overdose*
- *Intentional overdose*
- *Pediatric exposure/ingestion*

Illicit Drugs

- *Withdrawal symptoms*
- *Injuries caused by the influence of illicit drugs*
- *Medical problems caused by illicit drugs*
- *Unintentional overdose*
- *Intentional overdose*
- *Pediatric exposure/ingestion*
- *Violent acts related to the buying or selling of illicit drugs*

Alcohol

- *Acute poisoning*
- *Withdrawal symptoms*
- *Injuries due to alcohol intoxication*
- *Medical problems caused by chronic alcohol abuse*

Tobacco

- *Chronic heart and lung disease*

Introduction

Substance abusers represent about 30% of all emergency department patients. Many of these patients are addicted to more than one substance. And many of these patients present with acute medical problems or injuries related to substance abuse.

Prescription Drugs

Drug Seeking Behavior

There are two major classes of addictive medications prescribed by physicians: opioids (pain killers) and benzodiazepines (sedatives). Terms like, “drug seekers” and “doctor shopping” were first coined for patients desiring these medications. In the Emergency Departments we are seeing large numbers of patients seeking prescriptions for these medications.

These patients require an inordinate amount of time to manage as the physician is charged with the responsibility to ensure that patients do not suffer excessive pain. Also, great care must be made to avoid harming patients through the indiscriminate prescribing of these medications.

Drug seeking patients are very skilled at manipulating the health care system and staff in order to obtain the desired prescription. For example, “drug-seeking” patients often present to the emergency department after office hours when their doctor is not on call, making it impossible to verify the accuracy of their stated illness.

Many of these patients will feign illness or injury in any number of ways, giving “Academy Award” (no pun intended) performances to demonstrate their “pain”. It is a relatively well-known practice for “drug seekers” to feign kidney stone pain and provide a specimen of bloody urine produced by

pricking a finger in the bathroom when collecting the urine. One such patient presented a small stone he had “passed” while urinating in the bathroom- the hospital pathology lab could not identify the material and thus referred it to a national lab for further analysis- the final elemental analysis showed the stone to be consistent with “common gravel”. Other such patients feign cancer, heart disease and injuries from motor vehicle crashes and assaults.

The indiscriminate prescribing of addictive medications has serious long-term consequences not only for the patients but also the medical facility from where the prescriptions originate. If word on the street gets out that a certain facility is “easy,” the volume of “drug seekers” can rise dramatically, creating longer waits for other patients and bogging down the facility.

On the other hand, when not receiving the medication or prescription desired, “drug seekers” can become boisterous, angry, unruly and even threatening to physicians, nurses and staff members - as a result, health care professionals have been assaulted and even murdered in Oklahoma emergency departments. This problem is compounded by the lack of a standard approach to drug-addicted patients by physicians throughout the community.

Withdrawal Symptoms

Abrupt cessation of opioids and benzodiazepines can create vomiting, diarrhea, restlessness, agitation, sleep deprivation psychosis, seizures and violent behavior depending on the medication and individual circumstances.

Injuries Caused by the Influence of Prescription Drugs

On occasion an injured opioid- or benzodiazepine-intoxicated patient will present to the emergency department after causing a motor vehicle crash. These cases are rarely handled by the police as knowledge of the patient’s drug use is confidential and cannot be shared with police officers.

Unintentional Overdose

Most commonly, we see unintentional overdoses in patients requiring large doses of opioids because they are suffering from a terminal disease such as cancer. As the patient becomes tolerant to the pain killers and the disease process worsens, larger doses of the medication are often required to bring comfort to the patient. With these larger doses, however, comes the potential for serious side effects such as impaired consciousness and depressed respiratory effort.

Intentional Overdose

This is usually seen in patients who are depressed and wishing to commit suicide or make a gesture of suicide.

Pediatric Exposure/Ingestion

This is rare but is seen from time to time.

Illicit Drugs

Personal Observation: When asked how he continues to obtain methamphetamines after the passage of strict decongestant purchasing laws, a drug addict in the ER responded, “Man, crank is easier to get than ever- they’re shipping the stuff in from Texas and Mexico by the truck loads.” Regardless of the decrease in “meth busts” - this emergency physician has not yet observed a decrease in patients using methamphetamines.

Withdrawal Symptoms

We see far fewer patients withdrawing from illicit drugs than from prescription drugs. When suffering withdrawal symptoms the addicted patient will usually return to the source of the drug. If that source is a street drug dealer, the addict will show up at the street corner where the drugs can be purchased.

Injuries Caused by the Influence of Illicit Drugs

We see great numbers of patients who have injured themselves or others in various mechanisms of injury (i.e., motor vehicle, drowning, falling, guns, etc) as a result of being impaired by illicit drugs. About 2-3% of all injured patients presenting to the ER have been using illicit drugs.



Medical Problems Caused by Illicit Drugs

Various street drugs are well-known to cause specific medical problems: cocaine and methamphetamine can trigger arrhythmias, heart attacks, intracranial bleeding; intravenous use of any drug when needles are passed from person-to-person can spread hepatitis B and C and HIV. Needles contaminated with bacteria can also lead to a multitude of infectious processes in patients, including overwhelming sepsis, cardiac infections, and abscesses in the lung and brain- all of which can lead to disability and death.

Unintentional Overdose

Because a user of illicit drugs rarely knows the concentration of the drug they are using, overdoses are common. On occasion, overdose outbreaks will occur on the streets when a shipment of high concentration drug arrives in the community.

Intentional Overdose

This is seen on occasion in suicidal patients or persons attempting to dispose of evidence while being pursued by police officers.

Pediatric Exposure/Ingestion

Case examples include: parents sedating young children with methamphetamines, young children ingesting small amounts of drug found on a table top or floor, children drinking lye placed in a glass

(used for the manufacture of methamphetamine) because it looks like water sitting in a household refrigerator.

Violent Acts Related to the Buying or Selling of Illicit Drugs

These patients are often severely injured by gun shot and knife wounds. Also, we see many assaults by addicts needing money to buy more drugs.

Alcohol

Acute Poisoning

Severe acute poisoning can cause respiratory depression, violent retching and aspiration of gastric contents into the lungs- all of which can cause death and disability.

Withdrawal Symptoms

Alcohol withdrawal syndrome includes anxiety, high blood pressure, intractable seizures, hallucinations and psychosis.

Injuries Due to Alcohol Intoxication

The acute effects of alcohol impair a person's physical and mental abilities. The popularity and social acceptance of this drug have created a long-standing epidemic of alcohol-related injuries, particularly motor vehicle crashes. Twelve percent of injured patients in the Emergency Department are intoxicated with alcohol.

Medical Problems Caused by Chronic Alcohol Abuse

The chronic effects of alcohol abuse lead to a myriad of medical problems, including cirrhosis of the liver, pancreatitis, gastritis, anemia, dementia, delirium and a multitude of severe vitamin and nutritional deficiencies. Approximately 20% of all Emergency Department patients are alcoholics, though not always presenting with alcohol-related illnesses.

Tobacco

Emergency departments are full of patients suffering exacerbations of heart and lung diseases caused by the chronic use of smoking tobacco.

Who's Coming Into My Office?

Rosemary Priest, M.S., Tulsa

Rosemary Priest, M.S., is both a Licensed Professional Counselor, and Licensed Marital and Family Therapist. She practices in Tulsa.

I have been a licensed mental health counselor for over 20 years. My office is the “crossroads” for the ill-effects of illegal drugs, abuse of legal medicines and how they are intertwined with behavioral and/or mental health problems.

I am an eye-witness to how legal and illegal drugs affect the lives of those who use/abuse - and how the effects ripple through family systems and employment settings. I do not specialize in the treatment of substance abuse problems. Nevertheless, one of five clients will present with a problem unrelated to substances that soon incorporates the use or misuse of drugs and/or alcohol in one form or another.

Drug use and misuse will continue to rise and fall in our lifetime but the general trend is up, and has continued so for decades. The difference today is that people seem somewhat anesthetized to the effects of drugs. They blink and don't see what would have shocked and appalled them 10 years ago.

It is no longer clear that all biomedical advances are seen as good for society. Now certain advances are giving us the capability of accomplishing things that do not clearly solve a specific societal problem. Rather than improving the quality of living that exists at the time of a biomedical breakthrough, these advances sometimes greatly change the character of our culture. Many cultural changes have resulted from some of the advances in the field of pharmacology. There have been literally hundreds of drugs developed since the turn of the century. Psychoactive drugs, chemicals that affect the mind, are and evermore shall be here to stay.

It appears that our contemporary culture believes that anything can be cured with a pill, or some form of mind altering chemical. People don't use just any old drug anymore. They take only those that provide for them either a positive, satisfying, pleasurable effect or a decrease in their discomfort. There are obviously valid uses for some substances, especially prescription medications. However, prescription medications and even over-the-counter medications are extremely overused (shall we say abused?) in America. Rather than “fixing” a person's problems, the “drug cure” may cause an iatrogenic problem, dependency or addiction to the medications or substances they are taking to help them overcome their original problems. Dependence may indicate the importance of a drug, or the use of the drug, as a life-organizing factor. Psychological dependence on drugs refers to the prominent role of drug use in the person's repertoire of coping mechanisms.

How does the person cope with a stressful situation? Take a pill.

Drug taking behavior is not unique. It is the result of a complex interaction of past experiences and present environmental factors. Taking drugs does solve some immediate problems; however, it may have adverse long-term effects either by causing a new problem to arise or by preventing a better solution to the original problem.





Pills: How Many Is Too Many?

John, a 65 year old retired man, came for therapy for a phase of life problem. During the lengthy initial diagnostic interview, he revealed he had been prescribed and was taking 19 different medications, all prescribed by the same doctor. When I asked John if he was concerned about how many drugs he was taking, his response was “I never really thought about it. Should I be concerned? I figured the doctor put me on them for good reasons.” He actually had not given much thought about taking that many medications. This scenario is not uncommon. Many clients have reported taking four or more medications, some for physical problems, some for mental/emotional problems. How would anyone, even a physician or a pharmacist, know what the chemical interaction of that many medications will do to the person taking them. When one antidepressant, or anti-anxiety medication is not doing the trick, why not add another medication to see if that will give relief or help the person cope. John was using a prescription for anxiety that causes sleeplessness, then another one to help him sleep. He took a drug to elevate his mood that has a side effect of sexual dysfunction and another drug to help obtain an erection and that drug causes a heart problem. Then he took a medication to overcome the heart problem that exacerbates the erectile dysfunction. John was taking pills to counteract the side effects of the other pills he was taking. He felt better only temporarily until he needed another pill to help him counteract what he had just taken. Who would even begin to know how to cope with real life situations with that many different medications on board.



Tylenol?

Even over-the-counter medications can and are abused, either intentionally or unintentionally. Shelly, a 55-year-old female, was told by her doctor to take Tylenol after a recent medical problem, so she bought Tylenol PM. She took it four times a day and after about 3 days, she was acting bizarre. Shelly had an auto accident while under the influence of the Tylenol PM. She learned from her doctor that it contained Benadryl which, if taken in large quantities, can cause physical and mental problems. Shelly had taken so much after three days that she did not even know she was not functioning well; only her friends noticed there was something different about her behavior. Fortunately the officer working the accident did not have her drug tested or she would have received a DUI and perhaps her license would have been suspended.



In Love

Kim, a young 22 year old female with a disabled 5 year old son, found the “perfect” man and decided to marry him. When she found drug paraphernalia in her fiancé’s truck, she was advised that she needed to stop the wedding. If she proceeded, both she and her son would be at risk if her husband got caught with drug paraphernalia. DHS could take the little boy away from her. She was in love and married him against the therapist’s advice. Her new husband had promised to stop but continued to hide his use from her until one day she found evidence of him still using. She became very upset because of her concern with the possibility of losing her son if her husband was caught under the influence or with drug paraphernalia. She left her husband and filed for divorce. Would Kim have had enough courage to leave him if marijuana was legal and there would be no risk to her losing her son?

His Son's Ritalin

Tom, a 45 year old father who had been dealing with Adult Attention Deficit Disorder all of his life, had a child who also had A.D.H.D. The child was prescribed Ritalin. The father began taking his son's Ritalin because he thought if it helped his son, it would help him. Tom had a job that required non-use of drugs and his employer performed random drug testing. When the father's behavior became suspicious, the employer requested Tom to get a random drug test. Tom was surprised when the test came back positive for amphetamines. Ritalin is a central nervous system stimulant that is addictive. Tom's employer nearly fired him on the spot but instead sent him for treatment. Tom is now learning to manage his A.D.D. with more than just pills.



Bill Got Caught

Bill, a pharmacist, got caught stealing drugs that he was dispensing. He was released from his job and is going through a one-year suspension of his license. He has no income, his wife is working 50 hours a week to try to cover all the bills and they are slowly losing ground. The marital strain is becoming unbearable for them both. His career and his marriage may be ruined forever.



I Believe ...

Although it is my professional job, I'd much rather not have to counsel the parade of drug (legal and illegal) caused problems in my practice. It is "business" that I neither want or need.

These people were not falling down drunks, nor were they getting stoned every day. And these are not unusual stories. It is a serious problem. The pharmaceutical companies have made us believe that we need their products to make our lives happier and to be healthier. Their marketing appeals to an instant fix society, that drugs make us "feel better" by lifting our spirits, calming us down ... and helping us sleep, lose weight, concentrate, focus, etc etc. There seems to be a drug for everyone and everything. America has become too darned drug dependent!

Drugs are an insidious evil. They can take control of what we do, how we think, and how we act. We have come to believe that we can work longer, play harder, have more energy, and do whatever we want as long as we can rely on drugs to do it for us. We don't have to exercise to be healthy we can just take a pill. Where is this nonsense coming from? Pharmaceutical companies? Doctors? Insurance companies? The Cartel? Perhaps everywhere - for good reasons and bad. We are not controlling drugs, they are controlling us. And in a much more organized way today than ever before. Individuals need to know this. They need to fight back and take control of their own lives.

- Our society needs to get back to learning and using good coping skills to manage our lives more effectively rather than relying on legal and illegal drugs to do it for us. We need to be making wiser choices in our own healthcare decisions rather than blindly turning decisions over to others and assuming they are doing the right thing.
- Consumers of healthcare need to demand alternative treatments, and insurance companies need to allow more healthy alternatives to be prescribed, rather than solving every problem with a prescription or seeking illegal drugs on the streets. We have become so wrapped up in an instant fix that we quit before we have even begun to find appropriate answers to our daily living problems. Drugs are not the answer to all of our woes.
- We need to reserve the use of substances as a final answer not the first answer, not the easiest answer not the only answer. Healthcare alternatives are essential for America to begin to think differently about how to deal with our difficult living problems.

Legal Drugs

Legal drugs (pharmaceuticals and medicines) are increasingly becoming loud and contentious public policy issues. Why? Because the pace of research and development in the past 25 years has overrun our ability to sort out all the attendant public policy dilemmas while enjoying the obvious positive effects of pharmaceutical miracles. And because the sheer financial success of the industry has become a political story of envy, greed, social good and unintentional harm. When such divisive elements exist - can partisan politics be far behind?

This section provides information concerning the pharmaceutical industry, clinical issues, consumerism, optimizing medicines, and the little understood and illusory issue of “importing drugs because they are cheaper.”



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Rethinking Prescription Drugs

Malcolm Gladwell, *The New Yorker*, October 25, 2004. Permissions Granted.

Shark Fin

Ten years ago, the multinational pharmaceutical company AstraZeneca launched what was known inside the company as the Shark Fin Project. The team for the project was composed of lawyers, marketers, and scientists, and its focus was a prescription drug known as Prilosec, a heartburn medication that, in one five-year stretch of its extraordinary history, earned AstraZeneca twenty-six billion dollars. The patent on the drug was due to expire in April of 2001. The name Shark Fin was a reference to what Prilosec sales—and AstraZeneca's profits—would look like if nothing was done to fend off the ensuing low-priced generic competition.

The Shark Fin team drew up a list of fifty options. One idea was to devise a Prilosec 2.0—a version that worked faster or longer, or was more effective. Another idea was to combine it with a different heartburn remedy, or to change the formulation, so that it came in a liquid gel or in an extended-release form. In the end, AstraZeneca decided on a subtle piece of chemical reengineering. Prilosec, like many drugs, is composed of two “isomers”—a left-hand and a right-hand version of the molecule. In some cases, removing one of the isomers can reduce side effects or make a drug work a little bit better, and in all cases the Patent Office recognizes something with one isomer as a separate invention from something with two. So AstraZeneca cut Prilosec in half.

Shark Fin to Nexium

AstraZeneca then had to prove that the single-isomer version of the drug was better than regular Prilosec. It chose as its target something called erosive esophagitis, a condition in which stomach acid begins to bubble up and harm the lining of the esophagus. In one study, half the patients took Prilosec, and half took Son of Prilosec. After one month, the two drugs were dead even. But after two months, to the delight of the Shark Fin team, the

single-isomer version edged ahead—with a ninety-per-cent healing rate versus Prilosec's eighty-seven per cent. The new drug was called Nexium. A patent was filed, the F.D.A. gave its blessing, and, in March of 2001, Nexium hit the pharmacy shelves priced at a hundred and twenty dollars for a month's worth of pills. To keep cheaper generics at bay, and persuade patients and doctors to think of Nexium as state of the art, AstraZeneca spent half a billion dollars in marketing and advertising in the year following the launch. It is now one of the half-dozen top-selling drugs in America.

In the political uproar over prescription-drug costs, Nexium has become a symbol of everything that is wrong with the pharmaceutical industry. The big drug companies justify the high prices they charge—and the extraordinary profits they enjoy—by arguing that the search for innovative, life-saving medicines is risky and expensive. But Nexium is little more than a repackaged version of an old medicine. And the hundred and twenty dollars a month that AstraZeneca charges isn't to recoup the costs of risky research and development; the costs were for a series of clinical trials that told us nothing we needed to know, and a half-billion-dollar marketing campaign selling the solution to a problem we'd already solved.



“The Prilosec pattern, repeated across the pharmaceutical industry, goes a long way to explain why the nation's prescription drug bill is rising an estimated 17 % a year even as general inflation is quiescent,” the *Wall Street Journal* concluded, in a front-page article that first revealed the Shark Fin Project.

In “The Truth About the Drug Companies: How They Deceive Us and What to Do About It” (Random House; \$24.95), Marcia Angell offers an even harsher

assessment. Angell used to be the editor-in-chief of *The New England Journal of Medicine*, which is among the most powerful positions in American medicine, and in her view drug companies are troubled and corrupt. She thinks that they charge too much, engage in deceptive research, produce inferior products, borrow their best ideas from government-funded scientists, and buy the affections of physicians with trips and gifts. To her, the story of Nexium and drugs like it is proof that the pharmaceutical industry is “now primarily a marketing machine to sell drugs of dubious benefit.”

Of course, it is also the case that Nexium is a prescription drug: every person who takes Nexium was given the drug with the approval of a doctor—and doctors are professionals who ought to know that there are many cheaper ways to treat heartburn. If the patient was coming in for the first time, the doctor could have prescribed what’s known as an H2 antagonist, such as a generic version of Tagamet (cimetidine), which works perfectly well for many people and costs only about twenty-eight dollars a month. If the patient wasn’t responding to Tagamet, the doctor could have put him on the cheaper, generic form of Prilosec, omeprazole.

Nexium to Maalox

The patient’s insurance company could easily have stepped in as well. It could have picked up the tab for Nexium only if the patient had first tried generic Tagamet. Or it could have discouraged Nexium use, by requiring anyone who wanted the drug to pay the difference between it and generic omeprazole. Both the physician and the insurance company, meanwhile, could have sent the patient to any drugstore in America, where he or she would have found, next to the Maalox and the Pepcid, a package of over-the-counter Prilosec. O.T.C. Prilosec is identical to prescription Prilosec and effectively equivalent to prescription Nexium, and it costs only twenty dollars a month.

Throughout the current debate over prescription-drug costs—as seniors have gone on drug-buying bus trips to Canada, as state Medicaid programs and employers have become increasingly angry over rising health-care costs, and as John Kerry has made reining in the pharmaceutical industry a

central theme of his Presidential campaign—the common assumption has been that the rise of drugs like Nexium is entirely the fault of the pharmaceutical industry. Is it? If doctors routinely prescribe drugs like Nexium and insurers routinely pay for them, after all, there is surely more than one culprit in the prescription-drug mess.

Thinking About Prices

The problem with the way we think about prescription drugs begins with a basic misunderstanding about drug prices. The editorial board of the *Times* has pronounced them much too high; Marcia Angell calls them “intolerable.” The perception that the drug industry is profiteering at the expense of the American consumer has given pharmaceutical firms a reputation on a par with that of cigarette manufacturers.

In fact, the complaint is only half true. The “intolerable” prices that Angell writes about are confined to the brand-name sector of the American drug marketplace. As the economists Patricia Danzon and Michael Furukawa recently pointed out in the journal *Health Affairs*, drugs still under patent protection are anywhere from twenty-five to forty per cent more expensive in the United States than in places like England, France, and Canada. Generic drugs are another story. Because there are so many companies in the United States that step in to make drugs once their patents expire, and because the price competition among those firms is so fierce, generic drugs here are among the cheapest in the world. And, according to Danzon and Furukawa’s analysis, when prescription drugs are converted to over-the-counter status no other country even comes close to having prices as low as the United States.

It is not accurate to say, then, that the United States has higher prescription-drug prices than other countries. It is accurate to say only that the United States has a different pricing system from that of other countries. Americans pay more for drugs when they first come out and less as the drugs get older, while the rest of the world pays less in the beginning and more later. Whose pricing system is cheaper? It depends. If you are taking Mevacor for your cholesterol, the 20-mg. pill is two-twenty-five in America and less than two dollars if you buy it

in Canada. But generic Mevacor (lovastatin) is about a dollar a pill in Canada and as low as sixty-five cents a pill in the United States. Of course, not every drug comes in a generic version. But so many important drugs have gone off-patent recently that the rate of increase in drug spending in the United States has fallen sharply for the past four years. And so many other drugs are going to go off-patent in the next few years—including the top-selling drug in this country, the anti-cholesterol medication Lipitor—that many Americans who now pay more for their drugs than their counterparts in other Western countries could soon be paying less.

The second misconception about prices has to do with their importance in driving up over-all drug costs. In one three-year period in the mid-nineteen-nineties, for example, the amount of money spent in the United States on asthma medication increased by almost a hundred per cent. But none of that was due to an increase in the price of asthma drugs. It was largely the result of an increase in the *prevalence* of usage—that is, in the number of people who were given a diagnosis of the disease and who then bought drugs to treat it.

Asthma and Cholesterol

Part of that hundred-per-cent increase was also the result of a change in what's known as the *intensity* of drug use: in the mid-nineties, doctors were becoming far more aggressive in their attempts to prevent asthma attacks, and in those three years people with asthma went from filling about nine prescriptions a year to filling fourteen prescriptions a year. Last year, asthma costs jumped again, by twenty-six per cent, and price inflation played a role. But, once again, the big factor was prevalence. And this time around there was also a change in what's called the therapeutic mix; in an attempt to fight the disease more effectively, physicians are switching many of their patients to newer, better, and more expensive drugs, like Merck's Singulair.

Asthma is not an isolated case. In 2003, the amount that Americans spent on cholesterol-lowering drugs rose 23.8 per cent, and similar increases are forecast for the next few years. Why the increase? Well, the baby boomers are aging, and so are at greater risk for heart attacks. The

incidence of obesity is increasing. In 2002, the National Institutes of Health lowered the thresholds for when people with high cholesterol ought to start taking drugs like Lipitor and Mevacor. In combination, those factors are having an enormous impact on both the prevalence and the intensity of cholesterol treatment. All told, prescription-drug spending in the United States rose 9.1 per cent last year. Only three of those percentage points were due to price increases, however, which means that inflation was about the same in the drug sector as it was in the over-all economy.

Cause and Effect

Angell's book and almost every other account of the prescription-drug crisis take it for granted that cost increases are evidence of how we've been cheated by the industry. In fact, drug expenditures are rising rapidly in the United States not so much because we're being charged more for prescription drugs but because more people are taking more medications in more expensive combinations. It's not price that matters; it's volume.

This is a critical fact, and it ought to fundamentally change the way we think about the problem of drug costs. Last year, hospital expenditures rose by the same amount as drug expenditures—nine per cent. Yet almost all of that (eight percentage points) was due to inflation. That's something to be upset about: when it comes to hospital services, we're spending more and getting less. When it comes to drugs, though, we're spending more and we're getting more, and that makes the question of how we ought to respond to rising drug costs a little more ambiguous.

CareSource Case Study

Take CareSource, a nonprofit group that administers Medicaid for close to four hundred thousand patients in Ohio and Michigan. CareSource runs a tightly managed pharmacy program and substitutes generics for brand-name drugs whenever possible. Nonetheless, the group's pharmacy managers are forecasting at least ten-per-cent increases in their prescription-drug spending in the upcoming year. The voters of Ohio and Michigan can hardly be happy with that news. Then again, it's not as if that money were being wasted.

The drug that CareSource spends more money on than any other is Singulair, Merck's new asthma pill. That's because Medicaid covers a lot of young, lower income families, where asthma is epidemic and Singulair is a highly effective drug. Isn't the point of having a Medicaid program to give the poor and the ailing a chance to live a healthy life? This year, too, the number of patients covered by CareSource who are either blind or disabled or have received a diagnosis of aids grew from fifteen to eighteen per cent.

The treatment of AIDS is one of the pharmaceutical industry's great success stories: drugs are now available that can turn what was once a death sentence into a manageable chronic disease. The evidence suggests, furthermore, that aggressively treating diseases like AIDS and asthma saves money in the long term by preventing far more expensive hospital visits. But there is no way to treat these diseases in the short term—and make sick people healthy—without spending more on drugs.

The economist J. D. Klienke points out that if all physicians followed the treatment guidelines laid down by the National Institutes of Health the number of Americans being treated for hypertension would rise from twenty million to forty-three million, the use of asthma medication would increase somewhere between twofold and tenfold, and the number of Americans on one of the so-called "statin" class of cholesterol-lowering medications would increase by at least a factor of ten. By these measures, it doesn't seem that we are spending too much on prescription drugs. If the federal government's own medical researchers are to be believed, we're spending too little.

Volume and Price

The fact that volume matters more than price also means that the emphasis of the prescription-drug debate is all wrong. We've been focussed on the drug manufacturers. But decisions about prevalence, therapeutic mix, and intensity aren't made by the producers of drugs. They're made by the consumers of drugs.

This is why increasing numbers of employers have in recent years made use of what are known as Pharmacy Benefit Managers, or P.B.M.s. The

P.B.M.s draw up drug formularies—lists of preferred medications. They analyze clinical-trials data to find out which drugs are the most cost-effective. In a category in which there are many equivalent options, they bargain with drug firms, offering to deliver all their business to one company in exchange for a discount. They build incentives into prescription-drug plans to encourage intelligent patient behavior.

If someone wants to take a brand-name oral contraceptive and there is a generic equivalent available, for example, a P.B.M. might require her to pay the price difference. In the case of something like heartburn, the P.B.M. might require patients to follow what's called step therapy—to try the cheaper H2 antagonists first, and only if that fails to move to a proton-pump inhibitor like omeprazole. Employers who used two or more of these strategies last year saw a decrease of almost five per cent in their pharmacy spending.

There is no mention of these successes in "The Truth About the Drug Companies." Though much of the book is concerned with the problem of such costs, P.B.M.s, the principal tool that private health-care plans use to control rising drug costs, are dismissed in a few paragraphs. Angell's focus, instead, is on the behavior of the pharmaceutical industry. An entire chapter, for instance, centers on the fact that the majority of drugs produced by the pharmaceutical industry are either minor variations or duplicates of drugs already on the market. Merck pioneered the statin category with Mevacor.

Now we have Pfizer's Lipitor, Bristol-Myers Squibb's Pravachol, Novartis's Lescol, AstraZeneca's Crestor, and Merck's second entrant, Zocor—all of which do pretty much the same thing. Angell thinks that these—"me-too" drugs are a waste of time and money, and that the industry should devote its resources to the development of truly innovative drugs instead. In one sense, she's right: we need a cure for Alzheimer's much more than we need a fourth or fifth statin. Yet me-too drugs are what drive prices down. The presence of more than one drug in a given category gives P.B.M.s their leverage when it comes time to bargain with pharmaceutical companies.

Medicare

With the passage of the Medicare prescription-drug-insurance legislation, late last year, the competition created by me-toos has become even more important. The bill gives responsibility for managing the drug benefit to P.B.M.s. In each therapeutic category, Medicare will set guidelines for how many and what kinds of drugs the P.B.M.s will have to include, and then the P.B.M.s will negotiate directly with drug companies for lower prices. Some analysts predict that, as long as Medicare is smart about how it defines the terms of the benefit, the discounts—particularly in crowded therapeutic categories like the statins—could be considerable. Angell appears to understand none of this. “Medicare will have to pay whatever drug companies charge,” she writes, bafflingly, “and it will have to cover expensive me-too drugs as well as more cost-effective ones.”

The core problem in bringing drug spending under control, in other words, is persuading the users and buyers and prescribers of drugs to behave rationally, and the reason we’re in the mess we’re in is that, so far, we simply haven’t done a very good job of that.

“The sensitivity on the part of employers is turned up pretty high on this,” Robert Nease, who heads applied decision analysis for one of the nation’s largest P.B.M.s, the St. Louis-based Express Scripts, says. “This is not an issue about how to cut costs without affecting quality. We know how to do that. We know that generics work as well as brands. We know that there are proven step therapies. The problem is that we haven’t communicated to members that we aren’t cheating them.”

Celebrex

Among the costliest drug categories, for instance, is the new class of antiinflammatory drugs known as cox-2 inhibitors. The leading brand, Celebrex, has been heavily advertised, and many patients suffering from arthritis or similar conditions ask for Celebrex when they see their physician, believing that a cox-2 inhibitor is a superior alternative to the previous generation of nonsteroidal anti-inflammatories (known as nsaids), such as ibuprofen. (The second leading cox-2 inhibitor, Merck’s Vioxx, has just been taken

off the market because of links to an elevated risk of heart attacks and strokes.) The clinical evidence, however, suggests that the cox-2s aren’t any better at relieving pain than the nsaids. It’s just that in a very select group of patients they have a lower risk of side effects like ulcers or bleeding.

“There are patients at high risk—people who have or have had an ulcer in the past, who are on blood-thinning medication, or who are of an advanced age,” Nease says. “That specific group you would likely start immediately on a cox-2.” Anyone else, he says, should really be started on a generic”nsaid first. “The savings here are enormous,” he went on. “The cox-2s are between a hundred and two hundred dollars a month, and the generic nsaids are pennies a day—and these are drugs that people take day in, day out, for years and years.” But that kind of change can’t be implemented unilaterally: the health plan and the employer have to explain to employees that in their case a brand-new, hundred-dollar drug may not be any better than an old, one-dollar drug.

PBMs

Similarly, a P.B.M. might choose to favor one of the six available statins on its formulary—say, AstraZeneca’s Crestor—because AstraZeneca gave it the biggest discount. But that requires, once again, a conversation between the health plan and the employee: the person who has happily been taking Pfizer’s anti-cholesterol drug Lipitor for several years has to be convinced that Crestor is just as good, and the plan has to be very sure that Crestor *is* just as good.

The same debates are going on right now in Washington, as the Medicare program decides how to implement the new drug benefit. In practice, the P.B.M.s will be required to carry a choice of drugs in every therapeutic category. But how do you define a therapeutic category? Are drugs like Nexium and Prilosec and Prevacid—all technically known as proton-pump inhibitors—in one category, and the H2 antagonists in another? Or are they all in one big category? The first approach maximizes the choices available.

The second approach maximizes the bargaining power of P.B.M.s. Deciding which option to take will have a big impact on how much we end up

paying for prescription drugs—and it's a decision that has nothing to do with the drug companies. It's up to us; it requires physicians, insurers, patients, and government officials to reach some kind of consensus about what we want from our medical system, and how much we are willing to pay for it. AstraZeneca was able to do some chemical sleight of hand, spend half a billion on advertising, and get away with the "reinvention" of its heartburn drug only because that consensus hasn't yet been reached. For sellers to behave responsibly, buyers must first behave intelligently. And if we want to create a system where millions of working and elderly Americans don't have to struggle to pay for prescription drugs that's also up to us.

We could find it in our hearts to provide all Americans with adequate health insurance. It is only by the most spectacular feat of cynicism that our political system's moral negligence has become the fault of the pharmaceutical industry.

Another Book

There is a second book out this fall on the prescription-drug crisis, called "Overdosed America" (HarperCollins; \$24.95), by John Abramson, who teaches at Harvard Medical School. At one point, Abramson discusses a study that he found in a medical journal concluding that the statin Pravachol lowered the risk of stroke in patients with coronary heart disease by nineteen per cent.

That sounds like a significant finding, but, as Abramson shows, it isn't. In the six years of the study, 4.5 per cent of those taking a placebo had a stroke versus 3.7 per cent of those on Pravachol. In the real world, that means that for every thousand people you put on Pravachol you prevent one stroke—which, given how much the drug costs, comes to at least \$1.2 million per stroke prevented. On top of that, the study's participants had an average age of sixty-two and most of them were men. Stroke victims, however, are more likely to be female, and, on average, much older—and the patients older than seventy in the study who were taking Pravachol had *more* strokes than those who were on a placebo.

Whose Fault?

Here is a classic case of the kind of thing that bedevils the American health system—dubious findings that, without careful evaluation, have the potential to drive up costs. But whose fault is it? It's hard to blame Pravachol's manufacturer, Bristol-Myers Squibb. The study's principal objective was to look at Pravachol's effectiveness in fighting heart attacks; the company was simply using that patient population to make a secondary observation about strokes. In any case, Bristol-Myers didn't write up the results. A group of cardiologists from New Zealand and Australia did, and they hardly tried to hide Pravachol's shortcomings in women and older people. All those data are presented in a large chart on the study's third page.

What's wrong is the context in which the study's findings are presented. The abstract at the beginning ought to have been rewritten. The conclusion needs a much clearer explanation of how the findings add to our understanding of stroke prevention. There is no accompanying commentary that points out the extreme cost-ineffectiveness of Pravachol as a stroke medication—and all those are faults of the medical journal's editorial staff. In the end, the fight to keep drug spending under control is principally a matter of information, of proper communication among everyone who prescribes and pays for and ultimately uses drugs about what works and what doesn't, and what makes economic sense and what doesn't—and medical journals play a critical role in this process. As Abramson writes.

When I finished analyzing the article and understood that the title didn't tell the whole story, that the findings were not statistically significant, and that Pravachol appeared to cause *more* strokes in the population at greater risk, it felt like a violation of the trust that doctors (including me) place in the research published in respected medical journals.

The journal in which the Pravachol article appeared, incidentally, was *The New England Journal of Medicine*. And its editor at the time the paper was accepted for publication? Dr. Marcia Angell. Physician, heal thyself.

Generation Rx?

Pharmacy Today: American Pharmacists Association, June 2005

Medication abuse a growing problem among nation's youth

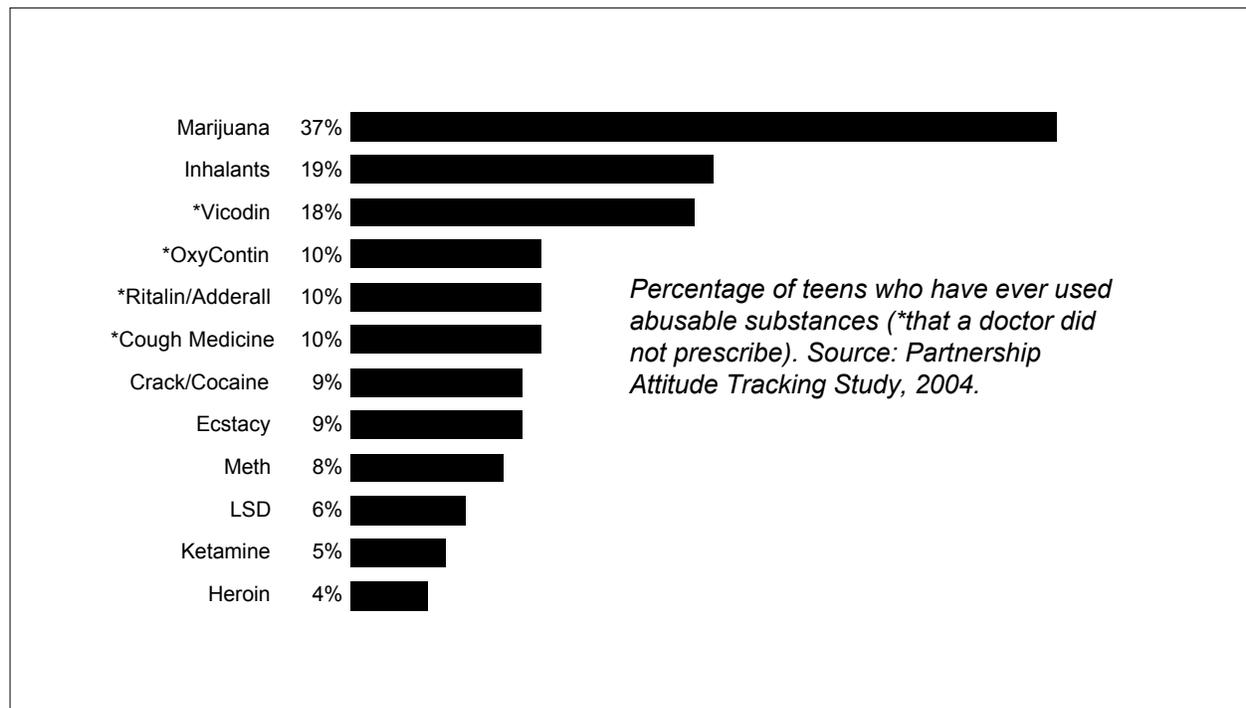
Just as common as use of cocaine, Ecstasy, meth, survey shows

Even as medical experts debate the wisdom of the increasing use of psychotropic medication in children and adolescents, millions of teenagers are conducting their own unlicensed experiments. Abuse and misuse of prescription and nonprescription medications have become so common among America's middle and high school-aged children that, according to the 17th annual study of teen drug abuse conducted for the Partnership for a Drug-Free America, several products trailed only marijuana in the frequency with which they are abused.

"Maybe we've been too successful at getting young people to understand that street drugs are dangerous and of uncertain quality and purity," Paul L. Doering, MSP, of the University of Florida told *Pharmacy Today*. "But for the first time in my years of speaking to youth groups about drug abuse, I am concerned about the rampant misuse of both prescription and nonprescription medications among teenagers."

'Generation Rx'

Reflecting a disturbing "normalization" of using medications ranging from painkillers to nonprescription cough products to get high, the 2004 Partnership Attitude Tracking Study (PATS) showed for the first time that 39% of teenagers had learned "a lot" about drug risk from television commercials, while only 30% said they had learned a lot from their own parents or grandparents. In a news release that was picked up by many daily newspapers, Partnership Chairman Roy Bostock labeled this youthful cohort "Generation Rx." Projected nationally, PATS data would be per the chart below:



Productivity (Attributable to Biomedical Research) in the 21st Century

Frank Lichtenberg, Professor, Columbia University School of Business

This material is excerpted from published conference proceeding. The Productivity Conference was hosted on October 23, 2002 by the Department of Labor's Office of the 21st Century Workforce and the American Enterprise Institute. In addition to this complete text, a Webcast can be viewed at www.dol.gov. U.S. Department of Labor Office of the 21st Century Workforce, 200 Constitution Ave., N.W., Washington, D.C. 20210 Library of Congress Control Number: 2003100214

Biomedical Research

Now, I am going to talk about one particular type of research and development, biomedical research. According to the National Science Foundation (NSF), the percent of U.S. R&D that is primarily associated with the life sciences increased from 12 percent in 1985 to 16 percent in 1996. That is before the NIH budget doubled.

There has been very rapid growth in private R&D spending as well. By the way, that is total R&D. If we take out defense R&D, then biomedical research would look even more important, a bigger share of the total pie of R&D.

If we look at the industry breakdown of who does a lot of R&D, the most R&D intensive sector of the economy is pharmaceuticals and biotech. But if you think computers are R&D intensive, take a look at drugs. They are much more R&D intensive.

I am going to talk about the hypothesis that new drugs increase productivity in three different ways, at least three that I have thought about and done some research on.

New drugs and other medical technology as well increased productivity both outside the healthcare sector and within the healthcare sector.

The three kinds of pathways that I am going to discuss are:

- 1 *that new drugs increase ability to work, they increase labor supply.*
- 2 *new drugs increase longevity. I think a meaningful comprehensive definition of economic growth should also take into account improvements in longevity and quality of life.*
- 3 *new drugs reduce the utilization of other medical services, especially hospital care, which is quite expensive.*

Therefore, through all these mechanisms or pathways, new drugs and other medical technology have increased productivity per capita and are likely to continue to do so.

Increasing Ability to Work

First, let me talk about some recent research I have done that tries to examine the impact of new drugs on ability to work. The reason one can examine this in a meaningful way is that the rate of pharmaceutical innovation varies across medical conditions.

There are some diseases where there have been a lot of new drugs introduced in the last 20 years, but for other conditions there have been relatively few new drugs. Now, thanks to FDA regulation, we can actually measure very precisely the number of drugs that are available to treat different conditions over time.

Between 1979 to 1984 there was a 30 percent increase in the number of drugs available to treat diabetes disorders. The bad news is there has not been anything new to treat diabetes disorders since 1984 or so. I have talked to endocrinologists about that and they say, "Yes, that is right. We had Synthroid in the early 1980s and there really hasn't been much new to treat thyroid disorders since then." By contrast, for disorders of the endocrine glands, including diabetes, there have been a lot of new discoveries, all during the last 20 years. By 1998, there were 50 percent more drugs available

to treat diabetes and other disorders of the endocrine glands than there were in 1979. So, because diseases are heterogeneous and there is a lot of progress, a lot of innovation for some diseases and less for others, we can study the correlation across diseases between innovation and changes in outcomes.

The change in outcome I am emphasizing here is ability to work or inability to work.

There is a survey called the National Health Interview Survey where people are asked, first, “Do you have a particular condition? Do you have diabetes? Do you have asthma?” If a person says, “Yes, I have that condition,” then they are asked, “Are you unable to work because you have this condition?” Or, “If you are able to work, how many days of work did you miss last year because of that condition?”

What I (examined) is the correlation across conditions between the percentage increase in the number of drugs available to treat the condition, essentially the number of FDA approvals during the period, and the change in the percent of people who say they are unable to work because they have the condition.

What we observe is a significant negative correlation. That is for the conditions where there has been the most innovation, we have seen the greatest declines in inability to work.

If one does a back-of-the-envelope calculation based on that correlation, I estimate that if we take the drugs that were approved between 1983 and 1996, about 25 new drugs per year, then the net effect of those new drug approvals was to reduce the number of people who were unable to work in 1996 by about 1.4 million.

In other words, if there had been no new drugs, not a single new drug after 1983, there would have been 1.4 million more people unable to work in 1996 than there actually were. If we use the average annual compensation of U.S. workers, the value of that reduction in the number of people unable to work is about \$43 billion a year.

There are also reductions in work-lost days per year of people who are employed of about 100 million fewer lost workdays per year as a result of the new drugs that were introduced during that 13-year period. I think this provides pretty strong evidence on the first hypothesized mechanism.

- reduction in number of people unable to work: 1.44 million.
- value of reduction in number of people unable to work (@ \$30K/year): \$43.3 billion/year.
- reduction in work loss days per year of currently employed persons: 98.8 million/year
- value of reduction in work loss days (@ \$100/day): \$9.9 billion/year.
- reduction in restricted activity days of all persons: 423 million/year.
- reduction in bed days of all persons: 178 million/year.

Increasing Longevity

The second way in which new drugs have increased productivity is via increased longevity. Many economists realize that utility or welfare depends on time as well as goods. Gary Becker and many others have written treatises about this, the idea that people value leisure time as well as goods. The increase in longevity has been the major source of increased leisure time over the life cycle. Back in 1900, life expectancy at birth was about 50 years. By the end of the 20th century, it was about 78. So people live 60 percent longer than they did in 1900.

Bill Nordhouse of Yale has argued that to a first approximation, the economic value of increased longevity over the 20th century is about as large as the value of measured growth in non-health goods and services. In other words, the growth in per capita GDP underestimates true economic growth by about half. Where does that come from? It comes from a variety of sources, but one source is medical innovation and new drugs, in particular. I looked at the last 20 years of the 20th century. During that period, longevity, or mean age at death, increased by about 3.8 years, but the increase in mean:

- Utility, or welfare, depends on (leisure) *time* as well as goods
- Increase in longevity (from about 50 years in 1900 to 78 years in 1997) has been the major source of increased leisure time over the life cycle
- Nordhaus: “to a first approximation, the economic value of increases in longevity over the twentieth century is about as large as the value of measured growth in non-health goods and services” age at death varied considerably across diseases.

Survival from some diseases has increased more than from others. What I found was that mean age at death increased fastest for the diseases with the largest increase in the number of available drugs.

We talk about the 1960s as being about the miracle decade. In fact, there was very little longevity growth during the 1960s. It really took off after 1970. That is partly due to the expansion of Medicare, Medicaid and so forth.

- I estimate that the increase in the stock of drugs increased mean age at death by at least 0.39 years (4.7 months) during this period.
- According to Murphy and Topel, average willingness to pay to live an additional year is approximately \$150,000
- Hence the per capita value of the 20-year increase in longevity attributable to new drugs is \$58,500.

Reducing Medical Services Utilization

Finally, the last hypothesized way in which new drugs increase productivity, this time within the healthcare sector, is by reducing utilization of other medical services like hospital care. Although new drugs are more expensive than old drugs, as everyone knows, not everyone knows that people who use newer drugs tend to use fewer non-drug medical services, like hospital stays, office visits to physicians, and home healthcare than people who use older drugs.

A spectacular example of this is Gleevec, which is a leukemia drug that was launched about a year ago. It only works for certain forms of leukemia, but up until the arrival of Gleevec, the only treatment for that kind of leukemia was to get a bone marrow transplant, which is enormously expensive and has a success rate of about 50 percent. Gleevec is a miracle drug for people who have that condition. It results in almost complete remission with virtually no side effects and obviates the need for a bone marrow transplant.

- Although new drugs are more expensive than old drugs, *people who use newer drugs tend to use fewer non-drug medical services (hospital stays, MD visits, home health care) than people who use old drugs* (Example: Gleevec).
- The reduction in non-drug medical costs exceeds the increase in drug costs by a substantial margin (4:1 or more).
- Consistent with Grossman & Helpman (1991): “Innovative goods are better than older products simply because they provide more ‘product services’ in relation to their cost of production”.

I have found in a couple of studies that the reduction in nondrug medical costs on average exceeds the increase in drug costs by a substantial margin. That is, people using new drugs will reduce their expenditure on other medical services by about four times as much as the increase in spending on the new drugs. That is consistent with theoretical models of economic growth. To conclude, Solow and subsequent research has argued that R&D is the fundamental source of productivity growth.

Pharmaceuticals and biotech is the most R&D intensive sector of the economy, and new drugs and other medical innovations resulting from both public and private R&D have increased productivity in several different ways.

The Trouble With Cheap Drugs

The Economist, January 29, 2004

Europe pays a lot less for its drugs than America. But do hidden costs mean that Europeans are actually worse off?

In the drug industry, they call it “Europe’s free ride”. Government pricing regimes mean that prescription drugs cost far less in Europe than in America, where a growing proportion of new drugs are developed—presumably because Americans are willing to bear the lion’s share of development costs. On the face of it, Europe reaps big rewards. It spends 60% per head less on drugs than America. In 1992, the gap was 30%. Had spending kept pace with America, last year alone Europe would have shelled out an extra \$160 billion. The cumulative “saving” since 1992 is approaching \$1 trillion—quite some free ride.

Europe’s drug firms do not appear to suffer unduly as a result. On January 26th, Sanofi-Synthelabo made a EURO48 billion (\$60 billion) hostile bid for Aventis, a larger French group. The combined entity would be the industry’s third-biggest firm, behind Pfizer of America and Britain’s GlaxoSmithKline (GSK). A combination of cheap drugs and successful big drug firms would seem to suggest that Europe is doing something right.

But is the saving from cheap drugs more apparent than real? And are Europe’s drug firms in fact struggling to keep up with more dynamic American competitors? A new study*[1] by Bain, a consultant, argues that the existing pricing regimes are bad for everyone, including patients. “The free ride is not free,” argues Paul Rosenberg, a co-author. “If governments and drug companies begin to accept this, then future policy on health-care innovation and spending can be far more rational.”

America certainly resents European meddling with prices, blaming it for higher drug prices at home. Mark McClennan, head of the Food & Drug Administration (FDA), which oversees America’s drug industry, said recently: “The main reason [American drug] prices are higher is that

our country is paying the bulk of the costs of developing new treatments. That’s got many Americans angry.”

But should Americans be angry? And should they force down drug prices at home? True, a few big firms, such as Pfizer, the global leader, feel that in Europe they lose profits that could otherwise fund new research (or go to shareholders). True, also, America suffers from large “grey” import markets in both Canada and Mexico, as canny consumers cross the border into cheaper markets to buy otherwise costly drugs.

On the other hand, America gains from its growing dominance of drug research and development (R&D). A decade ago, Europe and America each spent roughly \$10 billion a year on drug R&D. Now, America spends almost \$30 billion annually, and Europe a little more than \$20 billion. A growing number of firms now base their R&D efforts in America. Drugs R&D in Germany fell by 3% in 1992-2002.

One result is a striking decline in European drug innovation. Bain examined how many so-called new molecular entities (NMEs) have been produced in recent years. In 1993-97, Europe launched 81 NMEs and America 48. But in 1998-2002, the respective figures were 44 and 85, almost an exact reversal.

With the transatlantic shift in R&D goes many high-value jobs, as well as a greater share of the industry’s profits. According to Bain, America created 42% more high-value pharmaceutical jobs in 1999-2001, and the trend is continuing. In 1992 the global drugs industry made profits of \$60 billion, less than half of which were in America. In 2002, industry profits were \$121 billion— 60% generated in America.

European drug executives are increasingly concerned. On January 26th, for instance, Jean-Pierre Garnier, boss of GSK, spoke out against the

loss of jobs, arguing that Europe's love of red tape is throttling innovation. Maybe so. But the thrust of Bain's study is that the main reason for America's growing dominance of drug R&D is not the red tape so much as Europe's tougher price controls on drugs, particularly new drugs.

Exactly how drug-pricing regimes influence innovation is complex—and much debated. According to Bain, research shows that the main economic factor driving where firms locate their R&D is how big, and quick, are the potential profits. That gives America an advantage over Europe, where price controls slow down profit-taking. True, early-stage research can take place anywhere in the world—and big drug firms are increasingly looking to shift this to lower-cost places. (GSK recently linked up to do research with Ranbaxy, a leading Indian drug firm.)

But the bulk of costs are incurred in the development phase between early-stage and market. And the process of drug approval remains very much a national, as opposed to global, activity. So it makes sense for firms to put promising drugs on trial in the market where there is most to gain—namely, for now, America.

Germany and Europe

Bain looked closely at Germany, Europe's biggest drugs market—accounting for one-fifth of total spending and of the industry's European jobs. Germans have relatively high life expectancy, but get access to new drugs relatively slowly and by many measures their overall health standards are worse than those in America. Germans spend more time in hospital and lose far more working days to sickness than Americans. Germans suffering from heart disease and breast cancer have worse mortality rates, thanks to the unwillingness or inability of doctors to prescribe the newest, most effective—and most expensive—drugs.

A decade ago, Germany boasted two of the world's top ten drug firms—Bayer and Hoechst. Now it has none. Hoechst, for instance, merged with

France's Rhone-Poulenc to form Aventis, which itself might now disappear, either in a merger with Sanofi or into the arms of a white knight.

According to Bain, a proper accounting for Germany's spending on drugs produces an alarming result. In 2002, Germany saved \$19 billion because it spent much less per head than America on drugs. On the other hand, says Bain, in the same year, Germany lost out on \$4 billion from R&D, patents and related benefits that went elsewhere. It lost \$8 billion because high-value jobs went somewhere else—plus the benefits of those jobs from the “multiplier effect”. German drug firms would have made \$3 billion more profit if they had kept pace with rivals elsewhere. A further \$2 billion was lost as the country shed corporate headquarters and the benefits they bring. The cost of poorer-than-necessary health was \$5 billion.

Of course, these calculations rely on some rough and ready assumptions. Even so, Bain arguably errs on the side of caution. It plays down, rather than up, the multiplier benefits of jobs in the drug industry, for instance. In sum, it reckons that Germany's \$19 billion saving is in fact a \$3 billion net loss. “When you add up all of the costs, the free rider model is actually quite expensive,” argues Mr Rosenberg.

Even if Europe's governments accept the logic of the Bain study, it seems unlikely that they will abandon price controls, not least because of short-term budget constraints for publicly financed health care. (More likely, America will impose its own tougher price controls.) A more typical, though less effective, European response would be to strive harder to attract, or at least keep, drugs R&D by offering a mix of tax relief and subsidy. And Mr Garnier might get some help with red tape. Faster drug launches, fewer restrictions on access to consumers, even faster price negotiations, would all make the pill easier to swallow. But it remains a bitter and, despite appearances, expensive one.

Pharmaceutical Drugs: Conception to Commercialization and Beyond

Thomas C. Kupiec, Ph.D., Oklahoma City

Dr. Thomas Kupiec is the Director of Laboratories and CEO of Analytical Research Laboratories (ARL) in Oklahoma City, Oklahoma. Dr. Kupiec's vision of entrepreneurial research is manifested by his contributions at ARL, which include supplying technical expertise and business development in the pharmaceutical and forensic fields. His professional experience includes Associate Director of the Workplace Drug Testing Division of NWT, Inc, Senior Research Chemist in Toxicology, FAA and Senior Forensic Chemist at the Oklahoma City Police Department.

Pharmaceutical drugs are a panacea to millions of people, and are instrumental in improving the quality of life of an ever increasing populace. An improved standard of living has brought about increased access to medications and a longer life span. Although the prescription drug industry is a multi-billion dollar enterprise, the process of developing and facilitating the availability of a drug is largely an obscure one.

The drug development process can be elucidated in two words: Safety and Efficacy. To integrate both these ideals, the drug is subjected to a series of research based trials, with varied parameters (dose, intervals, etc).

Developing a new drug can take approximately 15 years and cost anywhere from 800 million to 1 billion dollars. In a chronological manner, drug development proceeds in the following steps:

1. **Drug discovery and pre-clinical research:** This step represents the discovery of the compound or drug, followed by lab research and animal testing to determine product efficacy

2. **Investigational New Drug Application:** This step involves FDA evaluation of the biology and toxicity profile of the product, before human testing
3. **Phase I trials:** The product is evaluated for safety on 20 to 100 volunteers
4. **Phase II trials:** These involve testing efficacy and side effects in 100 to 500 patients who have been identified as potential candidates for the drug
5. **Phase III trials:** These trials confirm product efficacy and study long term toxicity in 1000 to 5000 patients
6. **New Drug application:** The FDA performs a thorough appraisal of the evidence from the clinical trials before deciding whether the drug is safe and effective enough to approve

Generally, successful animal trials segue into controlled human trials, where the drug is selectively given to a closely monitored human population. In the past, adverse effect discovery had been incidental, for example, the antibiotic penicillin and its associated hypersensitivity in certain people. However, certain disastrous ramifications of approved pharmaceuticals like thalidomide served as a harbinger of tightened regulations and protracted protocol. The grueling regulatory process of new drug introduction is the reason for the low number of new drugs approved annually. A sensitive balance between cost, quality, safety and efficacy creates a "tight rope" for the FDA.

Most new drug development is based either on 1) minor structural variations of currently existing drugs, such as isomers, or on

2) variations in delivery systems like transdermal patches, subskin implantation and modified inhalers. However, the future promises a paradigm shift in drug development, prescription guidelines and treatment philosophy. The application of genomic technology to drug development serves as a rejuvenating influence.

Pharmacogenomics, a blend of genetics and pharmacology, is projected to revolutionize the concept of individualized medicine by the incorporation of genetic data. Target specific drug development presents very attractive applications; for example, most anticancer drugs are lethal to both cancerous cells and the body's normal non-cancerous cells, therefore leading to severe toxicity. With the advent of target specific medicine, the cancerous gene/protein/cell is targeted exclusively, therefore sparing the body's normal cells from collateral damage during chemotherapy.

Some new methods of molecular diagnosis focus on Single Nucleotide Polymorphisms (SNPs) or single base pair substitutions in DNA that can lead to variations in form and function. SNPs may be found in DNA segments encoding drug metabolizing enzymes, transport proteins or drug receptors thereby affecting the normal function of these entities. The majority of prescription drugs are broken down by the cytochrome P450 (CYP) group of enzymes into less active components for excretion.

SNPs in the genes, coding for CYP enzymes, can lead to increased enzyme activity, thereby increasing drug metabolism and decreasing drug availability. Conversely, they can also cause decreased enzyme activity leading to drug accumulation and toxic drug levels. Polymorphisms in drug transporter systems can lead to decreased or increased drug uptake

and transport, thus correlating into therapeutic inefficacy or toxicity. Drug receptor polymorphisms can affect drug activity at the receptors.

The potential role assumed by the incorporation of molecular and genetic information in new drug development is represented in the process below:

- Identification of biomarkers for disease at protein/gene level
- Research on product that restores normal cellular physiology
- Genotyping of potential patients for clinical trials, in order to identify genetic variants with potential for adverse effects
- Evaluation of effect of product on protein/gene, on a molecular basis, and assessment of improvement in symptoms
- Drug forwarded to FDA for approval

The applications of genetic data will provide new information on drug enzymes, targets and drug receptors. Devising clinical trials with genomic data provides hitherto unexplored dimensions and exciting possibilities. Using this information, adverse effects to drugs can be predicted and prevented, thereby reducing the billions of dollars used to treat them. A new drug or product with significant adverse effects may either be relinquished, or, if it has significant therapeutic benefit, it could be specifically marketed to a small sub-population.

Molecular diagnostics are paving the way to the elucidation of the biochemical basis of disease at the genetic level. Identification of the aberrant protein, and the culpable gene will allow target specific drug development

Pill-Gotten Gains?

The Economist, April 7, 2004

There are few industries which have fallen in public esteem quite so far and so fast as drugmaking.

Once celebrated as the engine of modern medical innovation, pharmaceutical firms are now lambasted for the low productivity of their research, their wasteful marketing and, above all, for the high prices that their products command.

The drug companies defend their prices, and their profits, by citing the high cost of making drugs. The bulk of that cost—the more than \$800m required to develop a new drug, according to one controversial estimate—provides the title of Merrill Goozner's book.

Mr Goozner, an economics journalist, challenges the drugmakers' defence. With detailed accounts of the rise of some of today's blockbuster drugs, such as Epogen for anaemia, "The \$800 Million Pill" shows how much of the early development of these medicines comes from public-sector research, and how the cost of turning a bright idea into a life-saving medicine comes from the taxpayer's pocket, not just the company's coffers.

He argues that drug companies need to shift their attention, and their money, away from "me-too" drugs, which offer little benefit beyond those already available, towards truly innovative medicines which might indeed justify higher prices. To this end, Mr Goozner suggests that a new government institute be established in America, where the pricing debate is fiercest, in order to compare the performance of drugs on the market. Drug companies are understandably reluctant to perform such tests since they might scupper their latest product.

"Providing physicians, consumers and payers with better information will force drug companies to pare back meaningless and therefore wasteful projects," he argues. It is an interesting idea and,

indeed, one that is already in practice in some countries. Alas, such are the powerful entrenched interests in drugmaking that it will take something stronger than a dose of information to calm the current fever over pill-pricing.

While drugmaking has certainly become a more costly and controversial business in recent years, the path to miraculous medicines has never run smooth. A case in point is the development of penicillin, detailed in a new book by Eric Lax.

History gives most of the credit for this revolutionary drug to Alexander Fleming, a Scottish scientist who first noticed the powerful anti-bacterial effects of a fungus growing in his laboratory in 1928; the reality is that penicillin would have remained a scientific curiosity had it not been for the ingenuity and tenacity of a group of scientists at Oxford University led by Howard Florey, an indomitable Australian.

The book's title, "The Mold in Dr Florey's Coat", refers to the desperate times in which this life-saving medicine was born: working in the shadow of the second world war and often short of funds, the Oxford scientists planned how to save their research should the Nazis invade Britain. Their idea was that they would sow spores of penicillin-producing fungus in their clothes, and then carry their work literally on their backs to safer shores.

"The Mold in Dr Florey's Coat" debunks many of the myths surrounding the discovery of penicillin, revealing its developers' tense relationships and shedding new light on one of its unsung heroes, Norman Heatley, whose technical virtuosity was essential for early production of the drug but who, unlike his more famous colleagues, went unrewarded by a Nobel prize. Today, scientific and commercial concerns mean there are few drug companies that take an interest in developing new antibiotics. Yet growing bacterial resistance to existing drugs and novel microbial threats make the urgency which drove the original development of penicillin as vital as ever.

Safety in Numbers

The Economist, March 17, 2005

Americans are in danger of over-regulating the drug industry. There is a better way.

“The dose makes the poison,” was the advice of Paracelsus, one of medicine’s most famous practitioners. In other words, anything powerful enough to help also has the power to harm.

It is a rule which applies equally to prescription drugs, and to government regulation of drugmakers. America has, in recent years, been a far friendlier place for drug firms than Europe, with its penny-pinching price controls, restrictions on direct-to-consumer advertising and other curbs on the market in medicines. But now American politicians, from state capitals to Capitol Hill, are clamoring for more control over drugs especially when it comes to safety and pricing.

Last month, yet another new product—Tysabri for multiple sclerosis—fell by the wayside. And in September, Merck withdrew Vioxx, its new anti-inflammatory medicine, because of potentially lethal cardiovascular complications. This event prompted a heated debate over the value, not just of Vioxx and its COX-2 inhibitor cousins, but of America’s drug-regulatory system as a whole.

These developments, and growing arguments about the price of drugs, have tarnished the image of the industry. A poll last month by the Kaiser Family Foundation found that 70% of Americans surveyed think that drug firms put profits before people. On the other hand, the poll found that almost four-fifths of respondents remain confident in the ability of the Food and Drug Administration (FDA), the industry’s primary regulator, to ensure that prescription drugs are safe. The challenge now lies in keeping this faith.

Strong Medicine

The recent outbreak of drug withdrawals is not the first, and will not be the last, as medical science grapples with complex diseases in more complex ways. Tools are emerging that will help detect and reduce some of these risks. But to pick up every side-effect of a new drug before it is allowed on to the market would require huge and protracted clinical trials. This would not only delay potentially useful therapies, to the detriment of patients whom no other treatment can help, but would also increase the costs of drug development to a point where drugmakers shy away from projects unless they are guaranteed top dollar for the new product—far from a sure thing in today’s cost-conscious health-care climate.

Bringing a drug to market, and keeping it there, depends on striking the right balance between risk and benefit. America urgently needs better ways to continue assessing this balance once prescription drugs have been approved by the FDA. The creation of a new safety board within the agency, announced last month, could be a step forward, provided it has enough power to monitor, and control, prescription drugs once on the market. To do its job properly, such a safety board needs more and better information about the effects of drugs in real-life medicine.

This means, for example, stronger incentives for doctors to report side-effects they encounter in routine practice. The FDA also needs more leverage—and possibly new legislation—to deal with drug firms in regard to post-marketing studies, labelling, advertising and withdrawals.

But this greater focus on risk needs to be balanced by a clearer view of benefits. Various efforts are under way in America to assess the cost-effectiveness of medical treatments—and

prescription drugs in particular. Other countries do this already. Such assessments are a step in the right direction, especially since the information they generate could usefully inform America's current debate over drug pricing. At the moment, much of the negotiation between those who make and those who pay for America's drugs comes down to price—the lower, the better. What is needed is more systematic, rigorous and impartial assessment of the benefits of prescription medicines and a willingness to pay top dollar for those drugs which truly represent an advantage over existing treatments, and less for those that do not.

Stronger FDA enforcement of post-marketing studies and stronger signals from payers—especially the federal government, which will cover much of elderly America's drug bill from 2006—are needed to encourage drug firms to provide rigorous, unbiased evidence of the cost-effectiveness of their new products. This is something drug firms ought to welcome, despite short-term costs. In the long run, it is better for them, as well as for the public, to have pricing based on reliable evidence than on politicians currying popular favor. An industry which prides itself on science should surely welcome a more scientific approach to its own regulation.

The Newest War On Drugs *Elizabeth Querna, USA Today, 2/21/05*

When Anne's grandmother was hospitalized two years ago with chest pains, she couldn't remember what medications she was on. So doctors sent Anne to the woman's home in eastern Washington State to look in her cabinets. What they found shocked both the family and the doctors. In the basement, the woman had several copies of the

Physician's Desk Reference, scales for weighing pills, and a cupboard chock-full of both prescription and over-the-counter medications. All in all, doctors told the family later, she had 11 types of prescription medications, including at least 400 Valium pills. Her medications, doctors said, would probably fetch about \$15,000 on the street. "When I went down there," says Anne, "I thought, 'Oh my God, it looks like a pharmacy in here.'"

To get pills, Anne's grandmother would go from doctor to doctor complaining of anxiety, asking each for a prescription so that, unbeknownst to the doctors, she racked up a huge stockpile of drugs. The practice is known as "doctor shopping," and it's one of the most common ways that prescription pills are obtained illegally. Figuring out how to stop the practice, along with other strategies people use to obtain prescription drugs illegally, is a major challenge facing law enforcement, the medical profession, and government agencies.

Though use of illicit drugs has held relatively stable, prescription-drug abuse has risen dramatically in the past few years. Indeed, only the illegal use of marijuana is more prevalent today. Although abuse is rising among all age groups, officials are especially concerned about abuse among teenagers: One in 10 high school seniors has tried the painkiller Vicodin without a prescription, and 1 in 20 has taken the potent pill OxyContin.

Local, state, and some federal agencies have been combating this problem for decades. But the issue started getting widespread attention just last year, when the Bush administration released its first-ever plan targeting prescription-drug abuse. The White House set up new federal programs—including increased physician education and support for state prescription monitoring efforts that can catch people with multiple prescriptions for the same drug. In addition, two members of Congress introduced the Prescription Drug Abuse Elimination Act, some provisions of which passed as part of another bill. And outside the government, the Partnership for a Drug-Free America recently completed a study of adolescent attitudes on prescription drugs and will most likely release an ad campaign later this year warning of the dangers of popping pills. As these efforts gear up, experts at all levels are realizing that fighting the war on prescription drugs may be unlike anything they've done before.

"Kiddie dope."

"We are faced here with a different kind of threat," says John Walters, the U.S. drug czar. "With most illegal drugs, such as cocaine, production and distribution are illegal activities. In this case, this is a diversion from a legitimate source."

In contrast to other types of illicit drugs, fighting this threat takes more finesse than force. Education is one of the main components—people are still unaware that prescription drugs can be just as dangerous as illegal drugs. There's an idea that because doctors recommend prescription drugs for some uses, they must be safe. The perception even extends to law enforcement, says John Burke, vice president of the National Association of Drug Diversion Investigators. Federal agents and others refer to prescription pills as "kiddie dope" and don't regard rounding up those who sell it illegally as a top priority, he says.

This drug war also has different players: medical professionals, patients, and pharmaceutical companies, all of whom have legitimate uses for the drug—and lobbyists in Washington to make sure their interests have a voice. The word *balance* is often used to describe the complex task of keeping these groups happy while preventing the drugs from falling into the hands of illicit users and criminals. The most delicate relationship right now is between law enforcement and doctors, who want to be able to prescribe medication as they see fit without evoking suspicion of drug trafficking—a fact not lost on the Drug Enforcement Administration. Says William Walker, head of the agency’s Office of Diversion Control: “The DEA in no way attempts to hinder any medical practitioners who are legitimately prescribing and administering controlled substances to their patients.”

Anxiety and pain. Haley Bruns knows firsthand how dangerous prescription drugs can be. She became addicted to the anxiety medications Xanax and Ativan but has been sober for about five years now. When she had knee surgery last month, however, and was prescribed the painkillers Percocet and OxyContin, she was wary. Even though she’s never been addicted to those drugs, she says: “I didn’t want to tempt myself.” She solved the problem by getting only a few pills at a time from the pharmacist, even though it meant going into the store every day. “The first time I did it, the pharmacist was like ‘you’re nuts,’ “ she says. “I think it’s a great way of doing it.”

Painkillers like Vicodin, Percocet, and OxyContin, derived from opiates, technically known as narcotic analgesics, are the biggest concern among policymakers and experts because they can be very addictive. Even patients who use them properly for pain can become addicted, though it happens rarely. Abuse of these drugs is increasing “quite dramatically,” says Nora Volkow, director of the National Institute on Drug Abuse. More than 31 million Americans say that they have illicitly used narcotic analgesics, and emergency room visits related to this type of drug have more than doubled in the past decade, to 108,000 in 2002. People take the drugs because they produce a sense of euphoria, similar to the high from heroin. When taken improperly, these drugs can be fatal.

But the heavy focus on abuse of painkillers, along with several high-profile court cases involving doctors, has had a chilling effect on pain medicine, doctors contend. Millions of patients, they say, are suffering because doctors are either underprescribing to avoid suspicion or are leaving the field altogether. One woman in New York started a patient advocacy organization, the Pain Relief Network, because of her husband’s chronic joint pain. “These people deteriorate because it hurts to move,” says Siobhan Reynolds. “I can’t even begin to explain the severity of the repercussions on their lives.”

Rift. The Office of Diversion Control says it’s not in the business of prosecuting doctors who operate legitimate medical practices. The problem is that there isn’t an agreed-upon definition of what prescription practices are legitimate. Diversion Control tried to address this problem several years ago when a couple of its agents teamed up with four pain specialists and spent two years writing a “Frequently Asked Questions” document that addressed issues like how narcotic analgesics should be used to manage pain and what federal regulations were involved with prescription painkillers. The 32-page document was released in August 2004 and lauded in the *Journal of the American Medical Association*. Shortly after, the DEA pulled the FAQ off its website with no explanation, according to David Joranson, the director of the Pain and Policy Studies Group at the University of Wisconsin and a member of the drafting committee. “It was just amazing to have that collaboration unilaterally ended,” he says, “without explanation.”

If that rift is not mended, it could impede the war on prescription drugs, which depends on cooperation between the medical community and law enforcement. Ensuring such cooperation will require strategies new to drug enforcement. But at least one person is optimistic. “Unlike street drugs, people don’t want to do the wrong thing here,” says Walters. “The vast majority of the people we’re dealing with are committed to people’s health and welfare.”

Pharmaceutical R&D: The Next 25 Years

H. David Bergman, RPh, PhD, Dean, College of Pharmacy, Southwestern Oklahoma State University

Although the discovery of penicillin is considered to be the beginning of the era of research and development of new chemical entities, emphasis on pharmaceutical research and development in the United States has only been in the forefront since the end of World War II. However, during this time period significant improvements in pharmaceutical research and development, particularly in the areas of chronic diseases and infectious disease, have occurred.



The mapping of the human genome provides the potential for scientists to develop therapies designed to treat a specific gene or genes and even modify those treatments to accommodate the needs of a specific person who may have a prescriptive problem related to or caused by their genetics.

The next twenty-five years should provide similar results, but will have different foci. The future directions will not only depend on the research and development of new chemical entities and therapies, but will also be a product of public demand as well as the continued need to attempt to be as effective and efficient as possible within our complex health care system.

With regard to research and development, the emergence of technology and biotechnology, the mapping of the human genome, the evolving sophistication of stem cell research, and the continuing commitment by all areas of pharmaceutical research are significant activities that should continue to provide enhancements to health care.

Technology has resulted in improvements in communication, so that experts can share information and data as well as have access to complex equipment and techniques for research and development of pharmaceuticals. Technology will continue to be a cornerstone of our society and will enrich all functions that are involved in our daily lives. Biotechnology is a subset of technology and pharmaceuticals that are a product of biotechnology to date are those that have been engineered from substances in humans that are restructured to treat chronic disease.

Although there have been multifaceted concerns regarding the ethics of stem cell research, modifications in this arena could result in major health care advances without encountering as many ethical concerns that have been paramount in recent years. The use of replicated cells from an individual that could multiply and be used to form healthy cells, tissue, etc could result in the development of excellent therapies for chronic diseases and/or disabilities.

The majority of these specialized breakthrough therapies will be developed slowly. The development of new chemical entities will continue to provide the mainstay as well as the primary advances in pharmaceutical therapies. The areas that have the most interest are chronic diseases and infections. Drugs for AIDS as well as infections that have demonstrated resistance to current therapies will be important areas for research and development. Alzheimer's disease, cancer, hypertension, diabetes mellitus, asthma, and the many neurological problems that are encountered will continue to be significant issues in research and development. In addition, there will be new drug formulations of current as well as new chemical entities and medications that will enhance the method of delivery (e.g., through the skin, complex sustained release formulations, under the tongue) of drugs to humans. This will result in a reduction of invasive processes and the ability of individuals to continue their daily routine and lifestyles while maintaining and regenerating their health.

Diagnostic medications will continue to be developed at a rapid pace. These coupled with the evolving development and implementation of nanotechnology (e.g., the use of very small amounts of required material to provide information from a specific test or diagnostic procedure or the use of advanced machines or equipment that can measure very small amounts of material to provide required information) and complex molecular biology methods will be valuable complements to enriching health care. These advances should provide new techniques and methods that will enhance the processes for the diagnosis and evaluation of diseases while reducing the invasive component for individuals that is associated with many of the procedures.

There are concerns regarding the future of pharmaceutical research and development. Although new and valuable chemical entities are developed each year, during the past decade there has been a reduction in this area. This reduction may be attributed to several factors. These include the primary research directions of large and complex organizations, a reduction in resources in all areas, and a variety of government rules and regulations that could impede progress.

Large and complex organizations, such as found in pharmaceutical research industry, can direct activities and resources in specific directions which could hinder their progress in research and development as well as the creative potential of scientists. In recent years, resources in all sectors of the economy have not grown significantly, which could also reduce progress. Government regulations, which are often very good, can also result in a less cost effective environment and impede progress in research and development in all private and public institutions and industry.

With regard to public demand, our society would like to have rapid cures for all ailments with as low of financial burden as possible. Although this may not be realistic, it is a desirable goal to want to have productive and happy lifestyles, which requires good health. Our society will continue to age, which is a result of a variety of improvements,

including health care. However, this will result in increased demands for health care and pharmaceuticals, which are the primary treatment for the majority of illnesses. The addition of a Medicare drug benefit will also be a major factor in increasing demand for prescription drugs.

The health care system attempts to be structured as effectively and efficiently as possible and the desired outcomes reflect the public demands. Therefore, it would be very valuable to have pharmaceuticals that are better and less expensive, so that the public will be able to overcome any ailments and remain productive and enjoy their lives. Unfortunately, all of these goals are desirable, but are not congruent. In order to meet the goals and objectives of the public and health care system, pharmaceuticals will continue to improve, but the costs will continue to increase.

The areas of research and development previously described will eventually provide better drugs and therapies for the public, but the investment by the various constituencies associated with research and development will be significantly greater than today. The time required for a new chemical entity to be discovered, evaluated, formulated, and studied for safety and efficacy will not be decreased. In fact, it is possible that the time could be extended depending on regulations and further advancements in technology.

A primary question is whether the real cost of pharmaceuticals in the total health care system is more economical than portrayed in the media. Although prescription medications are expensive, they remain an effective and efficient means to treat illness and maintain normalcy in our daily lifestyle. In addition, although there will be costs, the continuous development of safer and better pharmaceuticals should result in enhancements in our lifestyle in the future. In general, at this time, one must also realize that pharmaceuticals cure the majority of infections, but are used primarily to treat many other diseases and disorders. The hope for the next twenty-five years is that the expectations for new pharmaceuticals will be realized or exceeded.



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Psychopharmacology and Mental Health Therapy

Oklahoma Department of Mental Health and Substance Abuse Services

The contribution was submitted by Rand L. Baker, Deputy Commissioner for Mental Health Services; Peggy Jewell, M.D., Medical Director; Melody Riefer, Director, Office of Consumer of Affairs; and Jackie Shipp, Director of Children's Services.

In the book *The Anatomy of Hope*, prominent oncologist Jerome Groopman, M.D., shared this message to new patients:

"No one ever wants a problem like this, but given that it's happened, better now than 10 years ago. Ten years ago we didn't have the kind of drugs we do now and the supportive therapies that put people in a position to recover."

The same can be said for mental illness. Significant advances in science related to medication, and other treatments and supports, have made recovery from mental illness and "a life in the community" possible for everyone (New Freedom Commission on Mental Health, 2003).

As new research reveals amazing information about brain function, new treatments are discovered that can more precisely target certain psychiatric conditions and symptoms.

Newer generation drugs include antipsychotic medications, antidepressants, and agents for anxiety, ADHD and addiction, as well as anticonvulsants, which have gained widespread use for mood disorders such as bipolar disorder. Some alternative forms of these medications (sustained release and dissolvable, as well as short and long acting injectables) have been developed, allowing them to be more suitable for certain people.

Despite their significantly greater cost, these newer generation medications have been extremely popular for a number of reasons. First, they have been shown to be at least as effective as older

agents. Second, they are much less likely to cause some of the serious and sometimes permanent side effects of earlier drugs. The reduction in these symptoms contributes to better adherence to the medication regimen by the person being treated. Newer antidepressants also have fewer side effects and are less lethal in the case of overdose, making them a safer choice for persons who are depressed.

More recently, concerns have emerged regarding the safety of some newer antipsychotic agents with different, but potentially serious, side effects such as obesity and metabolic problems including hyperglycemia and hyperlipidemia. Other concerns have been raised about a potential increase in suicidal ideation in persons treated with antidepressants, especially children and adolescents. Regular medical monitoring for these conditions is critical.

We also know that medication alone is never enough. Based on the belief that all people can recover from mental illness, medication is but one item in the "Recovery Toolkit." Recovery is a very personal journey. In attempting to define recovery so that it encompasses all the dynamics experienced by individuals, we can turn to the research of Steven Onken, et al.:

"Recovery is a product of dynamic interaction among characteristics of the individual (the self/whole person, hope/sense of meaning and purpose), characteristics of the environment (basic material resources, social relationships, meaningful activities, peer support, formal services, formal service staff), and the characteristics of the exchange (hope, choice/empowerment, independence/interdependence)." (Mental Health Recovery: What Helps and What Hinders?)

For one to recover, certain resources must be available for the individual, including a livable

income, safe and decent housing, healthcare, transportation, and a means of communication (e.g., a telephone or internet access). A lack of basic resources and living in poverty thwarts a person's sense of safety and will only serve to hold one back in their recovery.

People need a sense of belonging. The ideas of citizenship or membership, beyond simple social expression, that moves toward and expands into a meaningful career, a sense of responsibility, and a sense of identity and mastery, allow people to fully embrace both the possibility and reality of recovery. Isolation, poverty, emotional withdrawal, controlling relationships, stunted social skills, past trauma, and cultural or social discrimination impede the recovery journey.

People also need a sense of self to recover. Personal qualities and attitudes can help (self-reliance, personal resourcefulness, self-determination, holistic view) or hinder (not taking personal responsibility, shame, fear, self-loathing, invalidation) the recovery process. Believing that recovery is possible and having this belief supported by others, including friends, family, peers and co-workers, helps fuel self-agency (the process of living one's life on one's own accord).

When medications are used as part of an individual's recovery process, it is imperative that the prescribing and monitoring process be managed in a way that ensures informed and shared decision-making. Psychotropic medications are powerful – both in their ability to aid in symptom management and in their complicating of basic human functions. Side effects of medications can be as debilitating as the psychiatric symptoms they are meant to treat. The best approach to medication management is one that allows the patient to be the expert regarding their medication history and experience, and to work in a power-sharing partnership with the prescribing psychiatrist.

Children

Children are susceptible to the same mental health disorders as are adults. These disorders are caused by a combination of genetic and environmental factors. Mental health disorders affect all aspects of children's lives, including the way they think, feel and act. National research indicates 15-21 percent of children have emotional and behavioral disorders of an intensity that would benefit from behavioral health services; 5-9 percent have severe emotional disorders that require intensive interventions.

Few, if any, of the commonly used medications for mental illness are approved for use with children. Physicians suggest that medication can help some children with disturbances of mood, attention, anxiety symptoms, certain impulse control problems, and confused thinking (Psychopharmacology for Children and Adults, Robert D. Fleisch). However, medication alone is seldom the answer to difficulties experienced by children and youth.

Unlike most heart disease and cancer, mental illness strikes when people are in the most productive time of their life. Recent research indicates that half of all cases of mental illness occur by age 14; with 75 percent by age 24 (Kessler, 2005). There often are long delays (10 or more years) between the onset of mental illness and first treatment contact.

A recent study indicates that untreated mental illness costs Oklahoma businesses and government more than \$2 billion annually (The Governor's and Attorney General's Task Force, 2005). The economic costs are significant, but so is the damage to human life when treatment for mental illness is available, but not accessed. Foregoing treatment, for whatever reason, can mean years of unnecessary mental, emotional, physical and financial strife, failed relationships, and substandard quality of life.

Oklahomans deserve better.

Oklahoma as Consumer

Nancy Nesser, PharmD, JD, Pharmacy Director, Oklahoma Health Care Authority

In May 2005, headlines across the country railed against the provision of Viagra to convicted sex offenders in the New York state Medicaid program. This event presents an opportunity to examine the legal requirements as well as public policy rationale for state Medicaid pharmacy programs.

Background

Although Medicaid is currently the largest publicly funded prescription program, the Medicare Part D program will likely overtake it in short order. The Veterans Affairs program is another example of a publicly funded program, as well as the prescription benefit programs for government workers at every level from city and county to state and federal employees.

Government employee benefit programs tend to be based on commercial pharmacy benefit models which include a significant personal responsibility component in the form of financial contribution. Entitlement programs such as Medicaid and the VA benefit generally lack this financial contribution component which may result in less personal responsibility for the beneficiary. The Medicare Part D program combines elements of both models, but will require a significant financial contribution from all but the neediest individuals.

This paper will focus primarily on the Medicaid program in order to dissect the law and policy issues which shape this publicly financed pharmacy benefit.

Medicaid History

Medicaid is funded jointly by the federal and state governments. Each state has a separate Medicaid program, of their own design, which must meet certain standards in order to receive federal financial participation. In Oklahoma, the federal share of the program is roughly 67%. Every state dollar in the Medicaid program is matched by more than two dollars of federal money.

Medicaid was enacted in 1965 to provide health care to low income individuals who received cash assistance payments from the government. Since that time, it has been expanded to include individuals with disabilities and those in long term care facilities.

Medicaid is administered at the state level by the Oklahoma Health Care Authority and at the federal level by the Centers for Medicare and Medicaid Services (CMS), which is part of the Department of Health and Human Services. Until 2002, CMS was known as the Health Care Financing Administration (HCFA).

Forty years ago, prescription drugs were not included in the list of mandatory services that states must provide in order to receive federal financial participation. Today, in spite of the prevalence of pharmaceutical care and the apparent benefits which can be derived from them, drug coverage is still optional for state Medicaid plans. However, all states provide a pharmacy benefit for their Medicaid recipients due to the evidence supporting the use of prescription drugs for treatment and prevention of illness, disease, and complications.

The Medicaid Pharmacy Benefit

Until 1991, states had little incentive to provide prescription drugs to their Medicaid recipients. Many states, including Oklahoma, administered a limited pharmacy benefit for clients, covering medical necessities such as heart and blood pressure medications, cancer chemotherapy, pain relievers, and antibiotics. The Omnibus Budget Reduction Act of 1990 (OBRA 90) changed that by setting requirements for Medicaid pharmacy programs and tying those requirements to a drug rebate program with pharmaceutical manufacturers.

The Medicaid Drug Rebate Program requires pharmaceutical manufacturers to guarantee that the Medicaid program pay the “best price” for all pharmaceutical products. In exchange for this, Medicaid programs are required to cover all drugs distributed by participating manufacturers.

The exceptions to this requirement include drugs in the following therapeutic categories:

- 1) *Drugs for weight loss or weight gain*
- 2) *Fertility*
- 3) *Cosmetic or hair growth*
- 4) *Symptomatic relief of cough and colds*
- 5) *Smoking cessation*
- 6) *Prescription vitamins and minerals, other than prenatal preparations and fluoride*
- 7) *Barbiturates*
- 8) *Benzodiazepines*

All states currently cover at least some of these drugs. Oklahoma Medicaid covers both prescription and non-prescription products used to assist clients with tobacco cessation and covers barbiturates and benzodiazepines for treatment of seizures and behavioral health conditions.

Like other services covered by Medicaid, pharmacy services must be “medically necessary” in order to qualify for reimbursement through the program. OHCA policy outlines criteria for medical necessity:

“Services provided within the scope of the Oklahoma Medicaid Program shall meet medical necessity criteria. Requests by medical services providers for services in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority shall serve as the final authority pertaining to all determinations of medical necessity.

Medical necessity is established through consideration of the following standards:

- (1) *Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention,*

diagnosis or treatment of symptoms of illness, disease or disability;

- (2) *Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the client’s need for the service;*
- (3) *Treatment of the client’s condition, disease or injury must be based on reasonable and predictable health outcomes;*
- (4) *Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the client, family, or medical provider;*
- (5) *Services must be delivered in the most cost-effective manner and most appropriate setting; and*
- (6) *Services must be appropriate for the client’s age and health status and developed for the client to achieve, maintain or promote functional capacity. (Citation: OAC 317:30-3-1(f))”*

These two broad requirements – the drug rebate and medical necessity – form the basis of the Medicaid pharmacy program in each state.

Medicaid Coverage of Viagra

In a letter dated November 30, 1998, HCFA directed states to develop a policy for coverage of Viagra that would “...provide appropriate access ...in the appropriate medical circumstances for the appropriate segment of the Medicaid population.” The letter specifically lists the exclusions allowed under the Medicaid Drug Rebate law as shown above and states that Viagra does not fall under any of the excluded categories, since it was approved to treat erectile dysfunction in men.

The letter goes on to state “[t]he fundamental agreement of the rebate legislation is responsible for ensuring Medicaid coverage of breakthrough pharmaceutical treatments such as protease

inhibitors and atypical antipsychotic drugs.” Protease inhibitors are used to treat HIV/AIDS and atypical antipsychotic drugs are used to treat severe mental illnesses such as schizophrenia and bipolar disorder.

The inclusion by inference of two significant medical conditions seems to suggest that the federal government classified the treatment of erectile dysfunction on par with the treatment of HIV and psychosis. States, however, were not so sure about the medical necessity of the treatment of erectile dysfunction or that the use of Viagra fell outside the scope of fertility drugs. Many states did eventually approve limited coverage of drugs for the treatment of erectile dysfunction, but a handful of states, including Oklahoma, did not.

Medicaid was designed as a safety net for those citizens who would otherwise have no means to obtain life-sustaining medical care. As the practice of medicine has matured over the past four decades, the focus has shifted from treatment of acute illness to prevention of illness and delayed onset of the complications of chronic disease.

There has been a corresponding shift in research and development of new drugs, which has also included some drugs which have been categorized as “lifestyle” or “convenience” drugs. Some would say that the drugs used to treat erectile dysfunction would be included in this group of non-essential medications. Should public funding be used for non-essential treatments?



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Things Consumers Should Know About Nonprescription Medications

*W. Steven Pray, Ph.D., D.Ph., Bernhardt Professor of Nonprescription Products and Devices
College of Pharmacy, Southwestern Oklahoma State University*

Dr. Pray is one of the nation's foremost authorities on "non-prescription drugs". We would normally call these drugs "over-the-counter". Their use and misuse is often an overlooked factor when considering chemicals in our society. Dr. Pray is the author of "Nonprescription Product Therapeutics" (see right), an industry standard reference. The 2nd Edition will be released in October 2005.



However, as soon as the medication is switched to nonprescription status, it can be obtained at any gas station, beauty shop, vending machine, hotel lobby, airport gift shop, or five and dime. It can be sold by anyone, even an illiterate cash register clerk.

The reason that a medication can move from restricted status to gas station sales is based on the Food and Drug

Administration's mistaken assumption that patients will "read and heed" every bit of information on the nonprescription product label. This assumption is false.

Research confirmed that many consumers fail to read the label for precautions, active ingredients, warnings, and often exceed the labeled dose. Clearly, the FDA and lawmakers in Congress do not understand the ramifications of selling powerful pharmacological agents to patients who fail to inform themselves prior to use. This leads to numerous medication misadventures wherein consumers suffer grievous harm.

In one example, an Oklahoma high school student took a fatal overdose of a popular painkiller. Just prior to her death from acetaminophen toxicity, she said to her mother, "It's only Tylenol, ma." It is axiomatic that clerks who are medically illiterate cannot begin to communicate the various warnings and precautions associated with use of nonprescription products such as Tylenol to consumers like this young lady. Counseling about dosing from a pharmacist at the point of sale might have prevented her death.

To remedy this situation, Oklahoma can become the first state in the nation to restrict sales of nonprescription products to pharmacies, where patients can obtain the counseling they need to prevent misadventures. A precedent is already in

At the present time, nonprescription products pose numerous unnecessary dangers to the American public. Some of the dangers are a direct result of unrestricted sales, and some are caused by a failure of Congress to protect the American consumer.

First, it is vital to understand that in the United States consumers face a strange situation in regard to sales of nonprescription products.

Nonprescription products are powerful, medically active molecules. In Australia, all nonprescription products are restricted to sales in pharmacies, so that a knowledgeable professional may assist with their purchase. There are no such restrictions on sales in the U.S. Perhaps the greatest incongruity arising from this flawed policy can be illustrated by the phenomenon known as prescription-to-nonprescription (Rx-to-OTC) switching.

Within the last twenty years, a number of prescription medications have become available for purchase without a prescription. Thus, in the years prior to a medication switching, the medication can only be obtained after a visit to a prescriber, who weighs benefit against risk, and decides to prescribe it. The patient must visit a pharmacy, where pharmacists are required to counsel the patient on its use prior to dispensing it.

place in Oklahoma. This is the Oklahoma law restricting sales of pseudoephedrine to pharmacies. The proposed restriction would be similar to that law.

A second problem arises directly from Congress and its propensity to pass retrogressive laws that benefit industry and special interest groups but expose the consumer to risks. There are currently hundreds of thousand of nonprescription products available to the American consumer. Some have proven safety and efficacy, while many others are unknown quantities because of these special interest laws.

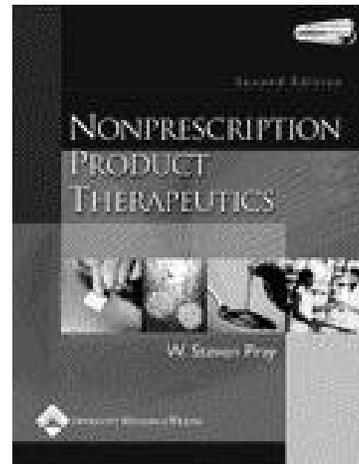
The first group of nonprescription products are those that must prove evidence of safety and effectiveness, to be referred to as the “legitimate nonprescription products.”

The Food and Drug Administration required legitimate products to submit sufficient evidence of safety and effectiveness if they wished to remain on the market. A review of these products has been proceeding since 1972, and is still active. The requirements of science are rigorously applied to this category, so that when the consumer purchases them, there is assurance that they will work as directed for their labeled indications, and that they will be safe for most people when taken according to the label directions.

The products that have not undergone this extensive FDA review, lack scientific evidence of safety and effectiveness, but are freely and legally sold to an unsuspecting public. They fall into three general groups: homeopathics, herbals, and dietary supplements. Their use can be directly hazardous, and can also prevent patients from seeking legitimate medical help.

Homeopathic products are highly diluted, expensive placebos sold as though they were legitimate medicine. In 1938, a federal law was passed that tightened existing laws for nonprescription and prescription products. However, an exemption was intentionally inserted in the law for homeopathic placebos by the Senator

***Nonprescription Product Therapeutics
Second Edition by W. Steven Pray, PhD,
DPh, Bernhardt Professor of
Nonprescription Drugs and Devices***



This important reference is your best resource for helping customers safely and wisely choose their over-the-counter treatments. Known for its lively, friendly writing style and presentation, it has quickly become a favorite among practitioners, faculty and students. The Second Edition emphasizes the pharmacist's role in triage—leading you through the maze of self-care topics, clarifying which conditions are appropriate for self-treatment and which products should be used, or when a medical condition warrants a referral to another health professional.

Organized by condition rather than by drug, the text complements a disease-based approach to therapeutics. You will find useful information on ingredients, interactions, contraindications, and other essentials for patient counseling situations. Treatment algorithms placed within the chapters lead you through the decision making process of recommending the right nonprescription products and devices. Content is up-to-date with FDA regulations, giving you recommendations for products and doses that are proven safe and effective.

primarily responsible for the law. (He was a homeopathic practitioner, a clear conflict of interest). As a result of the exemption, the FDA cannot require that these products' manufacturers submit proof of safety or effectiveness prior to their sale. Thus, the retrogressive inclusion in the 1938 law allows homeopathic placebos of unknown safety and efficacy to be sold in any health food store or gas station. To remedy this situation, Oklahoma could be a national leader by prohibiting their sale.

Herbal medications and dietary supplements are two additional groups of medications that lack proof of safety and effectiveness, in accordance with the rules of good science. In this case, the fault lies with Utah Senator Orrin Hatch. In the early 1990s, the FDA attempted to gain control over unproven products. Utah is the top state for production of unproven products, and Hatch responded to his financial backers by championing the 1994 Dietary Supplement Health Education Act, arguably one of the most retrogressive pieces of legislation to appear in the last millennium.

It tied the hands of the FDA with respect to unproven herbals and dietary supplements, allowing them to be sold without FDA oversight.

As a result of the 1994 DSHEA, the FDA is only able to act against unsafe herbals/dietary supplements after patients have been harmed. Thus, Hatch virtually guaranteed that consumers would suffer harm and death from dietary supplements and herbals that are not proven safe or effective.

To remedy the unfortunate situation with herbals and dietary supplements, Oklahoma could once again take the national lead by halting sales of any product that does not have full approval from the FDA according to the precepts of legitimate science. This might force the manufacturers to finally conduct the safety and efficacy studies that they have so far refused to carry out.

Consumers deserve the best that science can offer in caring for their health. No medication offered for sale should be exempt from proving its safety

and efficacy. To cave in to the demands of the herbal/dietary supplement industry is not in the best interest of the American public. Just because people demand the purchase of these products is not sufficient reason to permit it. Oklahoma must take the lead in forcing manufacturers of unproven products to the same level of responsibility as that demanded of manufacturers of legitimate nonprescription products.

In summary, Oklahoma consumers face a hazardous situation. The fact that federal law allows widespread sales of products of unproven safety and efficacy by anyone is a national scandal. As a result, consumers routinely obtain pseudomedical advice from nonmedically trained sales people such as clerks at health food stores or beauty shops. Further, products not proven safe or effective are offered for sale in hundreds of nonmedical stores all over Oklahoma. To remedy this situation, Oklahoma should restrict sales of all nonprescription medications to pharmacies. This would stop sales by nonlicensed personnel without any medical training and would close health food stores.

The state should also require proof of safety and efficacy for all medications offered for sale to the public without a prescription. This would immediately halt sales of homeopathic, herbals and dietary supplements, in pharmacies and nonpharmacy venues alike. These unproven products would only be reintroduced for sale in the state when the Food and Drug Administration agrees that sufficient data has been submitted to prove safety and efficacy for use.

Oklahoma consumers deserve medications that are proven to be effective, and that are proven to be safe when used as directed. They also deserve the protection that arises from purchasing nonprescription products directly from a registered pharmacist.

Oklahoma can be a model for the nation in upholding the principle of consumer protection in purchase of medications in the face of retrogressive national legislation, unscrupulous manufacturers and nonmedical salespeople.

RPh Oklahoma - Helping The Consumer

Jack Coffey, D.Ph., Associate Dean, OU College of Pharmacy

*RPh Oklahoma is the acronym for this proposal
“Responsible Pharmacists Helping Oklahoma”*

The consumers of health care (patients) are becoming more educated and knowledgeable about legal and illegal medications. The educational possibilities for patients taking medications have increased precipitously by the media, especially television, newspapers, magazines, computer access, and more publications. Generally this provides useful information about the use of the medication and some unintelligible side-effects and complications. Unfortunately this information does not provide sufficient knowledge for the patient to be adequately informed about medications. Physicians and pharmacists sporadically provide good information regarding the proper administration, intended effects, side effects, and storage of medications.

The smart consumer of medications will seek the information about all medications, any variant usages, or the effects of a combination of medications. This is not enough. The real crux of medication use is the outcomes. Is this medication working as intended for me? The over-riding factors of providing positive outcomes are a monitoring process that is critical and crucial to the proper health care of individuals and the cost of medication use to the people of our country.

The following proposal, produced by The University of Oklahoma College of Pharmacy, has the potential of providing better health care and reducing all health care expenditures, including medications.

Background

Several studies have documented that the inappropriate use of medications causes over 125,000 deaths annually and up to \$177 billion of health care expenses annually.¹⁻⁶

Clinically-trained pharmacists, by reducing medication-related morbidity and mortality, can prevent hundreds of thousands of deaths and reduce national annual health care expenses by approximately \$45 billion.⁷⁻¹¹

Drug Related Problems

- For older patients with chronic diseases, the under-use of medications has been identified as a cause of tens of thousands of heart attacks, strokes, deaths, and hospitalizations.¹²⁻¹⁶
- Direct cost of drug-related morbidity and mortality among ambulatory patients is estimated to be \$76.6 billion annually.²
- Lazarou et al³ concluded that 1 million patients are hospitalized annually due to adverse drug effects (ADE's) and that 106,000 of these ADE's are fatal.
- These data place ADE's as the 5th leading cause of death... ahead of motor vehicle accidents, breast cancers, or AIDS.⁴
- More than 1.9 million negative side-effects occur annually among the nearly 40 million Medicare beneficiaries in the United States. Approximately 75% of ADE's in seniors could be prevented.¹⁷
- Of the 15 million patients who could benefit from cholesterol-lowering drug therapy, fewer than 2 million receive such therapy.¹⁰
- A large portion of the 3 to 4 million patients nationwide with congestive heart failure do not receive adequate therapy.¹¹
- A survey by Piette et al¹⁸ found that two-thirds of patients with chronic disease never informed their doctor that they planned to under-use medication because of the cost.
- 40% of falls and fractures could be prevented by eliminating inappropriate medications in the elderly.¹⁹

Oklahoma Health Problems

As a state, Oklahoma consistently ranks in the lowest one-third in the nation on health scores. Inherent in this well-known problem is the need for improved usage and monitoring of medications, both prescription and over-the-counter items.

Other Oklahoma stats:

- Oklahoma ranks 2nd highest in the nation in cardiovascular disease mortality
- 300,000 Oklahomans have diabetes mellitus
- We are the only state where the age-adjusted death rates became worse through the 1990's and into this century.²⁵
- In 2000, 56% of Oklahomans were overweight or obese (Body Mass Index >30)
- Approximately 26% of Oklahomans smoke
- In overall health scores, Oklahoma ranks 48th in the nation

Pharmacist-driven Pilot and Demonstration projects in Wyoming, Iowa, and North Carolina have shown significant short- and long-term savings on overall health care costs and short- and long-term savings on health outcomes.²⁰⁻²³

Pharmacists who are clinically-trained to provide patient care are uniquely qualified to decrease the misuse of medications, improve clinical outcomes, reduce costly hospitalizations and emergency department visits, and thereby, save billions of dollars in health-care expenses. In 1995, it was estimated that drug-related problems cost \$76 billion per year, but that appropriate counseling by pharmacists could reduce this by more than \$45 billion.

We request your consideration of a proposal to take advantage of the opportunity for pharmacists to improve the health of all Oklahomans.

Proposal

Increasingly the citizens of Oklahoma are trying to find ways to make their dollars stretch for the purchase of necessary medications in order to live productive lives. The purpose of this proposal is to provide another avenue to help all Oklahomans

reach this goal. Oklahoma citizens who are concerned about their medications and medication costs will be able to access a toll-free number for information. If it is determined that an Oklahoma constituent is a candidate for a consultation with an Oklahoma Network Pharmacist, he/she can complete a short survey and application.

An Oklahoma Network Pharmacist will review the information provided, will contact the applicant for additional information, and will arrange a face-to-face consult in the near future. This referral system will be established for all Oklahomans to access the services of trained, professional, Oklahoma-licensed pharmacists.

These pharmacists will complete a comprehensive consultation, including review of the medication profile, an examination of the patient's health history, and evaluation for possible drug interactions, therapeutic duplications, cost alternatives, and other medication-related problems.

If deemed appropriate, the Network Pharmacist will then provide the patient and his/her health care providers with a list of clinically-effective recommendations to aid all parties in making informed health care decisions regarding the use of medications.

By working together with physicians, pharmacists will help solve drug- therapy problems for all Oklahomans.

Oklahomans who will benefit the most (1) the uninsured (2) individuals with health insurance who want to maximize their prescription and medical benefits (3) Medicare patients with a Drug Discount Card (4) Medicare patients who do not have a prescription drug benefit and (5) Medicaid clients with monthly prescriptions limits who need help optimizing their medication profiles

Criteria for Participation

Any Oklahoma resident may participate if he/she: (1) would benefit from pharmacist consultation after an initial telephone screening (2) has a

chronic condition or multiple disease states or (3) is unable to purchase necessary maintenance medications

Physical Location:

Call Center will be located within The University of Oklahoma College of Pharmacy, Pharmacy Management Consultants

Program Goals

- Ensure the citizen is receiving the optimum health benefit from medication therapies by screen the citizen for medication-related problems, such as: side effects, drug interactions, therapeutic duplications, drug-disease contraindications, indication without treatment and receiving treatment without indication
- Ensure the appropriate use of medications and devices to achieve optimal therapeutic outcomes: proper use of inhalers, proper use of self-administered injectables, proper use of home-monitoring devices (ex., glucometers, peak-flow meters) and compliance and proper dosage regimen
- Help ensure improved cost-effectiveness while citizen receives quality pharmaceutical care: make recommendations of generic use when applicable, make recommendations of switching to therapeutic equivalents when possible to save money, utilize Maintenance Quantities when possible, keep and maintain accurate medication-profile records, including the source of the medications, and work in conjunction with physicians and other members of the health-care team to optimize patient care

Potential Savings

If the Wyoming "PharmAssist" Program scenario is applied to Oklahoma the potential savings using this program could reach as much as \$1,000 to \$1,500 per participant per year (conservatively). The potential savings for quality health for Oklahoma citizens are immeasurable at this point,

because this does not include reduced health expenditures for: emergency room visits, hospitalizations, Medicare and Medicaid related costs, or loss of work time.

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The Smart Consumer's Checklist

California Board of Pharmacy

Ask The Pharmacist

Talk with a pharmacist. Ask these questions about your medicines:

1. What is the name of the medicine and what is it supposed to do?
2. How and when do I take it and for how long?
3. What do I do if I forget to take my medicine?
4. Are there any side effects, and what do I do if they occur?
5. Is there any written information available about the medicine?

Pain Medications

Are you getting the pain relief you want?

1. If you are not getting pain relief or are having side effects that you cannot tolerate, call your doctor or pharmacist.
2. It is better to take your pain medication on a schedule if you are having constant pain. Do not wait until the pain is severe before taking your pain medication.

Narcotic Pain relievers

What to watch for and how to decrease side effects

1. Being sleepy, drowsy, dizzy or lightheaded is an expected side effect of narcotic pain relievers. The reaction is different for each person.
2. Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert and clearheaded.
3. Do not drink alcohol while you are taking this medication.
4. These drugs may cause constipation. To prevent this from becoming a problem you can:
 - Drink plenty of fluid
 - Take over-the-counter (prescription not required) laxatives such as Senokot, Colace, and Milk of Magnesia if needed for constipation.
5. If you have not had a bowel movement within three days after starting your pain medication, contact your doctor immediately.
6. Your pain medication may also cause an upset stomach.

Older Adults

1. More than 23 million Americans age 65 or older take, on average, between one and six or more prescription medicines each day.
2. There are 35 million older Americans who take more than half of all prescription medications dispensed.
3. The average person over 65 takes twice as many prescriptions as younger people.
4. The frequency of adverse reactions increases as the number of drugs prescribed increases.
5. Each year, more than 9 million adverse drug reactions occur in older Americans.
6. Unwanted side effects of medicines are seven times more common in the elderly than in younger adults, and the likelihood of drug-drug interactions occurring is increased in the older patient.
7. Nearly one-fourth of all nursing home admissions result from older people being unable to take their medications properly.

Older Adults: Improper Use of Medications

1. Poor communication between older patients and health professionals;
2. Taking several medicines at the same time, including prescription and nonprescription medicines;
3. Seeing and receiving prescriptions from more than one health care provider;
4. With advancing age, the body's response to medicine changes; and
5. The inability to take the medication as prescribed.

Older Adult Caregivers

1. What medicines their parents take and for what conditions;
2. How often are they supposed to take their medicines;
3. Whether their parents feel the medicine is helping; and
4. If there are any problems with the medicine.

Older patients taking multiple medicines should ask their health care providers about having a medicine "check up." It can help uncover problems they may be having taking their medicines, and it's a good time for asking questions.

Children

1. More than 200 million prescriptions are written annually for children and teenagers. That's more than 3 prescriptions per child, per year.
 - In any two-week period in the U.S., 13 million children take a prescription medicine.
 - Studies show that 46% of children take their medicines incorrectly.
 - More than 6 million children have chronic diseases that require medicines. The top five are:

Asthma	(3,500,000)
Epilepsy	(1,500,000)
ADD	(800,000)
Arthritis	(165,000)
Diabetes	(120,000)

2. Many children take their medicines incorrectly even when the disease is serious. For example, 75% of asthma patients and 43% of epilepsy patient take their medicines incorrectly. Four most common mistakes children make with medicines are:
 - Stopping too soon.
 - Taking too little.
 - Taking too much.
 - Refusing to take the medicine.
3. Parents should know the following things about the medicines their children take:
 - What condition the medicine is for, and what it is supposed to do;
 - How much to give
 - If there are any side effects and what to do if they occur; and
 - What to do if a dose is missed.

14 Reasons To Talk To A Pharmacist

1. Each year, up to half of the nearly 2 billion prescriptions taken in the U.S. are used improperly.
2. Medication-related problems are responsible for an estimated 10% of all hospital admissions.
3. 96% of patients don't ask any questions about their prescriptions.
4. Improper use of prescription medicines costs the economy over \$15 billion per year.
5. American businesses lose about 20 million workdays due to incorrect use of medicines prescribed for heart and circulatory diseases alone.
6. The average physician writes 8,000 prescriptions a year, and the average community pharmacy dispenses nearly 30,000 prescriptions annually.
7. American dentists write nearly 200 million prescriptions for their patients.
8. One in five patients cannot read well enough to follow a medication treatment regimen effectively at home.
9. More than half the U.S. population receives at least one prescription drug each year. The average per year is 7.5 prescriptions per medicine user.
10. A woman who is pregnant or thinks she may be should not take any medicines unless prescribed or advised by a physician who knows she is pregnant.
11. It's important to ask your pharmacist for information about the medicine you or members of your family are taking.
12. Be sure to tell your health care professionals:
 - The names of all the prescription and nonprescription medicines you are taking and the conditions for which you take them;
 - If you are allergic to any medicines;
 - If you have any problems with any medicines;
 - If you are, or could be, pregnant
13. There are important questions you should ask whenever you receive a new prescription medicine. Be sure you ask:
 - What is the name of the medicine, and what is it supposed to do?
 - What foods, drinks and other medicines or activities to avoid while taking this medicine?
 - Are there any side effects, and what should I do if they occur?
 - Will this new prescription work safely with the other medicines I am taking?
14. The most commonly prescribed medicines are:
 - Cardiovascular medicines (heart and circulation related);
 - Anti-infectives (antibiotics, such as penicillin);
 - Mental health medications;
 - Analgesics (pain killers); and
 - Diuretics (sometimes called "water pills")



Recycling of Prescription Medicine in Tulsa

Angie Jackson and Missy Kruse, Tulsa People, September 2004

A local study has resulted in a new law allowing unused prescriptions to be given away to the needy.

Canadian drug imports and the Medicare drug cards are symptomatic of a huge American problem. Prescription drugs are expensive.

According to the American Association of Retired Persons, drug costs are rising nearly three times the inflation rate. For the elderly on fixed incomes, increases like this can mean going without.

But a pilot program in Tulsa and Oklahoma Counties appears to have found a way to help more needy people, including the elderly, obtain the medicines they need.

Although its concept is simple, it has taken seven years for local health care and social service advocates to find a way to convince nursing homes, pharmacists and lawmakers of its efficacy.

The idea: Recycle unused and safety wrapped blister-pack drugs left at nursing homes when patients no longer need them.

According to a study by the University of Oklahoma Health Sciences Center for Health Policy, it could provide more than \$700,000 worth of additional – and free – prescriptions, which can be given to the needy at the Tulsa County pharmacy, proponents say.

Statewide it could provide \$7 million worth of additional free prescriptions, says Dr. George Prothro, one of those involved in proposing the legislation.

Although a number of people have been involved in the effort, Linda Johnston, Tulsa County director of social services; State Rep. Darrell Gilbert, Dr.

Gerald Gustafson and Prothro have been credited with talking to various parties and working for the enabling legislation which passed in 2000. That legislation includes the two-county pilot program that will help identify any problems.

The pilot is actually going more smoothly in Tulsa, Prothro says, in part because the Tulsa County pharmacy, which distributes drugs at cost to the poor, is a “full pharmacy;” Oklahoma County’s pharmacy provides only a few drugs. They are the only two county-wide pharmacies in the state.

Other Oklahoma communities or counties will be able to institute their own versions of the recycling program in January 2005. Participation by nursing homes, communities and pharmacists is voluntary. Already, other states are inquiring about how this program works.

Under the pilot program, 25 drugs are allowed to be recycled if the drugs are in blister packs –



individually encased pills that thwart tampering. The Tulsa County pharmacy distributes the recycled pills. The aim is to use the cache of free medicines before providing drugs at cost, Prothro says.

“But even at cost, many cannot afford their meds,” Johnson says. “Medicaid pays for only three prescriptions per month. Others without medical insurance are desperate. I have seen patients cry when they learn their medications are free.”

However, the pilot was difficult to establish. Fifty nursing home operators in Tulsa County had to be convinced they would not be liable for mishaps or added paperwork. The Oklahoma Board of Pharmacy had to be assured that medicines would stay pure and that distribution would be safe.

The genesis of the idea, however, belongs to The Committee on Concerns of Older Tulsans, a subgroup of the Tulsa County Medical Society.

Committee members read a report by Michael Lapolla, co-director of the Center for Health Policy. The report stated that \$708,000 worth of medicines are thrown away from nursing homes every year in Tulsa County.

“Nursing homes pay pharmacists to destroy leftover pills,” Prothro says. “They are flushed down the toilet or incinerated. Both methods pollute.”

After visiting with nursing home operators and pharmacists about what might be entailed, “We discovered that only legislation could change the bureaucratic red tape that stymied this simple recycle idea,” Gustafson says.

In 2003-2004, the county pharmacy filled 34,537 prescriptions at cost, helping 16,454 low-income Tulsans. The free, recycled drugs will allow the county to help more people, Prothro emphasizes. It is not meant to reduce the amount of at-cost drugs that the county purchases and provides to qualifying residents.

The county recoups about 50 percent of its pharmacy budget, which includes pharmaceuticals, either from the consumer or from an agency which covers the consumer’s costs, Johnston says. But the amount of pharmacy funds for drugs is going down.

In 2003-2004, \$429,202 was budgeted for pharmaceuticals; for the 2004-2005 fiscal year, it will be \$349,101; about an \$80,000 cut, she says. With increased demand, increased costs of meds and a reduced budget, the recycled drugs will become even more helpful, she adds.

The pilot program is limited to drugs for Alzheimer’s, arthritis, edema, hypertension, angina and mental health disorders. However, the new legislation will cover any drug, except narcotics.

As tested under the pilot program, a pharmacist controls the movements of the drugs. Once the program is statewide, each community or county will work out its own method, but in Tulsa, retired physicians like Gustafson and Prothro pick up the medications from the nursing home. After a manifest is logged, they deliver them to the county pharmacy.

“I arrived with eight grocery-size bags of meds the other day,” Prothro says. “I felt great.”

No matter how good they feel over their success, this group is not resting on its laurels.

“Not included in this legislation are much in-demand inhalers, and we wasn’t to open it up to generics, too,” says Gilbert, who says he wants to see continued progress of their program.

“I represent a low-income area,” he says. “Some of my constituents have had to choose between food and pills.”

Interim Report House Bill 1268
Utilization of Unused Prescription Medications Act
Linda Johnston, Director of Social Services, Tulsa County

January 7, 2004

God Bless the people who ... for this medication program to be possible. I currently need medication that I could not have afforded, which makes my life possible. Churches and other institutions that would normally help out are under funded, and without this program, I would not have been able to get my medication. Without this medication, I would probably end up suicidal again and in the crisis center. Thanks again, because with this medication, I no longer hear voices.

Sincerely,

Eric Blake Troy, Patient Recipient, Tulsa County Pharmacy
(Original signed letter on file)

January 9, 2004

TO WHOM IT MAY CONCERN:

ManorCare Health Services-Tulsa is participating in the pilot program of providing unused prescription drugs to a pharmacy operated by Tulsa County. This program takes very little effort on our part. It is an outstanding program and we appreciate the opportunity to participate and provide this service to the community.

Although we are sending unused drugs to the Tulsa County Pharmacy, we continue to destroy huge amounts of pharmaceuticals costing thousands of dollars. The amounts of antibiotics, respiratory, cardiac and blood pressure medications we destroy are almost criminal when you consider the good they can do. I encourage you to expand this program to all medications except controlled substances immediately.

This program can only relieve suffering and conserve state monies.

Sincerely,

Sandra Downing, RN, Administrator
(Original signed letter on file)

EXECUTIVE SUMMARY

This report will show that there are minimal operational problems with the program, and that patient safety is being safeguarded. It will also show a very positive reception by recipient clients and participating nursing homes. And finally it will suggest methods to make the provisions of HB 1268 more effective and more permanent.

This report will recommend that HB 1268 be amended to:

- (1) Make the program permanent by the removal of “pilot” designation.
- (2) Expand the formulary to include all non-narcotic prescription drugs.
- (3) Allow the transfer of all eligible unexpired medications.

INTRODUCTION

This report has been prepared by Michael Lapolla, Co-Director, Center for Health Policy, College of Public Health, University of Oklahoma Health Sciences Center. Data and assessments have been provided by the Concerns of Older Tulsans Committee of the Tulsa County Medical Society (coordinating volunteer donor nursing homes), and the Director of Social Services for Tulsa County (representing recipient pharmacy serving indigent patients).

It is recognized that the unanimously approved May 2003 amendments to HB 1268 required that:

“The State Board of Health, the Board of Pharmacy, the Oklahoma Health Care Authority, the State Board of Medical licensure and Supervision, and the State Board of Osteopathic Examiners shall review and evaluate the program no later than twenty-four (24) months after its implementation and shall submit a report and any recommendations to the Governor, the Speaker of the Oklahoma House of Representatives, the President Pro Tempore of the State senate, and the Chairs of the appropriate legislative committees.

It is probable that the due date of an evaluation is unclear. Therefore, this report has been prepared in recognition that (1) Tulsa County has now accumulated almost 24 months of operational experience since the original passage of HB 1268 in May 2001 and (2) that experience suggests modifications of HB 1268 to make it more effective and transferable.

OBSERVATIONS

The intent of the legislation was to redirect unused prescription drugs to the county pharmacy where they may be re-dispensed to poor persons at no charge. This report observes to what extent this is occurring, and to what extent is patient safety being protected. This report will measure:

- (1) Have significant supplies of drugs been transferred to county pharmacy?
- (2) Has the Tulsa County pharmacy successfully dispensed those drugs to poor persons?
- (3) Have participants adhered to the rules established for the program?
- (4) Have there been any reported adverse outcomes associated with this program?
- (5) Do recipient patients perceive a need for these medications?

Costs

It is noted that there are negligible program costs for participating nursing homes or the Tulsa County Pharmacy. No additional staff or expense has been required of the pharmacy. The nursing homes have reported no additional personnel requirements. Volunteers of the Tulsa County Medical Society have donated transportation time and expense.

Drug Transfers

There are 19 Tulsa county-based nursing homes that voluntarily contribute unused prescription drugs to the Tulsa County pharmacy. This represents half of all nursing homes and a majority of the beds in Tulsa County. The program is not an impediment to these volunteering nursing homes by definition. All donations are voluntary and any nursing home may discontinue donations if the process were a major operational problem.

Due to startup planning efforts, medication transfers did not functionally begin until September 2003. Given four months of operational experience, it is estimated that an annualized 1,000 prescriptions will be dispensed valued at over \$150,000 of medications. Once formulary and expiration restrictions are lifted, it is likely that the volumes and value will be multiples of the startup amounts.

The nineteen participating institutions (see right) are:

Tulsa County

Ambassador Manor Nursing Center; Baptist Village of Owasso; Bixby Manor; Colonial Manor Nursing Center; Forest Hills Health Care Center; Frances Streitell Villa; Lakewood Care Center; Leisure Village Healthcare; ManorCare Health Services, Oklahoma Methodist Manor; Saint Simeons; Tulsa Jewish Retirement Center; Tulsa Nursing Center; University Village Retirement Center; Village Health Center; Wildwood Care Center; Georgian Court (now closed); Gatesway; and Woodland Park.

There are an additional 11 nursing homes in outlying areas that are voluntarily contributing to the Tulsa County Pharmacy. These organizations contribute medications notwithstanding that residents of their county will not be eligible for pharmacy the benefits. They include: Betty Ann Nursing Center (Grove); Claremore Nursing Center; Elmwood Nursing Center (Wewoka); Grand Lake Manor (Grove); McAlester Nursing Center; Haskell Manor; Inola Healthcare; Leisure Manor (Okmulgee); Rebold Manor (Okmulgee); and Nowata Nursing Center.

Formulary

The majority of unused medications are still being destroyed because they are not on the program's allowed formulary.

Prescription Dispensing

All donated drugs are received by the pharmacist-in-charge of the Tulsa County pharmacy. There

have been no reported operation problems in this receipt; nor have there been any clinical or operational problems in filling prescriptions.

Rule Adherence

The pilot program rules require a chain-of-custody manifest; and require that the date of transfer be at least six months prior to expiration date. The major operational problem is the stipulation that all donated medications have six months remaining prior to expiration date. We believe that the only restriction should be that the drug has not expired; and that the dispensing of that medication prior to the expiration date is the responsibility of the dispensing pharmacist. Many medications could be immediately dispensed upon receipt without this restriction. The present time frame requires destruction.

Current Disposal Practices

Science does not support the common practice of disposing of antibiotics and other chemicals into the sanitary system.

Adverse Outcomes

There have been no reported adverse outcomes that were clinical, administrative or operational.

CONCLUSIONS

The current pilot program has limitations that preclude even much program productivity and success. These limitations include (1) a restrictive formulary (2) restrictive expiration dating (3) perceived liability issues and (4) program participants see much greater potential return once the program is allowed to function fully.

Public Support

There is a widespread public support for this program. The bill passed the Oklahoma Legislature with no dissent. Active supporters include the Tulsa medical community, participating nursing home staffs, local media outlets. State regulatory agencies can proactively accelerate the implementation of this program by recommending the removal of "pilot" status and allow a freer

exchange of medications in a professionally responsible manner.

Formulary

The current formulary is restricted to 25 drugs. This restriction precludes the transfer of valuable medications such as inhalants, antibiotics and other drugs and devices.

Expiration Dates

The pilot program rules prohibit the transfer of medications less than six months prior to the expiration (beyond use) date. Program participants note a significant number of medications that can be dispensed almost immediately upon receipt. These medications are now destroyed. It is observed that it is the responsibility of the dispensing pharmacist to comply with expiration dates.

Liability Concerns

The most often cited reason for nursing homes to not participate is the whispered threat of liability. It is believed that the existing legislation properly and universally addressed liability issues.

Current Disposal Practices

This program reduces the instances of environmental damage.

RECOMMENDATIONS

This report recommends that HB 1268 be amended to:

- (1) Make the program permanent by the removal of "pilot" designation.
- (2) Expand the formulary to include all non-narcotic prescription drugs.
- (3) Allow the transfer of all eligible unexpired medications.

SAMPLE RECIPIENT TESTIMONIALS

(Original signed letters on file)

"Thank you so much for the donated medication program. If it were not for this program, I would probably have to go without my meds or cut down on my dosage, since it is the most expensive of my six prescriptions that I need each month. I certainly hope you continue this program. It has been very helpful to me.." Jeanne Taylor, 1/8/04

"...if this program had not been in effect, we would not have been able to afford medication for a heart condition that we desperately need." Patricia and Gary Robison, 12/10/03

"...the program has helped me tremendously and has been a blessing today. I am thankful that we have people we can come to that we can get the services we need. If it weren't for places like this, I would not be able to get this medication." Deloris Cooper and Family, 12/17/03

RELATED EVENTS

OU Medical Center to close pharmacy
Norman, OK: "...OU Medical Center has now disclosed that it will shut down its busy retail pharmacy because it has been losing \$3 million a year. It serves the medical center complex and was providing free or low-cost prescription drugs to Oklahomans who have little or no medical insurance and who cannot pay for medications, officials said. The losses were suffered for a multitude of reasons ... but primarily it is related to the numbers of unreimbursed medications that are dispensed to patients..." November 26, 2003, Tulsa World.

Tulsa County considered in good shape
To sum it up, the state of Tulsa County is good, County Commissioner Wilbert Collins said Monday in his state of the county address ... Collins also recognized the county's pharmacy and its distribution of unused medications from nursing homes to indigent families. He said the service is

timely given the interest in obtaining cheaper drugs from Canada and questions surrounding the latest Medicare legislation.
January 6, 2004, Tulsa World.

Tulsa County Community Access Program
The final report of the Tulsa Community Health Needs Assessment (October 30, 2003 and presented January 9, 2004) is replete with evidence that Tulsa county residents value the provision of low cost medication to poor persons.

Focus groups consistently mentioned affordable medications as a significant need. Selected quotes from the final report include:

- “Twenty five percent (25%) of respondents mentioned specifically that medications are often out of reach for many clients, particularly for the unemployed and working poor without insurance. The limit of three prescriptions per month placed by Medicaid results in many individuals going without needed medication.”
- Focus groups identified “medication assistance” as the third most common barrier to services (after overall cost and case management). They said “assistance with obtaining medications is not offered in most health care settings. Patients were often not able to comply with medical treatment because they cannot afford prescribed medications and the health provider did not provide assistance to obtain these medications.”
- The Tulsa County Pharmacy and Neighbor for Neighbor were cited as the two primary referral resources of needed medications.

Respectfully submitted, January 15, 2004 by:

Linda J. Johnston
Director of Social Services, Tulsa County

Acknowledged Assistance: Concerns of Older Tulsans Committee of the Tulsa County Medical Society

Old Pills Finding New Medicine Cabinets

Stephanie Strom, New York Times, May 18, 2005

As the cost of prescription drugs climbs, more of the nation's officials and consumers are weighing how to salvage at least \$1 billion worth of unused drugs that are being flushed down the toilet each year.

Though the Food and Drug Administration generally forbids the redistribution of prescription drugs once they are dispensed to consumers, states are free to set their own policies for drugs controlled by nursing homes, long-term-care centers and other pharmacies.

"They seem content to let the states be laboratories, and that works out rather well because the dollars the states are saving are in a lot of cases federal dollars," said James Cooley, chief of staff for Diane Delisi, a Texas state representative and the author of legislation to expand Texas's limited drug recovery program, which may pass within a week.

Several states, including Oklahoma, Louisiana and Ohio, have passed legislation in the last few years allowing unused drugs to be recovered from those organizations for distribution primarily to poor patients.

Nebraska even permits consumers to return unused drugs if they are in tamper-resistant packaging, like the blister package most familiar in over-the-counter medicines, skirting the F.D.A. prohibition.

Recovery has been modest, but California, Maine, Washington and other states are pondering similar programs in hopes of lowering health care costs, however marginally.

Other supporters are trying to push the idea further. An inventor in Massachusetts is seeking a patent on a system that would knit together existing technologies to address the myriad issues of drug redistribution.

"We recycle newspapers, we recycle soda cans, we recycle plastic," said Moshe Alamaro, the inventor, who is a visiting scientist at the Massachusetts Institute of Technology. "It's ludicrous not to recycle expensive drugs."

Mr. Alamaro added, "It should be criminal to throw these drugs away, and instead it's required."

The concept has more skeptics than believers. The hurdles include concerns about patient safety and privacy, the lack of an infrastructure to process and redistribute drugs, and administrative requirements.

"I don't want to sound overly negative, but there are lots of obstacles," said Susan McCann, administrator of the Missouri Bureau of Narcotics and Dangerous Drugs, which is struggling to begin the state's redistribution program.

To sidestep the questions of recycling, Representative Tim Murphy, a Republican who represents Pennsylvania in Congress, suggests that the federal government take a different tack and make it easier for doctors to prescribe small quantities of drugs initially to determine whether a patient can use them.

Monthly or longer prescriptions, now encouraged and sometimes mandated by states and insurers to hold down costs, lead to waste that could be curbed through redistribution.

The amounts discarded are unknown. Though many states require nursing homes, hospitals and consumers to follow specified procedures for drug disposal, the rules add costs and are largely ignored, state health officials and others say.

A study published in the *Journal of Family Medicine* in 2001 estimated that \$1 billion a year in drugs prescribed to the elderly are thrown away, and Mr. Alamaro estimates that a more ambitious

system for drug recycling could recapture 5 percent of the nation's prescriptions, or about \$6 billion worth annually.

Existing programs are a long way from that, however. The prevailing method of dispensing prescription medicine in bottles leaves it too vulnerable to tampering and contamination for any chance of recovery.

Pharmacies, the most likely candidates for redistribution, have little incentive to take on the administrative burdens and potential liabilities.

And states have not committed to developing the databases and other systems that would be needed, much less wrestled with how to ensure adequate supplies of drugs for patients to continue a regimen.

"It doesn't matter how safe the drugs are, how many of them there are or how neat and crisp the records are, if there isn't a database to tell patients what's available and where it is," Ms. McCann said.

So far, only one clinic has expressed interest in participating in the Missouri program. Ohio has failed to get its program off the ground more than two years after it was approved by the legislature because of a lack of interest among nursing homes.

Among the handful of states pressing ahead, Louisiana is one of the most advanced, with 12 pharmacies that distribute unused prescription drugs. Expired drugs and controlled substances, those that are potentially dangerous, are not accepted. As in other states, the drugs are collected from nursing homes and assisted-living centers, which have a carefully controlled storage and distribution system and use blister packaging.

"We know those drugs are perfectly good," said William T. Winsley, executive director of the Ohio State Board of Pharmacy. "They've been under lock and key; they've been stored properly."

Nonetheless, concerns about safety and hygiene have dogged the Louisiana program, said Malcolm J. Broussard, executive director of the Louisiana Board of Pharmacy. "We run across the thought that these are secondhand drugs, and 'don't poor people deserve the same drugs as anyone else?' " he said.

Getting nursing homes to hand over unused drugs has also been a challenge.

"For years, they've been under the impression that they had to waste these medicines," Mr. Broussard said.

Louisiana's program intends to retrieve several million dollars' worth of medicines each year, Mr. Broussard said, though it is too early to gauge results.

The recovery and redistribution of unused medicines is handled by charity pharmacies that cater to the working poor, thus avoiding thorny questions of who gets reimbursed for returned medicines and how. Should a patient get back part of the co-payment, for example?

"You need to reimburse the state or insurer or individual who paid for the drug, and there's a big hassle in that paperwork," said Gay Dodson, executive director of the Texas State Board of Pharmacy.

Mr. Alamaro is convinced that many problems can be resolved with technology, greatly expanding the pool of retrievable medicines.

He and his partners want access to the shelved drugs in the medicine chests of consumers like Florence Weisfeld of New York. Mrs. Weisfeld, 80, a former social worker, ached and had flulike symptoms when she took Lipitor, the cholesterol-reducing medication. So her doctor changed her prescription.

"I had 25 Lipitor tablets left in my medicine chest, and all I could do with them was flush them down the toilet," Mrs. Weisfeld said. "Such a waste."

Re-importation: A Canadian Perspective

Christopher Ward, University of Michigan, October 30, 2003

Drug prices are lower in Canada than in the U.S. primarily because of government-imposed price controls in Canada, differences in exchange rates and differences in product liability laws between the two countries. A growing number of Canadian Internet pharmacies are taking advantage of these lower prices to ship prescription drugs to Americans at higher prices than they can charge Canadian patients. While this may benefit American uninsured or under-insured seniors and others struggling with high drug prices in the U.S. free market, this practice threatens the ability of both Canadian and American governments to ensure the safety of their drug supply systems. It also jeopardizes Canadian patient access to new medicines as Canada is beginning to suffer from shortages of drugs and pharmacists as this questionable but profitable business detracts human resources and supplies from Canadian patients.

The Safety of the Drug Supply System

In Canada, the federal government is responsible for the safety and efficacy of the drug supply system. New drugs must go through a review and approval system. Marketing and advertising practices are regulated to prevent direct-to-consumer advertising and ensure that claims made regarding a product correspond to published scientific evidence. Records of prescribed drugs are kept and recall mechanisms are in place to remove from distribution any drug found to have unanticipated adverse effects or defects. Strict packaging and labeling requirements are also enforced. The provinces provide additional protection for drug consumers by regulating the standards for safe prescribing and dispensing of prescription drugs. The importation of pharmaceuticals via the Internet circumvents all of the above safeguards.

The import and export of prescription drugs is strictly regulated. Canada is a net importer of drugs, and importers must be licensed and work within with federally negotiated mutual recognition agreements with other nations about pharmaceutical manufacturing processes. Canada has mutual recognition agreements with 18 countries ⁽¹⁾.

The equivalency of good manufacturing processes (GMP) compliance programs is determined through a documentation review of each country's regulatory agencies and an evaluation of processes and procedures involving on-site evaluations. In this way, the Canadian government ensures that any pharmaceutical product dispensed to Canadians meets with federal requirements and standards.

A prohibition on commercial parallel trade or unregulated importation of prescription drugs has existed in Canada and the U.S. since 1988 to prevent potentially unsafe re-packaging and minimize exposure to drug-counterfeiting. However, exemptions to the prohibition exist for the importation of drugs by individuals for personal use. The proliferation of Internet marketing has permitted technically "personal" use to explode as American consumers can now easily order their drugs by Internet. It is estimated that nearly \$1 billion worth of medicines is now flowing from Canada to the U.S. each year.

Government agencies in Canada and the U.S. do not attest to the safety of drugs imported under the loophole opened up by the personal use exemption. "The government of Canada has never stated that it would be responsible for the "safety and quality of prescription drugs exported from Canada into the United States, or any other country for that matter," said Diane Gorman, Assistant Deputy Minister of Health Canada in a letter to the Washington Post in

May, 2003. Her American counterpart, William K. Hubbard, Senior Associate Commissioner at the U.S. FDA echoed the lack of responsibility for foreign drug supplies in his testimony before the Senate Committee on Commerce, Science and Transportation in September 2001. "A growing number of Americans are obtaining their prescription medications from foreign locations," said Hubbard. "They often seek out Canadian Suppliers, or sources that purport to be Canadian. As we have said in the past, the FDA cannot ensure the safety of drugs purchased from foreign sources."

Despite the similar high manufacturing standards upheld in both Canada and the U.S., the assumption that drugs marketed in Canada are identical to those in the U.S. is flawed. There are often important differences in formulation and in manufacturing processes, and Canadian prescription drugs have Canadian labeling and prescribing information that is never identical to U.S. labeling and prescribing information. Concerns about safety increase, however, with the prospect that many of the drugs making their way from Canadian suppliers to American consumers are of neither Canadian nor American origin. According to Industry Canada data, pharmaceutical/medicinal product imports into Canada during the period from January to August 2003, increased by 24% over the same period the previous year. And since 1998 the proportion of total Canadian imports from the U.S. is dropping, from 60% in 1998 to 48% in 2002. While the total value of Canadian pharmaceutical imports from the U.S. continues to increase, imports of drugs to Canada from other countries are increasing.

With the growth in mail order pharmaceutical exports to the U.S., Canada has become an important market for imported pharmaceuticals. Between January and August 2002 and the same period in 2003, 36 countries exported \$500,000 or more in medicines to Canada, despite the fact that Canada has Mutual Recognition Agreements for pharmaceutical Good Manufacturing Processes with only 18 countries. Up until August of 2003,

imports from China to Canada increased over 38% over the previous year, imports from South Africa increased 98%, from Ecuador 292%, from Argentina 176%, and from Iran 327%. (Industry Canada Trade Data Online, www.strategis.ic.gc.ca).

As the end consumers in this chain, Americans have to deal with the safety issues that arise with unregulated importation. U.S. FSA spot checks at several mail facilities revealed that there were safety concerns regarding nearly 90% of mail order imported drugs coming in to the U.S. In a pilot project to inspect drugs imported through the mail. It was determined that less than 4% of the intended recipients had valid prescriptions, drugs not approved for use by the FDA or removed from the market for safety reasons were making their way into the hands of consumers, as were drugs with serious contra-indications and interactions. As long ago as July 2001, the FDA brought these concerns forward through testimony before various Congressional committees.

Perhaps most important is the elimination of real consultation with physicians and pharmacists in the process of obtaining drugs. Professional organizations representing physicians and pharmacists across Canada and the U.S. overwhelmingly agree that mail order importation puts patients at risk. College of physicians and Surgeons of Manitoba argues that "with no face-to-face contact between the co-signing doctor and the U.S. patient, Internet drug delivery is breaching the College's standards of practice" (Pills, profits and perils, Maclean's, September, 2002).

Keeping Control over Drug Prices

While it is primarily American patients who may suffer from the use of sub-standard, wrongly prescribed or wrongly labeled drugs, Canadian patients may soon feel the effects of unregulated importation and exportation in their pocketbooks and in the quality of their health-care system. Currently, the federal government imposes price controls on all patented drugs in Canada, essentially setting the manufacturer's price through

the Patented Medicines Prices Review Board ⁽²⁾. A breakthrough drug in Canada can be sold for no more than the price of existing drugs in the same therapeutic class or the median price of the same drug in seven other countries (U.S., U.K., Switzerland, Sweden, France, Germany and Italy).

Canadian drug prices are not freely negotiated by pharmaceutical companies. And while a company may delay the launch of a new drug in Canada because of price controls or other market restrictions, if it refuses to market a product in Canada altogether it risks losing patent rights through compulsory licensing. Similar mechanisms are used to control drug prices in European countries.

Prescription drugs are not covered under Canada's Medicare system, nor is there a federal mandate for the provinces to provide drug coverage. But every province has established a drug benefit program that limits the exposure to drug costs to a certain extent for seniors and other vulnerable populations. Provinces benefit from federal price controls as well as negotiations with drug suppliers in the price they pay to fulfill their coverage plans, which, as every health care report in recent years has shown, keep climbing steadily upwards. Spending on prescription drugs in Canada grew 13% between July 2002 and July 2003 attributable, according to a recent study by the PMPRB, primarily to increased utilization of prescription drugs.

We can expect spending on drugs to continue rising even if the PMPRB continues to be able to keep drug prices in Canada artificially lower than in the U.S. where dictates of a free market prevail and pharmaceutical companies are free to set prices according to market conditions. In Canada the government has been able to impose price control mechanisms on drugs for Canadian consumption in a country which represents only 2% of the global pharmaceutical market on the assumption that those prices will apply only to Canadian consumers. But if Canadian price controls continue to cut into the U.S. market,

which represents 40% of the global pharmaceutical market, through the diversion to drugs manufactured and priced for the Canadian market, Canada may become subject to trade actions that could threaten the sustainability of its prescription drug price controls. At a time when Canada is looking into ways of providing more cheaply to developing countries in dire need, unregulated exports and imports through Internet pharmacies in Canada are generating enormous profits for a small group of entrepreneurs at the expense of Canadian patients.

Finally, the Internet drug supply business is acting as a powerful draw on our country's pharmacists. In Manitoba, 200 of the 1000 pharmacists licensed to practice in the province have shifted from serving Canadians to serving the U.S. Internet business. As a result, pharmacies across the province are reducing their opening hours, the remaining pharmacists are severely strained and at least one rural pharmacy has been forced to shut down because of the acute pharmacist shortage. Pharmacists may not be part of the Medicare system, but are becoming increasingly important to Canadian patients in an era when ambulatory care and pharmacotherapy are replacing hospital and physician care for many conditions. The drug regimens for patients with chronic conditions such as heart disease and diabetes (whose numbers are growing at alarming rates as our population ages) are complex and require monitoring and advice, most effectively dependent on pharmacists to control health care costs by ensuring that prescriptions are properly used and advocating the use of less expensive alternative where appropriate. The health care system will not be able to count on pharmacists to play an ever more important role in health care if their ranks are decimated by the lure of Internet pharmacy experts and the remaining pharmacists are left struggling to provide basic service for Canadian patients.

A number of pharmacist groups are beginning to take a stand on the issue. The Nova Scotia College of Pharmacists issued a statement in 2002 that clearly sets out cross-border dispensing as a breach

of practice (Pharmacy Post, October 2002). As well, the New Brunswick College of Physicians and Surgeons suspended the license of a New Brunswick physician, also licensed in Maine, who was co-signing American prescriptions for a Manitoba Internet pharmacy (Pharmacy Post October 2002). In Manitoba, where most of Canada's Internet pharmacy business is based, concern over shortages of pharmacists and drugs prompted a group of pharmacists to form the Coalition for Manitoba Pharmacy in June 2003. They believe that international Internet pharmacy poses a threat to access to an adequate supply of prescription medicines, access to the care of a pharmacist, and maintenance of lower drug prices in Canada relative to the U.S. The Coalition successfully opposed regulatory changes that would have institutionalized cross-border pharmacy through the Manitoba Pharmaceutical Association. The Manitoba government, however, officially supports the cross-border Internet pharmacy trade and has therefore taken no measures to either track drug shortages in the province or impose controls on these businesses.

Without action at the federal level, the unregulated import and export of prescription drugs will only expand. Most schemes abuse the personal importation exemption as a mechanism to allow commercial mail order suppliers to provide lower cost drugs and to ignore drug quality safeguards. National state and provincial governments in both Canada and the U.S. are responsible for establishing a framework of laws and regulation that protect patients by setting standards for the safe and appropriate prescribing and dispensing of

drugs. In its submission to the Standing Committee on Health, the Coalition for Manitoba Pharmacy advocated that the federal government urge provincial governments to pass regulation prohibiting the export of Canadian prescription drugs. The Coalition points to measures New Zealand adopted when faced with a similar challenge, such as requiring that pharmacists fill prescriptions legitimately signed only by New Zealand physicians, and forbidding a doctor from writing a prescription for a patient unless they have physically examined that patient. Import permits and export controls could also be invoked at a federal level to deal with the problem.

As a final challenge, cross-border Internet pharmacies are encouraging less than ethical behavior from a number of vital players in our health care system, by seeking out doctors willing to co-sign a prescription for an American patient they have never seen, and by enticing pharmacies to order more products than they need and pass on the extra for a premium to an Internet pharmacy. Any practice that encourages the erosion of professional values with financial reward merits close examination from Canadian legislators.

Footnotes:

- (1) Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Netherlands, Portugal, Spain, Sweden, United Kingdom, Switzerland, Iceland, Lichtenstein and Norway.
- (2) Generic drug prices are not subject to Canadian controls and are, on the average, higher than in the U.S. Nearly half of the prescriptions in the U.S. are for generic drugs.

Canadian Ban On Bulk Drug Exports Urged

Lower House, Canadian Parliament, www.pharmacist.com

Motion passed by health committee in lower house of Canada's parliament; unclear whether country's health minister will follow recommendation.

Hoping to enhance the safety and attractiveness of its drug supply in the eyes of potential U.S. importers, Canada's House Standing Committee on Health has recommended a ban on the bulk export of foreign-made pharmaceuticals. The motion would prevent the practice of purchasing drugs from manufacturers based outside of Canada and turning around and reselling them to U.S. buyers.

The committee adopted the *Report on Internet Pharmacies* on June 1 and presented it to the full House June 6. The motion to accept the report had the support of three of Parliament's four parties, including the governing Liberal Party. Authors of the report say it will protect the Canadian Internet pharmacy business and hope it will forestall harsher action by Canadian Health Minister Ujjal Dosanjh; however, it is uncertain whether he will act on the committee's recommendations.

According to a June 3 Reuters report, Dosanjh has suggested even stricter measures, including totally banning the export of price-controlled patented drugs, banning sales to people who are not resident or present in Canada, and making it illegal for Canadian doctors to countersign prescriptions from U.S. doctors.

At issue for consumers and manufacturers in the United States is the safety of drugs that often are imported from other countries into Canada purely for export purposes. U.S. manufacturers are also concerned that, in effect, Canadian price controls are also being imported as the products are sold at a discount to U.S. prices.

Current law in the United States prohibits the importation of prescription drugs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) does include a provision that would allow the importation of prescription drugs, but only if the secretary of the U.S. Department of Health and Human Services (HHS) certifies to Congress that the imports provide cost savings and do not threaten patients' health—something no HHS secretary has ever been able to do. If the secretary were willing to make that certification, MMA would allow the importation of prescription drugs only from Canada, legalize the importation of prescription drugs for personal use, permit manufacturers to enter into agreements to prevent the sale of distribution of imported products, and give the secretary the means to terminate any import program.

Within the past year, several bills have been introduced in the U.S. Congress regarding prescription drug importation, and, on April 19, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing on prescription drug importation to discuss one proposal that had been introduced by Sen. Byron Dorgan (D-N. Dak.). At the end of the hearing, Sen. Mike Enzi (R-Wyo.) indicated that he will introduce his own legislation regarding prescription drug importation. While the senator did not provide the details of his proposal, he suggested the idea of collaborating with FDA on a single-state pilot program—a much narrower proposal than others that have been introduced. Drug importation proponents expressed opposition to the pilot project idea, arguing that a broad, national program to legalize prescription drug importation can be done safely. Enzi is expected to draft his proposal over the next few weeks.

Supporting Reimportation of Prescription Medicine

Challenging the Status Quo of High Prescription Drug Costs

Brad Henry, Governor, State of Oklahoma

Americans are living longer and more productive lives than ever before, and prescription drugs deserve at least some of the credit. New prescription medications that treat everything from high cholesterol and heart disease to allergies, along with other new medical technologies, are not only helping to extend our lives, they are making our lives better by alleviating the suffering caused by many previously untreatable conditions.

This is great news for most people. It should be great news for everyone, but increasingly our seniors and low-income families are finding themselves priced out of a healthy lifestyle.

According to a national AARP survey, the price of the name-brand drugs most commonly used by American seniors increased 7.4 percent from September 2003 to September 2004, a period in which inflation was only 2.3 percent. An AARP Oklahoma survey found that 60 percent of their members have difficulty paying for the medications they need, and nearly half their members pay more than \$100 a month out of their own pockets for prescription drugs. I have talked personally to many seniors about this issue, and I know the real and human toll of such financial strain.

Considering that 20 percent of Oklahomans have no health coverage, and many seniors live on fixed incomes, these figures represent a growing crisis for Oklahoma seniors and families.

Basic health should not depend on financial well-being, and Oklahoma seniors should never be put in the position of choosing between purchasing needed medication and putting food on the table.

Not only do we have a social obligation to take care of those least able to take care of themselves, it makes financial sense to ensure access to

affordable preventative care, such as prescription drugs, for seniors and families. Preventative care is far more economical for Oklahoma taxpayers and consumers, because those who cannot afford the appropriate preventative care will wait until an emergency develops—costing all medical consumers more in the long-run.

With Americans paying more for prescription drugs than anyone else in the world and prices rising every day, I felt it was critical to challenge the status quo and explore innovative ideas that would lower the costs of medications. My Prescriptions for Savings initiative, announced in January 2005, proposed allowing Oklahomans to reimport affordable prescription drugs safely from other industrialized countries.

This proposal has two components. First, a state-run website would allow Oklahomans to purchase U.S.-manufactured prescription drugs from reputable pharmacies in other developed countries. Secondly, the program would allow Oklahoma pharmacists to reimport wholesale drugs, manufactured in the U.S., for resale to Oklahomans.

A state-sponsored program would help provide accountability and certainty to drug reimportation. For example, it would require that only drugs manufactured in the U.S. could be reimported. Additionally, distributors would be required to be fully licensed in their own countries and be in compliance with local safety regulations.

Several other cities and states have implemented drug reimportation programs for their citizens. Springfield, MA instituted program for city employees and saved \$2.5 million in the first year. The cities of Burlington, VT; Montgomery, AL; Portland, ME have also created drug reimportation programs, as have the states of Minnesota and

Rhode Island, Illinois, Kansas, Missouri, Wisconsin, and Vermont have joined together to create the I-Save Rx program, and Connecticut is considering legislation to join.

These are programs created in states led by both Democrats and Republicans, proving that reimportation is a bipartisan issue. Although opponents, particularly the pharmaceutical industry, have criticized reimportation with dire warnings about potential safety issues, these programs have operated without incident in other states. Consumers have obtained the same medications that they had previously purchased in the United States. The only difference is the cost.

Critics have also argued that the prices Americans pay for prescription drugs are justified by the research and development needs of the pharmaceutical industry. Although exact figures on research and development expenditures are nearly impossible to come by, we do know that the pharmaceutical industry has spent \$758 million since 1998 on lobbying, including \$17 million contributed to federal candidates in 2004 cycle.

In addition to money spent lobbying Congress and other levels of government, the industry also spends large sums on advertising. Ten years ago, direct-to-consumer marketing of pharmaceuticals wasn't even allowed by the FDA. Now, it's impossible to turn on the TV or open a magazine or newspaper without seeing ads for name-brand prescription drugs.

As advertising has soared, prescription drugs have become an ever-increasing component of our healthcare regimen. These drugs improve and prolong the lives of many, but the astronomical increase in their use make it difficult to believe that new research will cease should Americans gain access to less expensive, reimported medications.

As an issue, essentially, of international trade, reimportation would ideally be addressed at the Congressional level, but Congress has been unable or unwilling to take any sort of action. Inaction at the federal level has left it to others to change this unacceptable status quo.

We harm our own citizens, and even the economic health of our state, when we throw up barriers to affordable health care. Others have shown that states, even cities, have the power to act in the best interests of their citizens. With the health of Oklahomans at stake, I don't believe we can wait any longer.

Editor's Note: While the Oklahoma Legislature approved one aspect of Gov. Henry's Prescription for Savings Initiative this year, a discount Smart Card for low-income and senior Oklahomans, it declined to act on his drug reimportation plan. The governor intends to pursue a reimportation program again next legislative session.

Related Recent News:

Nevada State Board of Pharmacy officials in September plan to approve the first applications from Canadian pharmacies to sell lower-cost prescription drugs to state residents, but "many questions remain unanswered," the Las Vegas Sun reports (Ryan, Las Vegas Sun, 7/18).

Under a law (SB 5) enacted by Nevada Gov. Kenny Guinn (R) in June, the board will license and inspect Canadian pharmacies that will appear on a Web site established by the Governor's Office for Consumer Health Assistance to help state residents purchase medications. State residents can purchase a 90-day supply of FDA-approved medications through the Web site (Kaiser Daily Health Policy Report, 6/22). (Las Vegas Sun, 7/18).

Supporting Reimportation of Prescription Medicine

Canadian International Pharmacy Association

Summary

The Canadian International Pharmacy Association (CIPA) strongly supports U.S. congressional legislation that would allow for the safe and legal importation of personal mail-order pharmacy products from Canada by Americans. CIPA believes the Canadian mail-order program should simply be an option for Americans that compliments other available drug benefit programs. CIPA applauds the initiatives undertaken by the American government to provide more support for seniors and the poor who need lower cost pharmaceuticals. The American government should move swiftly to provide a safe and secure Canadian mail-order option.

Recommendations:

For Americans to benefit from pharmaceuticals from Canada, CIPA urges the U.S. Congress to craft a bill that will do the following:

1. Limit importation to personal mail-order ONLY.

As the supplier with close ties to Health Canada and first-hand knowledge of the Canadian market, CIPA assures all stakeholders that implementation of any importation program based on a commercial wholesale channel of trade will quickly lead to the complete collapse of the program. Without adequate supply, the Canadian system will not be able to sustain the huge demand that would be placed on it by bulk cross-border transfer of drugs. This massive diversion of supply would result in wide-scale drug shortages for Canadians. The Canadian Government will not tolerate any program that jeopardizes the health of Canadians and will be forced to close the border to this trade.

Of equal concern is the opening of the supply chain to the increased likelihood of counterfeit penetration due to the introduction of a wholesale network that permits re-packaging and re-labeling.

Although legislation may contain prohibitions and incentives to reduce the likelihood of manufacturers cutting the supply to Canada, just the threat of wholesale distribution could force the Canadian government to intervene by halting cross-border trade. If American access to Canadian supply disappears, Americans will seek their pharmacy products from other sources over the internet — sources that are less secure, less safe, and more open to counterfeit and illegal substances.

2. Impose non-discrimination sanctions and incentives.

Canadian supply is jeopardized TODAY. Recent restrictive trade terms have been imposed on Canadian pharmacies and wholesalers by several manufacturers resulting in a supply crisis. Pfizer, Eli Lilly, Astra Zeneca, Wyeth, Novartis, Glaxo and Boehringer Ingelheim have successfully cut off supply of their drugs to Canadian mail-order pharmacies by engaging in a harsh distribution tactic known as “blacklisting”. This has resulted in complete lack of availability of select products, which casts patients into a dangerous scenario of non-compliance with their prescribed therapies. From a caregiver perspective this is unacceptable and begs the urgent assistance of U.S. legislators to intervene on behalf of our American patients.

Since the manufacturers seem determined to pursue an insensitive and unyielding course of prohibition of Canadian product, it will be up to Congress to ensure that strong and meaningful “non-discrimination” provisions be cemented into any proposed importation legislation. If the Canadian option is shut-out, millions of Americans will seek lower cost pharmaceuticals from other countries and suppliers that don’t meet the same strict regulatory requirements as pharmacies in Canada. These people may be inadvertently forced into the hands of counterfeiters and black marketers.

Opposing Reimportation of Prescription Medicine

Nina Owcharenko, Center for Health Policy Studies, The Heritage Foundation, July 20, 2004

Despite enactment of the Medicare Modernization Act of 2003, some policymakers continue to advocate for the importation of prescription drugs into the United States. They argue that Americans, especially seniors without prescription drug coverage, need access to more affordable prescription drugs—seemingly ignoring the current Medicare discount card program and the upcoming 2006 prescription drug benefit.

The Medicare Prescription Drug Discount Card program, a temporary discount card put in place by the Medicare bill, has already proven to save participating seniors—especially lower-income seniors who are also eligible for subsidies—between 50 percent and 78 percent.[1] With such significant savings already reaching seniors, policymakers supporting drug importation should pause and consider its consequences.

While an open, worldwide market for drugs would have long-term economic and other benefits, it would require wrenching policy changes in many countries and far higher prices in many poorer countries. The issue in the current debate, however, is whether drug importation would be the “quick fix” for the United States that its advocates claim, even without the necessary changes needed in other countries. Proponents claim numerous effects that would occur as a result of importation. But when their claims are explored further, in the context of current international arrangements, they turn out to be more myth than reality.

Myth #1: Importation will lead to lower prices in the United States.

Reality: Economists, both liberal and conservative, agree that drug prices will not drop in the United States as much as they will rise abroad. The Congressional Budget Office concluded that allowing importation would reduce prescription drug spending by only about 1 percent and that importation from Canada would result in a “negli-

gible reduction in drug spending.”[2] Even if importation were to lead to lower-priced drugs, the real winners might not be consumers; wholesalers could buy drugs at lower prices but would not necessarily pass those savings on to their customers.

Myth #2: Importation will force other countries to pay their “fair” share.

Reality: Forcing other countries to pay higher prices does not mean that prices in the United States will drop. According to economist Robert Helms of the American Enterprise Institute, the segmented marketplace in pharmaceuticals allows manufacturers to sell their products to different consumers at different prices.[3] Therefore, a price increase abroad would not necessarily cause a price drop in the United States. Producers would lower their U.S. prices only if market conditions in the United States forced them to do so.

Furthermore, the differences in drug prices between the United States and other countries are complex and not always so one-sided as importation proponents imply. To accurately assess drug prices in the United States and abroad, comparisons should not focus on a few select drugs, but the broadest range of options, including generic medications. Several studies do include such comparisons. Interestingly, these studies found that generics tend to cost less in the United States than they do in Canada and many other countries.[4]

Finally, this does not mean that foreign countries should not be encouraged to liberalize their markets. In a recent publication by the Institute for Policy Innovation, Merrill Matthews substantiates former Food and Drug Administration Commissioner Mark McClellan’s argument that other countries are not paying their fair share for pharmaceutical research and development. The best way for foreign countries to pay their fair share, concludes Matthews, is for those countries to “relax

their price controls and let the prices rise.”[5] The Medicare Modernization Act includes provisions asking the Administration “to conduct a study and report on drug pricing practices of countries...and whether those practices utilize non-tariff barriers with respect to trade in pharmaceuticals” and develop strategies to address price controls in trade negotiations.[6] Such discussions can be an effective and positive approach to persuading these countries to change their practices.

Myth #3: Importation is free trade.

Reality: Under genuine free trade, buyers and sellers negotiate to find a mutually agreeable price to buy and sell a product. If an agreeable price is not reached, a seller has the right to withdraw the sale and still have the confidence that their property rights will be protected—that is, that a buyer will not steal the seller’s product if he doesn’t like the price. Unfortunately, the United States is one of the only countries left with a free market for prescription drugs.

In Canada, for example, pharmaceutical companies wanting to launch a product must first receive authorization from the Patented Medicine Prices Review Board (PMPRB), a quasi-judicial body that determines the maximum price that can be charged for a patented drug. While the PMPRB does not directly purchase drugs, it does influence the price at which they can be sold. According to the PMPRB, one of its primary roles is “to ensure that the prices charged by manufacturers of patented medicines in Canada are not excessive.”[7] Other countries use different techniques to affect price and access to prescription drugs. By advocating for prescription drug importation, policymakers are indirectly promoting the importation of price controls into the United States.

It is true, of course, that in principle allowing imports from countries with price controls or subsidies would nudge the world towards freer trade. But while that may be theoretically accurate, the leading bipartisan proposal, S. 2328, introduced by Senator Byron Dorgan (D-ND) and others, includes a section entitled “Restraint of Trade

Regarding Prescription Drugs.”[8] Among other things, this section would make it unlawful for a pharmaceutical manufacturer to charge different buyers different prices for a drug, to deny the sale of a drug to a buyer, or to limit the supply of a drug to a buyer. Such policies would not create a “freer” market for pharmaceuticals, but would regulate the market even further.

Myth #4: Importation is safe.

Reality: The Food and Drug Administration (FDA) has been vocal in its concern over the safety of imported drugs. The FDA regulates the domestic market for pharmaceuticals, but not foreign markets, and has stated on numerous occasions that it cannot guarantee the safety of drugs obtained from foreign sources.[9] Even without the legalization of prescription drug importation, the FDA battles to keep counterfeit drugs out of the United States. According to FDA Associate Commissioner for Policy and Planning William Hubbard, “FDA has seen its number of counterfeit drug investigations increase four-fold since the late 1990s.”[10]

A review conducted by Giuliani Partners at the John F. Kennedy Airport Mail Facility found that of approximately 40,000 packages per day suspected to contain drugs, only about 500 to 700 are inspected. The drugs in those inspected packages came from around the world, and many were not FDA-approved. Some, for example, were past their expiration dates or inappropriately packaged.[11] Counterfeiting pharmaceuticals is very profitable. Therefore, counterfeiters will look for new opportunities to exploit the delivery system, exacerbating the dangers and the current safety problems. The Giuliani study concluded, “The limitations of our system should be addressed before it is opened to whole importation.”[12]

The Canadian government has also clarified its position: it says that Canada cannot be responsible for the safety of products exported to U.S. customers.[13] While Canada regulates its domestic supply, it does not regulate exported drugs. Moreover, many “Canadian pharmacies” on the Internet require customers to sign a waiver absolving the

pharmacies of any liability. States and local municipalities that promote importation to their citizens or employees also disclaim any responsibility for safety.[14]

Myth #5: Importation won't hurt research and development.

Reality: If importation forces prescription drug prices to the lowest regulated price or if it forces prices abroad to rise to levels that spur some governments to exploit intellectual property rights, there could be a downward spiral of pharmaceutical research and development. Future drug treatments and cures—whether for diabetes, cancer, Alzheimer's, or any other medical condition—would be at risk.

Some proponents of importation argue that such fears are overblown because the government, through its funding of the National Institutes of Health (NIH), spends heavily on the research and development of pharmaceuticals. While the NIH does conduct important research, a 2001 report from the NIH to Congress found that of 47 “blockbuster” drugs, NIH funding was involved in the development of only four and that much of that activity was through grants to universities.[15]

Conclusion

The current segmented market structure for pharmaceuticals, while not economically perfect, does give poorer countries access to modern medicines while ensuring that research on new drugs continues apace. Policymakers should hesitate to disrupt this balance by allowing importation without addressing its domestic and international consequences. For example, some countries may decide to restrict the sale of prescription drugs to domestic consumption only, while others, if prices were to rise, might even decide to circumvent the existing intellectual property rights of the manufacturers, undermining the incentive to invest in future research and development.

The best way to address the cost of prescription drugs in the United States is by providing access to discounts and helping individuals obtain health

care coverage that integrates prescription drug coverage. Such a policy relies on the private sector and the free market instead of relying on a government to set prices. Besides the Medicare discount card, other efforts are underway to reach those who lack prescription drug coverage. Pfizer, for example, recently launched a new initiative to extend discounts on Pfizer medicines to the uninsured.[16]

Policymakers should resist “quick fix” policies that may sound logical but are dangerous and potentially counterproductive. In the end, if importation is approved but constituents do not see significant price reductions, some policymakers will quickly respond by calling for government-negotiated prices or directly advocating for price controls on prescription drugs in the United States, moving the United States one step closer to socializing the American health care system.

[1]Joseph Antos and Ximena Pinell, *Private Discounts, Public Subsidies: How the Medicare Prescription Drug Discount Card Really Works* (Washington, D.C.: AEI Press, 2004), p. 18.

[2]“Would Prescription Drug Importation Reduce U.S. Drug Spending,” Congressional Budget Office, April 29, 2004, at <http://www.cbo.gov/showdoc.cfm?index=5406&sequence=0>.

[3]Robert Helms, “The Economics of Price Regulation and Innovation,” *Supplement to Managed Care: Innovation and Drug Reimportation: Cost, Value, and Tradeoffs—Economic, Legal, and Public Policy Implications*, Vol. 13, No. 6 (June 2004), p. 10.

[4]For more information, see “Generic Drug Prices in the U.S. Are Lower than Drug Prices in Canada,” Office of Planning, U.S. Food and Drug Administration, November 2003, at <http://www.fda.gov/oc/whitepapers/drugprices.html>; John Graham, “Prescription Drug Price in Canada and the United States—Part 1: A Comparative Survey,” Fraser Institute, September 2000, at <http://www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=160>; and Patricia M. Danzon and Michael F. Furukawa, “Price and Availability of Pharmaceuticals: Evidence from Nine Countries,” *Health Affairs Web Exclusive*, October 29, 2003, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.521v1>.

[5]Merrill Matthews, “Riding on the Coattails of U.S. Patients,” Institute for Policy Innovation, July 2004, at <http://www.ipi.org>.

[6]See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Conference Agreement, Title XI—Access to Affordable Pharmaceuticals, p. 384, at <http://waysandmeans.house.gov/media/pdf/hr1/hr1jtexplstate.pdf>.

[7]“About the PMPRB,” Patented Medicines Price Review Board, at <http://www.pmprb-cepmb.gc.ca/english/View.asp?x=87>.

[8]S. 2328, Pharmaceutical Market Access and Drug Safety Act of 2004, pp. 56–63, at <http://thomas.loc.gov>.

[9]William Hubbard, testimony before the Subcommittee on Human Rights and Wellness, Committee on Government Reform, U.S. House of Representatives, June 12, 2003, at <http://www.fda.gov/ola/2003/canadian0612.html>.

[10]William Hubbard, testimony before the Committee on the Judiciary, U.S. Senate, July 14, 2004, at http://judiciary.senate.gov/testimony.cfm?id=1264&wit_id=3700.

[11]Rudolph Giuliani, Interim Report to the U.S. Health and Human Services Taskforce on Drug Importation, May 11, 2004, p. 6.

[12]Ibid., p. 13.

[13]Marc Kaufman, “FDA: Canadian Drug Position Misinterpreted,” *The Washington Post*, May 26, 2003, p. A11.

[14]The State of Wisconsin’s Prescription Drug Resource Center Web page, which enables citizens to order prescription drugs from Canada, includes a statement that “expressly disclaims any and all liability from such importation or reimportation or the use of any products so acquired.” See “Click Here for Important Information About the Legality of Purchasing Medications from Canada,” at <http://drugsavings.wi.gov/medicinelist.asp>.

[15]“NIH Response to the Conference Report Request for a Plan to Ensure Taxpayers’ Interests Are Protected,” Department of Health and Human Services, National Institutes of Health, July 2001, at <http://www.nih.gov/news/070101wyden.htm>.

[16]For more information, see http://www.pfizer.com/are/news_releases/2004pr/mn_2004_0707.html.

Time to Stop Drug Reimportation

*Nina Owcharenko, Center for Health Policy Studies,
The Heritage Foundation, August 25, 2004*

So the governor of Illinois plans to help residents of his state buy prescription drugs from other countries. And he’s only the latest politician to join a movement toward “reimportation” that’s popped up in other places nationwide.

It may seem like a good idea: help cash-strapped patients, particularly seniors, knock 30 percent or more off the price of drugs purchased in the United States. And as the governor, Democrat Rod Blagojevic, claimed in announcing the program, the federal government has failed to act on this increasingly significant problem.

Actually, the federal government has acted. Congress passed the Medicare Modernization Act of 2003, which, for now, gives seniors drug discount cards that reduce out-of-pocket expenses for some by as much as 70 percent.

Moreover, the governor’s approach is penny-wise, pound-foolish. Our pharmaceutical industry is the envy of the world precisely because we don’t take shortcuts, such as importing drugs. We don’t let governments control research budgets. (Of 47 “blockbuster” drugs studied for a 2001 report, just four had significant National Institutes of Health funding, and most of that was through universities.) We don’t let government set prices for drugs, and we don’t begrudge drug companies their earnings for performing what’s unarguably their most important function -- developing products that alleviate our pain or cure our maladies.

If the Food and Drug Administration allows Gov. Blagojevic’s program to go forward, a few residents of Illinois will reap some savings. But not as much as many might expect, according to the Congressional Budget Office. The CBO estimates policies similar to that proposed by Gov. Blagojevic would result in savings of only about 1 percent and that, before long, prices will rise in the foreign countries from which Illinois residents

Opposing Reimportation of Prescription Medicine

Carmen A. Catizone, MS, RPh, DPh, National Association of Boards of Pharmacy

Testimony of Carmen A. Catizone, MS, RPh, DPh, Executive Director/Secretary, National Association of Boards of Pharmacy before the Secretary's Task Force on, Importation, Chairman, Richard H. Carmona, M.D., M.P.H., F.A.C.S., United States Surgeon General, May 14, 2004

NABP does not oppose importation within the safe and secure regulatory framework of the Food and Drug Administration (FDA) and state boards of pharmacy. NABP does oppose the illegal importation of medications which is presently occurring and compromising the integrity of our medication system and state regulation of the practice of pharmacy. At our recently concluded Annual Meeting, which marked the 100th Anniversary of the founding of NABP, the member boards passed a resolution which resolved:

That NABP continue to oppose the illegal importation of medications and express to the Food and Drug Administration (FDA) the concerns of its member boards and strongly urge the FDA or appropriate legal authority to pursue actions against state and local governments for endorsing, promoting, or engaging in the illegal importation of medications.

Illegal Importation is a Real Threat to the Public Health and Safety

The illegal importation of drugs from Canada and other countries is one of the most complicated and frustrating issues confronting pharmacy regulators. It is an issue that has the potential of altering how medications are dispensed in the United States and how the practice of pharmacy is regulated. In fact, if the illegal importation of drugs into the US is allowed to continue, the impact on patient safety, pharmacy practice, and the regulation of pharmacy practice will be devastating. Patients illegally importing drugs are bypassing the drug approval process of the Food and Drug Administration (FDA) and the safety of licensed US pharmacies

thus placing their health and well being in the hands of the country, territory, or back room with the seemingly, lowest prices for pharmaceuticals.

At its worst, the illegal importation of drugs creates the opportunity for unknowing and unsuspecting patients to suffer harm, counterfeit and dangerous drugs to contaminate the US medication distribution system, and a thalidomide-like disaster to reoccur.

When the patient safety concerns of state boards of pharmacy, the FDA, and other regulatory agencies are ignored by patients, governors, mayors, and legislators with a chilling, "If the illegal importation of drugs is unsafe, then show us the bodies!" the situation becomes even more compelling. NABP cannot accept the premise that people must die from the illegal importation of drugs before the existing laws ensuring the safety of patients are complied with and enforced. The "show us the bodies" strategy proposed by some legislators, governors, mayors, and other public officials is irresponsible.

Critics of the regulatory actions of the FDA and state boards of pharmacy against entities distributing or assisting in the distribution of medications from other countries contend that there have been only a few reports of patient harm and injury. Although the number of reports may be low, the actual harm to patients is immeasurable and could be significant. NABP maintains that the number of reported patient injuries is low and immeasurable because patients may not be able to discern whether the drugs received from other countries are authentic or appropriate, injuries resulting from patients receiving wrong or counterfeit drugs may not manifest in the health care system until sometime later when the patient's condition worsens and requires emergency treatment or hospitalization, and consumers purchasing drugs from other countries are reluctant

to report any adverse consequences because of the fear of prosecution for violating federal and state laws.

NABP's response to critics of the actions of the state boards of pharmacy to enforce existing state and federal laws protecting the public and prohibiting illegal importation is the presentation of reports from consumers describing real problems which are occurring with illegal importation. Some of the incidents reported to NABP include:

- An Oregon patient being treated for breast cancer receiving the wrong medication from a Canadian pharmacy. The patient continued to take the wrong drug for three months as her condition worsened.
- Consumer complaints, totaling thousands of dollars, reporting that payment was made (credit cards charged) and no product received.
- Consumer complaints of counterfeit or inactive products:

Ordered Acyclovir 400MG from this site received some other medication. Verified using imprint codes.

Product has no effect. Seems counterfeit.

The pills have no obvious effect.

I have taken pain medication before (prescribed by a local doctor). The effects of such meds are obvious. For one thing, the taste is bitter, bordering on awful. In contrast, the pills from MedPrescribe have no taste (I split one in half and tasted it). More importantly, the MedPrescribe pills have no effect (no benefit). In short, they do nothing to alleviate my pain. Nothing.

The item I received was very close to the shape and size of genuine Viagra. However, they bore no marking, logo, or

insignia. Also the surface of the tablet was not as smooth and polished as real Viagra. The tablets were received sealed inside of a foil pouch with no indication of origin.

Order arrived with pills in a zip lock bag with drug name and dose on an adhesive label stuck on the bag. No return address on the mailing envelope and no receipt in the envelope.

I ordered "Tramadol" from this site, but what I received was not Tramadol. I contacted the poison control center, and they stated that they did not know what this medication was, nor did any local pharmacy know. I called [the site's] customer service number but they would not let me speak to the pharmacist that filled the script.

- Consumer complaints regarding illegal and life-threatening access to addicting drugs,

My wife is ordering drugs such as phendimetrazine and clonopin over the internet. They arrive by FedEx. Her charge card is charged because she gave the pharmacies her info. The pharmacies have some unknown drugs.

The header read, Vicodin, 24 Hour Sale Online - looks to be aimed at drug addicts. My son is a prescription drug addict (currently non-using), so the potential is very high.

One of the most startling examples of the atrocities of illegal importation drugs is the receipt of drugs wrapped in tin foil void of any labeling, product identification, directions for use, warning labels, or protective container.

NABP has also learned that the purchase and import of drugs from other countries is gravely compromising state laws and regulations by granting the authority to practice medicine and prescribe medications to unqualified, unlicensed

individuals and fueling the proliferation of solicitations for controlled substances:

- A US entity affiliated with a Canadian pharmacy operation is paying paramedics in the US to conduct the physical examination and diagnosis of patients. The paramedics' examinations and diagnosis are then forwarded to a Canadian pharmacy where prescriptions are issued by a Canadian doctor and drugs shipped to US patients. This activity contravenes US laws by allowing paramedics to practice medicine without appropriate education, training, and licensure.
- A certification/purchasing program is providing the means for psychologists to illegally order psychotropic drugs (e.g. barbiturates, Clozapine, haloperidol, etc.) for their patients through a Canadian pharmacy. Again, the opportunity to obtain prescription medications through foreign sources is directly abrogating the US regulatory system and allowing individuals to practice medicine without the appropriate education, training, and licensure.
- Within the last four months NABP identified a staggering number of web sites brazenly offering controlled substances without a valid prescription (as required by federal and state laws) and a never before witnessed preponderance of spam emails offering unrestricted and illegal access to controlled substances.

Importation Places Patients Outside of Regulatory Safeguards

NABP acknowledges that appropriate safeguards exist within Canada's federal and provincial regulatory systems to ensure that the dispensing of medications in Canada to Canadian patients is safe. Similarly, NABP attests that the dispensing of medications to US patients within the US regulated system is safe.

Unfortunately, the same safeguards do not exist for US patients purchasing and importing drugs from Canada and other countries. Information received by NABP indicates that although Health Canada prohibits the import of drugs outside of the Canadian approval system for dispensing to Canadian patients, it does not prohibit or regulate the import of such drugs for export to US patients. The regulatory void and breach of the safety net for US patients is significant and unknown to the overwhelming majority of patients ordering drugs from Canadian, or believed to be Canadian, pharmacies. NABP learned first-hand from the president of an Internet pharmacy corporation based in Canada that drugs shipped to US patients may not be approved by the Canadian drug approval process and may originate in New Zealand, Vietnam, Pakistan or any country in the world where prescription drug prices are lower than those in the US or Canada.

In fact, there are no limitations as to where drugs will originate from for delivery to US patients. Recent media reports indicate that the State of Illinois will be sending a team to visit sites in Europe with the desired outcome of allowing for the shipment of drugs to Illinois citizens from European countries. Although NABP has information regarding the drug approval process and provincial regulatory system in Canada, related information from countries in Europe and other parts of the world is extremely limited. Each progression to extend the distribution source to unknown borders further away from the FDA drug approval process and state regulation of pharmacy practice makes the situation more dangerous. The extension of importation to countries lacking effective drug approval processes, regulatory systems, or practice standards, the further the erosion and destruction of the entire regulatory structure for the practice of pharmacy. The US system, based within the states and the FDA, has been exemplary in protecting the citizens of the various states and providing patients and health care practitioners with the assurances and confidence that the medications prescribed and dispensed are safe and effective products. The

state based regulatory system successfully protects patients and is flexible enough to extend the regulatory framework and safety net across state borders and allow for the practices of telepharmacy and telemedicine to become realities.

The keys to this interstate regulatory framework have been uniform practice standards, licensure of pharmacists and pharmacies, and licensure or registration of non-resident pharmacies. In fact, all but a handful of states require that non-resident or out of state pharmacies license or register with them and comply with their applicable laws and statutes. These laws and regulations have been in place in some states for almost 20 years, effectively protecting the citizens of the states and fostering cooperation among the states. The nonresident pharmacy laws and regulations protect the practices of pharmacy and medicine across state lines without unduly burdening interstate commerce and rightfully restricting the operation of illegal operations seeking to bypass the regulatory system of the states.

State laws and regulations also allow for Internet pharmacies, the electronic transmission of prescriptions, shared data bases, electronic patient profiles, and other means for patients to receive pharmacist care and appropriately prescribed medications across state lines, through the Internet, or by the use of the mail. These laws and regulations transfer existing and accepted standards for patient care from traditional brick and mortar pharmacies to new, non-traditional Internet pharmacies and interstate practices. In order for importation to occur safely and appropriately, the same regulatory framework and safeguards must be in place across the borders of the US.

If the appropriate inter-border regulatory framework is not in place, then allowing for the purchase and import of drugs from pharmacies or foreign operations that do not comply with existing federal and state laws and regulations places US patients at risk. If the safeguards in place for the US drug approval system and state regulation of

pharmacies and wholesale distributors are deliberately compromised, US patients will be subject to the dangers of a “buyers beware” environment and left unprotected to gamble with their health and safety.

Inter-border Regulatory Proposal

NABP recognizes that a solution resolving the conflict of affordable access to medications versus safety concerns must be developed to address the needs of US patients and prevent irreparable damage to, if not the elimination of, the regulatory systems in the US. The first step of this process was the launching of the VIPPS program in Canada in November 2003 by NABP and the National Association of Pharmacy Regulatory Authorities (NAPRA) in Canada. The VIPPS Canada program mirrors NABP’s VIPPS program¹ in the US and will identify for Canadian patients legal and safe Internet pharmacies accredited by a credible and valid system with standards that focus on the protection of the public health and patient safety.

NABP is also in discussions with a variety of regulatory agencies and affected stakeholders to develop the necessary regulatory framework to regulate the inter-border practice of pharmacy and dispensing of medications to patients in the US and Canada. The framework would provide similar protections as those afforded US patients who utilize pharmacies engaged in the interstate practice of pharmacy and would focus on identifying and monitoring the source of medications. The framework will coordinate the regulatory efforts and resources of the Canadian provinces and US state boards of pharmacy.

In closing, NABP respectfully requests that the Task Force recognize that allowing and encouraging the purchase and importation of medications from other countries without the appropriate regulatory safeguards is a serious threat to our regulatory foundation and patient safety. NABP requests further, the Task Force’s assistance in preserving the sanctity of current regulations so as to prevent any patient from being

seriously injured by the illegal importation of medications from other countries where US laws and regulations are being ignored or the laws of that country or territory do not equate to US laws and regulations. NABP does not believe that even one patient should suffer or be harmed as a consequence of disregarding federal and state laws that ensure the dispensing of safe and effective medications to US patients.

Thank you for the opportunity to address this important issue.

Footnote

¹ NABP's VIPPS program was introduced by NABP in 1999 and fashions traditional regulation and consumer empowerment into a thorough and successful verification and authentication system.

The VIPPS process developed by NABP encompasses compliance with state and federal laws governing the practice of pharmacy and the direct verification of licensure of the Internet pharmacy with all states where licensure or registration is required. VIPPS certifies, through on-site inspections and the meticulous analysis of the site's operations and submitted written information, compliance with an 18-point criterion.

The VIPPS Criteria combine current licensure requirements in all of the US states and territories with additional criterion that concentrate on the distinctions of Internet practice such as the transmission of prescription information and patient data, confidentiality of patient records, and quality improvement and monitoring of prescription processing and patient interactions.

Illegal Drugs & Alcohol

Illegal drugs (and the illegal/inappropriate use of legal drugs) and alcohol continue to be loud and contentious public policy issues. Why? Because the burden of the costs of law enforcement and incarceration are beginning to crowd out other essential public functions such as education, transportation, infrastructure maintenance and more. And because Americans (and Oklahomans) are becoming fed up with the endless costs of the social damage caused by drug abuse. Some people say “treat and prevent” - others say “lock’em up” - while still others are thoroughly confused about what to do.

When such emotional and divisive elements exist - can partisan politics be far behind? This section provides information concerning the legal, moral and economic arguments of the policy options to address the consequences of illegal drug use and alcohol abuse.



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Rethinking Illegal Drugs and Alcohol

Julian K. Fite, Tahlequah

An Academy Salute to Ed Fite

This overview was crafted by Mr. Fite on May 16, 2005 ... several weeks before his unexpected death on June 2. It is a draft that we have left unedited. Julian was the first Academy member to register for the 2005 Town Hall; and this paper was his way of preparing himself for our Town Hall.

Mr. Fite was a former U.S. attorney, district attorney and present counsel for the Cherokee Nation at the time of his death. He held the position of U.S. attorney for the Eastern District of Oklahoma from 1978-'80. Since 1997, Mr. Fite has served as director of the Cherokee National Historical Society; director of the Cherokee Higher Education Foundation; and served as chair of the Cherokee Nation Tax Commission for 1990-'98.

He also served as president of Save the Illinois River Inc., a nonprofit group, since 1993. He served on the Governor's Illinois River Task Force from 1992-'95, was director of the Greater Muskogee Area Chamber of Commerce from 1993-'96, was involved with the Muskogee Convention and Tourism Council from 1990-'96, and was director of Muskogee Performing Arts Inc. from 1989-'97. He was a member of the Environmental Law Section of the Oklahoma Bar Association.

Mr. Fite received the Governor's Environmental Achievement Award in 1993, and was named Oklahoma Wildlife Federation water conservationist of the year, 1993. He had been working as an assistant professor at NSU in Tahlequah, where he taught a variety of criminal justice classes.

Mr. Fite had been an active member of the Oklahoma Academy and faithful participant in previous Town Hall meetings.



What Are Drugs?

What substances should we classify as drugs? All substances that affect our mental or physical condition should be considered as drugs. Currently our most troublesome drugs from a statistical, physical danger, and crime related standpoint are legal and available without prescription to the general public.

Far and away the most common addiction problem and the drug that causes the most sickness and death is tobacco (nicotine). The drug that causes the most crime by far, claims millions of addicts, and causes a great amount of sickness and death is alcohol. Over half of all homicides, most violent assaults, and a huge proportion of domestic and child abuse, not to mention 16,000 highway deaths yearly, are directly related to alcohol.

Our most dangerous drugs and those most often used by our youngest children are not subject to controls – gasoline, spray paint, glue and other substances that are inhaled. Many of these can cause death on the first use and can easily cause permanent brain damage.

Of course, we most often think of drugs as being those classified as illegal – heroin, cocaine, methamphetamine, marijuana and others. The other category is those sold by prescription from a doctor or sold as over-the-counter medicine.

Drug Abuse and Addiction

We probably can never agree on a precise definition of drug abuse. Certainly the use of drugs that cause physical or mental damage to a person, or which adversely affect those around them could be called abuse.

Much of the debate and policy and laws on drugs revolve around why we take them. Historically, drugs have been considered good if taken for valid medical reason, but considered bad (abused) if taken for recreational reasons (to feel good or better). Of course, from a legal standpoint, that distinction is lost in regard to nicotine, alcohol, and the caffeine in coffee, tea, soft drinks, etc.

Most drugs have very different effects depending on how much of them are consumed. Many doctors recommend one or two drinks of alcohol daily to their patients as beneficial for various conditions. Pharmacologists joke that the difference in a drug and a toxin (poison) is how much you take. Cough medicine is useful when taken as directed but is sometimes taken in large amounts to get 'high'.

Mankind has used drugs for thousands of years for various reasons. Drugs have been used as medicine, for religious and spiritual enlightenment, to change how we feel, and to improve mental and physical performance. Most agree that drugs as medicine is beneficial. There are various levels of tolerance and disagreement over the other uses. Most agree that addiction is bad, yet we do not seek to prevent people from becoming addicted to tobacco, alcohol, and caffeine. Our drug laws and policy address only limited categories of drug addiction – opiates, cocaine, methamphetamine, etc. Addiction is defined as the repetitive, compulsive use of a substance despite negative consequences to the user. Our drug laws and policies are not generally based on the addictive qualities of drugs (i.e. nicotine vs. opiates).

It is interesting to note that the drugs which have been the targets of prohibition have generally been associated with powerless minorities when prohibition was adopted (Chinese immigrants – opium; Hispanics – marijuana; African Americans – cocaine). It is also interesting to note that prohibition of various drugs corresponds to the rise of the pharmaceutical industry and the related

financial control of—"medicine". One might observe that opiates, cocaine, and marijuana are from agricultural products which are not generally subject to control of supplies (as are man-made pharmaceutical drugs). Medical opiates (like morphine from the opium poppy) are among the most effective pain relievers and cough suppressants, and are also some of the cheapest medical drugs; however, you will not see them advertised on television because they are not subject to patent protection (price and market controls by the pharmaceutical companies).

Drugs and Money

When we talk about drugs, we must talk about demand for those drugs and the money people pay for them. Americans, by government estimates, pay over \$100 billion a year for illegal drugs. About half of all Americans drink some alcohol and we spend about \$112 billion yearly on beer, wine, and whiskey. Roughly one fourth of Americans smoke tobacco and sales of tobacco total roughly \$83 billion annually.

The big ruckus over prescription drugs is well-founded – we spend over \$180 billion annually on prescription drugs and that amount is the fastest rising component of medical expense for Americans. In addition, we spend another \$15 billion for over-the-counter medications. There is an enormous demand for drugs for the various uses. Some of this is created by advertising, particularly for brand name recognition and market share by giant companies and to capitalize on patent protections and monopolize control of certain pharmaceutical drugs. Big business and politics are a huge proportion of how we approach drugs in our society.

Taxes and availability and public policy regarding drugs generate untold sums for lobbyists in Washington D.C. and every state capitol and generate fortunes in campaign contributions. Aside from big business and politics, there is also an underlying demand from the public for various types of drugs. From cold and flu medicine to beer and cigarettes Americans want many types of drugs.

Drug Policy

As of 1900, there were virtually no laws on drugs – anyone could sell or use any drug. The Harrison Narcotics Act of 1914 brought federal controls to opiates and cocaine. This law required registration of any person or business that dealt in these drugs. Policies evolved that only pharmacies and doctors could provide these drugs and only doctors could authorize sale of the drugs (by prescription). After a few years of debate doctors could only prescribe these drugs for medical treatment. Medical prescription for treatment of addiction was later prohibited.

For other drugs government policy and laws developed that drugs must carry directions for proper use and warnings of potential dangers. For drugs considered particularly dangerous if misused or with a danger of addiction public access was restricted to doctor prescription and pharmacy sales.

Marijuana was not made illegal under federal law until 1937 and then it was only prohibited after a particularly scurrilous campaign of false information by federal drug officials and their media and political allies. There was no constituency to challenge this movement. Interestingly, there has never been a large movement to prohibit our most deadly drug–tobacco.

Alcohol was prohibited in 1919. Fourteen years later, in 1933, we abandoned prohibition as unworkable. The continued demand for alcohol, even as an illegal drug, proved disastrous. Prohibition created large scale organized crime and corrupted law enforcement officers and agencies across America. It could not be enforced. Thus our existing drug policies are to give reasonable instructions and warnings on over-the-counter medicines, let doctors and pharmacies control certain medicines, loose regulation of tobacco and alcohol and prohibition of other non-medical drugs (and medical drugs not under a doctor’s prescription). Most of the dangerous drugs which are inhalants are neither prohibited nor regulated except for industrial safety reasons.

Many natural substances which could be classed as drugs are sold as dietary supplements without standards or warnings.

Our drug policies, except in regard to medical use, have never been science driven or even rational.

Drug Education and Kids

For most of the 20th century, there was not drug education. Harry Analing, the chief federal drug officer from 1930 to 1962, opposed drug education as being dangerous for young people. Education would only tempt children to try drugs.

More recently we have decided to educate and warn children about the dangers of illegal drugs. The content and effectiveness of drug education programs in schools are subject to great debate. Drug education focuses on the illegal drugs and mainly consists of a “just say no” or “they will hurt or kill you” approach.

Oddly enough, some programs leave out or at least don’t focus on alcohol, tobacco, or inhalants. Our children are regularly around drugs and high percentages use alcohol, tobacco, and marijuana. Many young people regard drug education as dishonest scare tactics and dismiss the effort as propaganda.

It is terribly important that drug education and prevention for our children gain credibility and effectiveness. Brain development and personality development have been medically and scientifically proven to continue into the late teens. Drugs affect children differently than adults and can have more serious effects on developing minds and their abilities to learn and cope with life. Our “feel good”, politically popular efforts at drug education and prevention need to be far more honest, sensible and effective if we hope to help our children develop into responsible, reasonably well-adjusted adults.

Drugs and Crime

When we think of the War on Drugs, we think of the evils of heroin, cocaine and methamphetamine addiction. However, we should realize that most

drug arrests are for possession of small amounts of illegal drugs (80%). Marijuana accounts for the largest percentage of drug arrests (U.S. 45%; Oklahoma 55%).

Drug authorities generally estimate that over 16 million Americans use illegal drugs. The most frequently used drug is marijuana (8 million regular users?). Our brimming prisons across the country hold around 1.5 million prisoners. If we were to arrest and imprison all drug offenders we would need over 10 times more prison beds. Most illegal drug users hold jobs and are criminal only in their choice to use drugs classed as illegal. A very serious problem with our drug laws is that it makes crime and criminals purely because of laws that prohibit the choice to use certain drugs. Most criminals use drugs and alcohol. However, most people who use alcohol are not criminals, and most people who use illegal drugs are not otherwise criminal.

From a purely economic standpoint, it would be far better to allow heroin addicts to receive prescriptions for their drugs (they are very inexpensive) and to completely legalize marijuana. This would make users non-criminals and would dry up the lucrative black market for these drugs. It would also be beneficial from a health point of view in that legal access to the opiates and needles would prevent spread of disease like AIDS and hepatitis in the fairly large heroin-using community.

While abuse of various addictive drugs (mainly stimulants like cocaine and methamphetamine) causes significant behavioral and health problems, most illegal drugs are relatively benign from both a health and behavioral point of view. Marijuana carries no risk of overdose and its main negative affect is some short term memory loss. Heroin and other opiates, aside from addiction, carry the main problems of constipation and impotence. Neither Marijuana nor opiates are generally associated with violent behavior as is found with alcohol and cocaine and methamphetamine.

Most illegal drugs are neither addictive, nor physically dangerous if taken in moderate dosages.

Most do not cause physical aggressiveness or other anti-social behavior – particularly when compared to alcohol.

We should consider the fact that illegal drug trafficking provides lucrative world-wide black markets that finance all kinds of criminal activities, corrupt law enforcement and governments, and are probably the main source of cash to finance terrorist activities.

The Drug War

Since President Nixon declared the “War on Drugs” in the early 1970s, prosecution and incarceration has been a major priority of our criminal justice system. We spend upwards of \$100 billion a year in this war and another \$40 billion to lock up drug criminals. Currently 57% of federal prisoners are there on drug charges. State figures vary from over 25% to over 40% of all prisoners serving time for drug offenses.

What have we accomplished from an objective standpoint? Virtually nothing. Drugs are readily available in virtually every city and town in America. Demand has not significantly reduced, and prices have remained steady. Neither supply nor demand have been significantly affected by a more than 30 year “War on Drugs.” It might be time to take a different approach.

“Drug Courts” (essentially treatment and rehabilitation) have been proven very effective, compared to other criminal sanctions. The Oklahoma Bureau of Narcotics has stated that methamphetamine users need to be gotten off the drugs rather than routinely released on bail to pursue their dangerous addiction. Arrest and the threat of prison does not deter them.

Addiction and Treatment

Addiction is the most often discussed negative aspect of drugs. It is related to anti-social and risky behavior as well as negative effects on health. The most trouble-causing addictions from a behavioral point of view are cocaine, methamphetamine and the related powerful stimulants. (Interestingly, only cocaine will cause laboratory rats to seek repeated doses to the point of death).

The most common addiction is to tobacco (nicotine) which is directly related to 400,000 deaths annually in the United States.

The largest number of people who are hazardous to themselves and others are alcoholics.

Common wisdom has long been that addiction cannot be treated until a person chooses to seek help. Numerous experiments and programs have shown that not to be true. Coercive treatment programs for substance abuse are demonstrating high success rates. Coercive treatment programs for substance abuse are demonstrating high success rates. Coercive treatment programs include “drug court” and inmate treatment for prisoners as well as some that are imposed as conditions for probation.

Most criminals have substance abuse problems which most often are directly tied to their criminal behaviors. Alcohol is the number one drug in its relationship to crime – from drunk driving to murder.

For decades we largely abandoned the concept of rehabilitation for criminals. Only in recent years we have begun to deal with the primary problems of most criminals – substance abuse, lack of education, and mental health problems. When we send a substance abuser to prison, the same substance abuse problem exists when they are released back into society. Our dismal recidivism rates tell us that, if we do not deal with basic problems like substance abuse, our prison gates will remain revolving doors merely re-circulating repeat offenders.

Early policy and philosophical decisions (1920s) have remained pillars of our criminal justice system – substance abuse and criminal activity are the result of individual choice and personal immorality – the way to deal with these failings is punishment. While these attitudes are attractive and largely true, they have not served us well from an economic or utilitarian stand point. Our corresponding policy of non-treatment of substance abuse and addiction has been a grave error. The pendulum is swinging toward the

treatment model but we have been slow to fund treatment programs, both coercive and voluntary. Today, if we would fight crime, we would emphasize and fund substance abuse programs.

A Modest Proposal – Things We Could Do

1. Carefully evaluate the content and effectiveness of drug education and prevention for both children and the general public. Adopt, or design the program with maximum effectiveness. Properly fund and implement the programs.
2. Carefully evaluate the content, effectiveness and performance standards for substance abuse treatment. These will vary somewhat depending on whether they are (1.) voluntary, (2.) coercive (mandatory) but non-custodial, (3.) coercive and delivered to those in custody.

We need to adopt and require high standards for delivery for those programs shown to have the best rates of success. This is also a fertile area for additional research.

Funding for these programs tends to be woefully inadequate and this issue should be addressed. Likely, the necessary funds could be provided through savings in avoided incarceration, and other reductions in the harm and expense from drug-related behaviors.

We already are focusing greater efforts on “Drug Courts” (largely treatment and rehabilitation) and required DUI classes for those convicted of drunk driving.

3. Require immediate mandatory substance abuse treatment following criminal arrest (not conviction) when an objective evaluation indicates an underlying substance abuse problem. This should apply particularly to drug problems related to anti-social behavior – alcohol, cocaine, methamphetamine, PCP, etc.

An analogy can be drawn here to involuntary commitment and treatment for mental

Costs Related to Substance Abuse in Oklahoma

The Governor's and Attorney General's Task Force

This analysis was commissioned by the Governor's and Attorney General's Task Force on Mental Health, Substance Abuse & Domestic Violence in 2004. The complete study is available in electronic form from the Oklahoma department of Mental Health and Substance Abuse Services.

Direct Costs

Over \$1.4 billion will be expended annually in Oklahoma to deal with the issues and problems related to substance abuse.

These costs are cash costs. These expenses are purchasing services, employing people and buying products. They are dollars not spent for schools, roads, bridges or the Oklahoma family. Some are the "costs of doing business in a free society" – many are not. Indirect costs such as lost productivity are not included in this summary; they are included in a separate report.

Substance abuse, including both alcohol and illicit drugs, also causes over \$1.4 billion of expense. The majority of the costs are related to safety and security issues (prisons, jails, prosecution, etc), and the contribution of substance abuse to domestic violence/sexual assault and resulting child abuse and neglect.

Economic Impacts

The bottom line is that the economic impact of substance abuse, domestic violence, and mental illness ranged from nearly \$4.2 billion to over \$5.4 billion in 2003. Of this amount, substance abuse accounts for almost all (\$3.2 – \$4.4 billion) of the foregone productivity. This is almost wholly due to academic underachievement and related criminal activity leading to incarceration.

OKLAHOMA	\$1,408,129,407
<hr/>	
CRIMINAL JUSTICE SYSTEM	787,923,409
Corrections Department	206,968,419
District Attorney's Council	44,579,320
Indigent Defense System	7,594,158
State Bureau of Investigation	11,587,629
Narcotics and Dangerous Drugs	6,715,000
Pardon and Parole Board	1,125,747
Public Safety Department	51,359,514
Office of Juvenile Affairs	29,360,005
State Legal and Judiciary	32,626,623
Federal Government	73,268,048
County/Municipal Government	322,738,946
 HEALTH CARE SERVICES	 398,369,618
Oklahoma DMHSAS	50,439,962
Community Mental Health Centers	4,205,556
Domestic Violence Programs	1,812,845
Substance Abuse Treatment	48,871,865
State Health Department	2,976,765
Native American Health Care	24,081,969
Hospitals	142,285,569
Special Injuries and Conditions	109,080,923
Workforce Development	12,626,978
Federally Sponsored Research	1,987,186
 SOCIAL AND HUMAN SERVICES	 83,443,669
Commission on Children and Youth	472,900
Department of Human Services	61,904,363
Federal OASDI Payments	11,199,257
Federal SSI Payments	1,229,471
County Government	461,157
Municipal Government	8,078,216
Native American Services	98,304
 EDUCATION	 19,693,900
Elementary and Secondary	5,509,575
Higher Education	11,266,000
CareerTech	2,918,325
 NON-PROFIT SERVICES	 31,590,699
 SPECIAL INTEREST ISSUES	 87,108,112
Property Loss - Crime	31,648,030
Property Loss-Accidents	30,314,581
Direct DUI Expense	15,512,250

Public Policy Recommendations For Oklahoma

The Governor's and Attorney General's Task Force

*Governor's and Attorney General's Task Force on Mental Health, Substance Abuse & Domestic Violence
Task Force Members: Tom Adelson, Tulsa; Mike Anderson, PhD, Oklahoma City; Governor Bill
Anoatubby, Chickasaw Nation, Ada; Judge Candace Blalock, Pauls Valley; Sue Buck, Hugo; Terry Cline,
PhD (Ex-Officio), Secretary of Health, Oklahoma City; Joe Hight, (Ex-Officio), Oklahoma City; Frank
Merrick, Oklahoma City; Saundra Naifeh, Edmond; Robin Parrish, Governor's Office, Oklahoma City;
Bob Spinks, EdD, Oklahoma City; Jeff Tallent, Oklahoma City; Jack Turner, Oklahoma City, and Rev.
Dick Virtue, Norman*

Preamble

Oklahoma is facing an escalating health and public policy crisis which, if not dealt with soon-, will deepen in both intensity and gravity. It will continue to adversely and directly impact the state's economy and, most importantly, the lives of thousands of Oklahomans. The Governor's and Attorney General's Task Force on Mental Health, Substance Abuse and Domestic Violence recommends immediate action.

A monumental study recently completed by this body details the threat and its significance. Studying the impact of untreated, under-treated and unserved mental illness, substance abuse and domestic violence, Task Force researchers determined that the fiscal and economic impacts on Oklahoma are staggering. Conservative estimates place the cost at more than \$8 billion annually.

These overwhelming figures are difficult for us, as task members, to fully comprehend. However, we do understand the tragic impact this crisis has on those in need, their families and communities, and ultimately, on Oklahoma's overall health, safety and quality of life.

As Task Force members, we have met, studied and deliberated for almost 12 months. We interviewed many subject experts; each represented different pieces of the overall puzzle. Each pleaded with us to either continue or expand vital services to help those in need. We examined issues involving the criminal justice system and heard about Oklahomans who are incarcerated for nonviolent offenses, in an overcrowded jail and prison system, when treatment for an existing mental illness or substance abuse was a viable alternative.

We were enlightened to the struggles of so many who are without access to treatment, or to the services needed to maintain their health and safety. We came to realize that victims of domestic violence and sexual assault need more support and care to be safe, and to begin the difficult recovery from their physical and emotional injuries.

Despite the efforts of many dedicated people in corrections, mental health, substance abuse, domestic violence and sexual assault, and the private sector, we found that the present system is overwhelmed, less than fully efficient and not optimally organized to address growing demands. Without more focused and effective support from the Executive and Legislative branches of our state government, this crisis will progressively worsen. The results of failure to act are unacceptable.

Therefore, the Governor's and Attorney General's Task Force on Mental Health, Substance Abuse and Domestic Violence has identified five overarching recommendations, to be followed by specific actions, that would impact how we as a state can begin to resolve the problems identified by this task force. These are as follows:

Recommendations

1. Prevention and early intervention programs, along with appropriate treatment and recovery support services must be made available to those in need.
2. Non-violent persons who suffer from major mental illness or addiction should be identified and targeted as early as possible upon entry into the criminal justice system for referral to more cost effective systems that are better able to treat, monitor, rehabilitate, and appropriately supervise these citizens.
3. The State of Oklahoma should establish minimum standards of mandated training for all who provide services to Oklahomans impacted by mental health, substance abuse, or domestic violence and sexual assault issues. The establishment of a Training and Coordination Council responsible for oversight, coordination and evaluation is recommended.
4. Oklahoma's leadership should work to increase, to the highest possible level, the number of trained and educated professionals and paraprofessionals equipped with the knowledge and expertise to address these issues.
5. The task force recommends that further study is needed in 2005-2006 to evaluate the needs of offenders and other custody populations who have mental illness and/or substance abuse issues, data collection systems on sexual assault and other related actions as identified by the task force.

This submittal concludes the work of the task force that was formed by Executive Order Number 2004-2 submitted on Jan. 21, 2004. It is our intent that these recommendations will have a positive impact on our state's economy as well as the many thousands of Oklahomans who suffer daily and are in need of our help in order to become functioning and/or productive members of society.

These recommendations become our plea for action, our hope that Oklahoma will respond as constructively as it has with other crises, and our desire that we become the national leaders in tackling the problems of mental illness, substance abuse and domestic violence.

Discussion of Recommendations

1. PREVENTION, EARLY INTERVENTION, TREATMENT, AND RECOVERY SUPPORT SERVICES

Primary Identified Problem

Untreated and under-treated people with mental illness, substance abuse or addictions, and survivors and perpetrators of domestic violence and sexual assault, represent a significant portion of those entering the state's criminal justice system. The resulting direct cost to the state is in excess of \$3 billion annually. In fact, these issues account for half of all criminal justice system expense; more than 11% of health care system expense; and are major contributors to the need for extensive social

services. Oklahoma will also lose more than \$5 billion of human productivity annually as a result of these issues.

Task Force Recommendation - Prevention and early intervention programs, along with appropriate treatment and recovery support services must be made available to those in need.

Rationale - Availability of these programs will significantly reduce the number of people with mental illness, substance abuse or addiction, and domestic violence victims and perpetrators, and consequently will reduce the number of these individuals being incarcerated, saving direct cost to the state.

Suggested Actions - The task force recommends the following actions:

- a. Identifying groups that are at risk of developing mental illness or substance abuse problems or becoming victims or perpetrators of domestic violence and sexual assault and provide targeted prevention efforts, including education, to those populations.
- b. Early identification of a possible mental illness, substance abuse problem or propensity to be a domestic abuser, confirmed by professional assessment and followed by proper treatment or services, will result in a greatly reduced ultimate financial cost to the state and of human pain and suffering that accompanies these problems.
- c. Intervention should be performed by trained educators in public schools and institutions of higher education, personnel involved in the criminal justice system and other state agencies providing services to the public.
- d. Mobile mental health, substance abuse and domestic abuse assessment services are needed.
- f. Alcohol and drug treatment capacity must be expanded. Services are needed to address specialized treatment needs for pregnant and parenting mothers. At least 100-200 additional adolescent residential substance abuse treatment beds are needed to address current demand, along with the provision of more outpatient mental health and substance abuse programs for adolescents and their families.
- g. Addiction is a family disease. To ensure the best possible treatment results, services should be available locally so family members can participate.
- h. Treatment services for families that do not qualify for state services should be addressed by the Oklahoma Legislature by enacting legislation requiring insurance parity for mental health and substance abuse – full coverage by insurance plans sold in Oklahoma for the comparable diseases of mental health and addiction.
- i. Funding for the services essential to reduce the ever increasing cost of substance abuse and addiction should come from an increased tax on beer and alcohol. Consumers of these products should pay for the consequences of their use as have tobacco users.
- l. Aftercare services should be made available throughout the state to people exiting intensive treatment for mental illness or addiction.
- m. The availability of Oxford House facilities for sober living needs to be increased.

2. COST EFFECTIVE ALTERNATIVES TO INCARCERATION

Primary Identified Problem - Oklahoma's Criminal Justice System spends 63% of its annual budget (over \$1 billion) to address the needs of people with mental illness or substance abuse/addiction. Our study found that almost 18% of prison inmates are being treated for a diagnosable mental illness and that 50 percent of all criminal justice system expense is attributable to substance abuse issues. Incarceration should be reserved to address societal problems involving violent or otherwise true criminal behavior and as a last resort for nonviolent offenses. It is the least cost effective governmental function.

Task Force Recommendation – Non-violent persons who suffer from major mental illness or addiction should be identified and targeted as early as possible upon entry into the criminal justice system for referral to more cost effective systems that are better able to treat, monitor, rehabilitate, and appropriately supervise these citizens.

Special priority should be given to the female inmate population. According to the Task Force on the Incarceration of Women, chaired by Lieutenant Governor Mary Fallin, and a report generated from their work entitled "Women Incarcerated in Oklahoma: Report from the Special Task Force for Women Incarcerated in Oklahoma," incarcerated women are statistically more prone to suffer from mental illness or addiction and are likely to be custodial parents whose children are in the costly foster care system.

Rationale – The cost savings, both in tax dollars and human capital, would be enormous.

Suggested Actions – The task force recommends the following actions:

- a. Expand and appropriately staff therapeutic-model courts and pre-trial conditional jail diversion programs. All counties should have regional access to therapeutic-model programs, including drug courts, mental health courts, and crisis centers, with oversight by the Department of Mental Health and Substance Abuse Services.
- b. Enact legislation permitting court referral hearings at initial entry into criminal court proceedings for people with mental illness or drug/alcohol addiction who are status offenders in order to consider whether they could qualify for community supervision programs if local resources are available. If successfully completed, a case would be resolved upon payment of assessed costs or restitution. Upon failure to complete rehabilitation within a reasonable time, the case would proceed to prosecution.
- c. Enact legislation to permit the Oklahoma Pardon and Parole Board to consider release of qualified offenders with mental illness or substance abuse addictions. These special docket settings would require participation in mandatory treatment programs supervised by established local community sentencing councils or drug/mental health courts.

3. TRAINING AND EDUCATION

Primary Identified Problem – Oklahoma tax payers fund numerous education and training programs, seminars, and conferences in order to prepare governmental and other workers for job responsibilities that require knowledge of mental health, substance abuse and domestic violence issues. Because the consequences of uninformed actions or choices can be so dire, it is paramount

that professionals and lay workers, in every discipline connected with these areas, receive comprehensive and on-going training that stress best practices.

Task Force Recommendation —The State of Oklahoma should establish minimum standards of mandated training for all who provide services to Oklahomans impacted by mental health, substance abuse, or domestic violence and sexual assault issues. The establishment of a Training and Coordination Council responsible for oversight, coordination and evaluation is recommended.

Rationale – Minimum standards allow for uniformity of services and overall cost effectiveness. These standards will address continuum of care issues and coordination of services.

Suggested Actions – The task force recommends the following actions:

- d. The Oklahoma Department of Labor in conjunction with the Training and Coordination Council should develop comprehensive educational and training programs addressing mental health, substance abuse, and domestic violence issues in the workplace. Programs shall educate the work force on emergencies/people in crisis, safety issues and drug testing, and provide example policies for employers. Certification awards for businesses who offer this training and Employee Assistance Programs (EAPs) should be created as an incentive.

4. WORKFORCE DEVELOPMENT

Primary Identified Problem —The presence of a proficient workforce, educated to recognize and serve the mental health, substance abuse and domestic violence needs of all Oklahomans, is needed. Efforts in this area are currently underdeveloped.

Task Force Recommendation – Oklahoma’s leadership should work to increase, to the highest possible level, the number of trained and educated professionals and paraprofessionals equipped with the knowledge and expertise to address these issues.

Rationale —Development in this area is integral to mitigation of the growing challenges associated with these conditions in our state.

Suggested Actions

The task force recommends the following actions:

- a. Encourage the development of substance abuse degree curriculum in colleges and universities.
- b. State scholarships must be offered to recruit professionals in the areas of mental health, substance abuse and domestic violence. Scholarship recipients would repay a scholarship by working in Oklahoma where professionals are needed. Additionally the State Regents for Higher Education should evaluate the need for social service professions to have more graduates trained in these areas, and recommend actions that will encourage colleges and universities to increase capacity in programs where there is a high demand for these trained graduates.

- c. Loan repayment options and other programs that already exist, such as Physician Manpower Training, should be examined to see if those programs could be expanded.
- d. The fee-for-service rate paid by DMHSAS to substance abuse providers should be increased from the existing rate to a rate commensurate with mental health and Medicaid fee-for-service rates.
- e. The certification program currently being developed for mental health peer support specialists should be expanded to include substance abuse peer support specialists.
- f. DMHSAS should have a plan to provide performance incentive payments to providers based on the outcomes of the consumers they serve.

5. FURTHER STUDY OR CONSIDERATION

Primary Identified Problem – Insufficient data exists related to some key populations.

Task Force Recommendation – The task force recommends that further study is needed in 2005-2006 to evaluate the needs of offenders and other custody populations who have mental illness and/or substance abuse issues, data collection systems on sexual assault and other related actions as identified by the task force.

Rationale – These studies could be used to determine whether further recommendations are warranted.

Suggested Actions

The task force recommends further study to address the following issues:

- a. Programming, services, transportation and housing issues involving people who have mental illness and/or substance abuse, and who have been or will be released from the corrections system. This should involve the Department of Corrections and the Department of Mental Health and Substance Abuse Services.
- c. Services or linkage to needed services, including discharge planning for those with substance abuse issues, for juveniles released from the custody of the Department of Human Services and the Office of Juvenile Affairs.
- d. The availability of psychotropic medications for mental illness, and specifically how medications and follow-up care can be made available for the indigent.

LIST YOUR BETTER IDEAS BELOW:

WDCD: (What Does Canada Do?)

Nancy Miller Chenier, Canadian Library of Parliament

Abstracted from analysis prepared by Nancy Miller Chenier, Political and Social Affairs Division, Parliamentary Research Branch (PRB) of the Canadian Library of Parliament Revised 23 January 2001



What Measures Are Currently Used to Address Substance Abuse?

Three potential approaches to control the use of drugs include: prohibition, legalization and medicalization. These models differ greatly in how they define drug use, the user, the consequences of drug use and appropriate societal reactions. Supporters of prohibition assume that the use of drugs is morally corrupt behaviour and that control is best achieved by legal sanctions. Proponents of legalization argue that problems are caused by the criminalization of drug use and users and that criminal penalties for use should be removed. Under the medicalization approach, the user is perceived to be sick and thus in need of medical attention and control.

A proposed alternative, “harm reduction,” grew out of efforts in the 1980s to reduce the risks for drug users. It adopts a value-neutral view of drug use and users, one that does not see these as intrinsically immoral, criminal or medically deviant.

Harm reduction, although subject to varied definitions, features in current initiatives aimed at prevention, treatment and control. Strategies aim to reduce the adverse effects of substances by discouraging their initial use and encouraging users to consume more moderately or to stop using the substances.

Strategies attempt to persuade people who use potentially harmful substances to incur reduced or minimal adverse effects through use of drug

substitutes, such as nicotine patches for cigarettes or methadone for heroin, or through medically managed and supervised use of heroin. Strategies can also be based on legalization, where the manufacture, sale or possession of substances is

authorized, with perhaps some regulations relating to their sale, advertising, or place of consumption. Other strategies incorporate decriminalization, either implicit, where certain actions such as needle exchange programs are allowed, or explicit, where criminal penalties for the consumption and possession of an illicit substance are reduced or eliminated.

Current action takes place in three areas:

1. Education and Prevention

Federal government interventions through education and prevention programs currently aim to help people avoid the use of harmful substances and to enhance their ability to control their use. Education, motivation, and awareness-building are combined with regulation and taxation to achieve the goals, recognizing that different groups have different needs in relation to prevention of substance abuse.

The Canadian Centre on Substance Abuse, an important partner in Canada’s Drug Strategy, was created in 1988 to increase public awareness through data gathering, information distribution and policy formulation. In the tobacco area, the National Clearinghouse on Tobacco and Health provides a comprehensive educational, social, fiscal and legislative approach to tobacco control information.

As a group, youth and young adults have the highest rates of alcohol, tobacco and marijuana use and require particular encouragement to avoid the

associated health risks. The federal government has a role in measures to encourage healthy choices; these measures include: increasing the price of alcohol and cigarettes; creating more smoke-free and alcohol-free environments; limiting advertising of tobacco and alcohol products; and supporting education programs in schools and media.

Researchers have drawn attention to the fact that, while seniors make up only 11% of Canada's population, they use 25% of all prescription drugs; 19% of hospital admissions for people over 50 years of age are related to the improper use and side effects of prescription drugs.

Older people may deliberately misuse drugs as a result of stress, anxiety, loneliness or a perceived inability to cope. But misuse can also result from over-prescribing by physicians, lack of monitoring by pharmacists, limited supervision by caregivers, poor communication between health professionals and patients, inadequate literacy levels (among seniors), and inadequate follow-up.

Educating physicians to take greater care in prescribing and involving pharmacists to identify unnecessary drugs or drugs that react badly with other medication is seen as a good preventive measure.

Needle exchange programs provide health professionals with the opportunity to offer treatments but are aimed primarily at harm reduction. By offering clean needles to addicts it is hoped to discourage their common practice of sharing dirty needles when injecting drugs. In 1994, of the 7.7% of Canadians who reported injecting drugs, 41% had shared needles at some time.

Some of the existing outreach programs involving needle exchange date from 1989, when the spread of AIDS among intravenous drug users became a major concern. Situated in mobile as well as stationary units, these programs deliver community-based and cost-effective prevention but have been threatened by governmental cost-cutting measures.

2. Treatment and Rehabilitation

Although the provinces and local communities have the primary responsibility for the development and implementation of drug and alcohol treatment and rehabilitation programs, the federal government has a role in funding them. These programs, which usually address addiction to alcohol and drugs together, include detoxification, early identification and intervention and assessment and referral, basic counselling, therapeutic interventions, clinical follow-up and some workplace initiatives.

Under the Drug Strategy, federal funding was committed to provinces and territories to increase the availability of alcohol and drug treatment and rehabilitation programs. In 1988, the federal government established cost-sharing agreements to provide \$70 million over five years; these agreements were established under the authority of the National Health and Welfare Act. In 1998, responsibility for administering the Alcohol and Drug Treatment and Rehabilitation Program was returned to Health Canada from Human Resources Development Canada. The aim is that, through agreements with the provinces, the department will support related programs, collaborate on national guidelines and best practices, and facilitate information synthesis and dissemination.

Treatment centres with specific programs for particular groups are a relatively new phenomenon. Women, Aboriginal peoples and youth are among the groups to be targeted. People who work in the field suggest that women are more likely to hide their substance abuse problems for fear of stigmatization or lest they might have to give up their children. Status of Women Canada examined the issue of substance use during pregnancy and recommended greater federal allocation of resources.

All young substance abusers need residential treatment centres and outpatient programs that are open at all times of the day and in many settings. The lack of facilities for young solvent abusers in northern Canada is particularly problematic. The

situation was only partially alleviated in 1995 when the federal Health Minister announced funding for six permanent national solvent abuse treatment centres for First Nations and Inuit.

Methadone maintenance programs are aimed at helping heroin addicts when other forms of treatment have failed. Under strict medical supervision, addicts – who must participate in mandatory counselling – are administered methadone, a chemical substitute for heroin. In 2000, Canadian researchers, as part of the North American Opiate Maintenance Initiative, began the process of obtaining federal approval for clinical trials involving the use of heroin as treatment for addicts.

3. Enforcement and Control

At the federal level, various government bodies are involved in control, detection and enforcement efforts that incur high costs for personnel and equipment. Efforts to control tobacco and alcohol include advertising restrictions, taxation, and limits on sales.

At the federal level, the 1997 Tobacco Act provides for a broad range of restrictions on the composition of tobacco products, young persons' access to tobacco products, tobacco product labelling, and tobacco product advertisement endorsement and sponsorship. For alcohol, the Broadcasting Act and the Code for the Broadcast Advertising of Alcoholic Beverages regulate advertising.

The Ministry of the Solicitor General is the lead department with respect to policing, including the Royal Canadian Mounted Police. The Ministry of National Revenue is responsible for the Customs and Excise Program charged with controlling the movement of certain goods, including tobacco, alcohol and drugs.

The failure of past law enforcement efforts to counteract the trade in illegal drugs has led to arguments for decriminalization or the lifting of criminal prohibitions on personal possession of currently prohibited substances. In support of decriminalization it is claimed that current enforcement costs deplete available resources for health-related programs, that violence is produced by the illegal drug trade, and that the treatment for abuse of harmful legal drugs and treatment for use of illegal drugs are inconsistent. Arguments against decriminalization cite the probability that health and social costs would increase if the stigma of drug use were to be removed.

One of the legal concerns with respect to substance abuse is the continued disparity between court sentences. For example, judges can give anything from an absolute discharge to up to seven years' imprisonment for simple possession of cannabis. The fear is that the current system continues the criminal penalties and social disadvantages resulting from encounters with the legal system yet without evidence that it is a major deterrent to illegal trade or drug use. It has been argued that court diversion programs are needed to treat drug users with major psychological or addiction or abuse problems.

Other efforts at control have focused on substance use in the workplace. Employers' concerns have led to various forms of drug testing programs in both the public and private sectors. At the federal level, testing of members of the Canadian Forces began in 1992; in the private sector, companies such as Imperial Oil Limited test new employees and employees in safety-sensitive positions. Both the federal Privacy Commissioner and Human Rights Commissioner have argued that such testing presents problems.

Complete text is at www.parl.gc.ca/information/library/PRBpubs/942-e.htm#PARLIAMENTARY

Ten Drug and Alcohol Policies That Will Save Lives

Join Together is a project of Boston University School of Public Health

PREVENTING UNDERAGE DRINKING

1. Increase alcohol prices through taxes, particularly on beer. Underage drinkers consume as much as 20 percent of all alcohol—mostly beer—sold in the U.S.¹ But youth drink less when beer costs more.² Fewer of them die from alcohol-related motor vehicle accidents, the leading cause of death for people aged 15-20, get into fights, and try to commit suicide.³ Alcohol taxes were once intended to keep prices high enough to deter excessive use. However, these taxes have not kept pace with general inflation, and the real price of beer has actually dropped in the past 30 years.³

2. Limit alcohol advertising and promotional activities that target young people. Like the tobacco industry, the alcohol industry targets advertising to children.⁵ Long-term exposure to alcohol advertising and promotional activities increases the likelihood that children will drink, and the kids who see the most ads are most likely to drink.⁶ The public knows these facts and backs advertising limits—a 2000 survey found over 60 percent of Americans support reducing alcohol ads on television, billboards, and at sporting events.⁷

3. Adopt laws that will prevent alcohol-related deaths and injuries among young people. Graduated drivers' license laws, "happy hour" restrictions, compliance checks, and similar policies change the context in which young people drink. These approaches have been shown to reduce underage drinking and fatal accidents among 15-20-year olds.¹

TREATING ADDICTION

4. Require and enforce equal insurance coverage for drug and alcohol treatment. Virtually all insurance plans either do not cover drug and alcohol treatment or require that people

pay a higher share of the costs of care, making treatment unaffordable for most families. Consumers do not get help early enough to avoid health and social problems, and must use the public system to get care, which hurts state budgets.¹¹ Numerous studies show that drug and alcohol treatment saves money, and that the total impact of adding treatment on insurance premiums is less than one percent.¹²

5. Support the development and use of effective medications for addiction treatment. Several medications, including buprenorphine, methadone, naltrexone, and acamprosate, can effectively treat addiction.¹³ But obstacles prevent their widespread use; for example, insurance companies that do not cover the costs of the drugs, and zoning laws that prohibit the establishment of methadone clinics.¹⁴ Medications are an important part of treatment, especially when combined with counseling, social support, and aftercare.¹³

6. Make screening for alcohol and drug problems a routine part of every primary care and emergency room visit. Screening people for substance use, counseling those who show risky behavior, and referring people to treatment if needed are remarkably effective techniques to reduce alcohol and drug problems.¹⁵ But laws in over 30 states allow insurance companies to refuse to pay for emergency room care if physicians discover alcohol use.¹⁴ Additionally, doctors are not paid to screen and counsel for alcohol use the way they are for other common conditions like diabetes and depression, and therefore may choose not to do so.¹⁷

7. Give higher payments to providers who get better results. Public and private payment systems should be revised to measure and pay for long-term results in order to improve the quality of care in the treatment system. The providers who get

better results should be paid more; those who do not should be paid less. Legislators should work with providers and single state agencies to identify and monitor outcomes.¹⁹

REDUCING AND PREVENTING CRIME

8. Require effective treatment and continuing, supervised aftercare programs instead of incarceration for non-violent drug and alcohol offenders.

More than half of individuals in the criminal justice system who complete treatment programs and participate in aftercare do not commit new crimes.²⁰ Most prisoners who serve mandatory sentences but get no treatment commit new crimes and resume their addictions soon after release.²¹ Convicted drunk drivers also need appropriate treatment and aftercare, even after a first offense.

9. Repeal policies that prevent ex-offenders from returning to full participation in society.

It is fundamentally unfair that people are punished repeatedly for the same offense. But that is exactly what happens to people with drug convictions. Federal and state laws impose lengthy or lifetime bans on federal student aid, cash assistance, food stamps, public housing, and many types of employment. These bans do not prevent drug use, but do impede recovery from addiction.¹⁵

10. Support the work of community coalitions.

Communities that have a written strategy to reduce alcohol and drug problems report greater citizen involvement, more constructive public policy change, better access to treatment, and increased diversity of funding sources. Helping coalitions sustain their community-wide strategies can help reduce substance use at the local level.²³

SOURCES

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I Lost My Sister ... Because of Drug Abuse

Anonymous Contributor, Altus

This story is true. The names and some circumstances have been changed. At the insistence of the Academy, the contributor will remain anonymous.

This testimony was solicited to illustrate that taking drugs is not “victimless” - that the behavior of one can lead to severe consequences for others. It is presented here to be a metric for damage caused and to allow others to think a bit more before blithely dismissing drug use as “just smokin’ a joint”.

Our Family

My family has lived in Bartlesville, Oklahoma since before statehood and benefited from times of prosperity, a community with strong values and a belief in education as a way to succeed. A World War II Veteran who fought in Iwo Jima, my father married his high school sweet heart, returned home to run a profitable family business and raise four children just a few blocks from where he grew up.

High Hopes For The Youngest

The youngest baby boomer in the family, my sister was fondly known as the “boss” in our family. At a very young age, Robin was the kind of kid who knew how to get every other kid in the neighborhood into our garage to “teach school,” organize a good game, and generally run her own personal camp. We use to tease her about being the “boss,” certain that she would be running a large school some day. Like many home-town folks in the 1950s, our family thought of ourselves as a typical middle- class family, with kids racing through green neighborhoods on bikes, softball games going every summer night among the lightening bugs, and all of us taking advantage of a well-run public school system to attain the American dream.

Sharing a room with Robin, I could not have known the depth of problems-to-come, even as the fights began to press on our home during our

adolescence. In her middle school years, Robin was bold enough to sneak out at night to meet “friends.” Unbeknownst to anyone, Robin was regularly seeing a number of kids to get high. Alcohol was an easy drug of choice, available in most parents’ liquor cabinets. She would simply slip out of our house after everyone went to bed, meet her friends, smoke, drink, and come home before anyone had a clue.

A Downward Spiral

Predictably, Robin’s schoolwork began to suffer; she became more reclusive, and increasingly detached from the family. We were all dismayed. We eventually learned of Robin’s delinquent behavior when my father rose one night and saw her empty bed. Confrontation led to conferences with doctors and eventual time in an out-of-state school—all, promising to help my failing sister. Yet, even now, no one knew that Robin was developing a serious drug and alcohol problem. With limited information in those days, my mother and father only knew that their child was in trouble, had learning problems, and needed some kind of help that few seemed to know how to provide.

Marital Trauma

This silent family drama ran what we now know is a typical course. Robin struggled, but graduated from high school and attempted to attend a state university to follow the footsteps of her siblings. Yet, by now her patterns of behavior were deteriorating and, during this chapter, she was staying far away from home. Out of the blue, our family learned that she spontaneously married an abusive young man, divorced within a short period of time, and found the means to move to a large city. Here, she set a path job-hopping. Indeed, Robin began a cycle of mysteriously stopping and starting employment. Attempts to advise and assist were always rebuffed and each one of us began dreading her calls. Most contacts involved a series of downcast stories and the need for money. Worried about her health and well-being and

unaware of a pattern of “enabling” their child, parental funds were usually sent and the cycle would begin again.

Another Marriage

When Robin turned thirty, she married a University professor’s son. They soon had a healthy child and returned to Oklahoma to set up a small business to repair cars. We thought things were looking up. However, Robin decided to take their business to Texas. With this move, Robin began using a number of substances—pills, marijuana, alcohol, and smoking cigarettes on a daily basis; the family only knew about her cigarette habit.

Sadly, the phone calls revealed her story—her voice began to sound slurred and Robin started to make belligerent demands. She called everyone in the family until her welcome ran out. A divorce ensued with bankruptcy and her son began having serious problems at school. When her first “drunk driving” ticket was reported to us, the family stepped in to help. With the second ticket and new knowledge that she was “using” with her teen-age son, we organized a “family intervention,” insisting on treatment. By now her addictions were running her life completely and she quickly ran into another “drunk driving” incident with the police. She was also exhibiting the symptoms of serious clinical depression.

Into Court and Jail

The third ticket ultimately moved Robin into the court system, with the choice of a full program of services through the “drunk driving” court system or jail. We were grateful that Robin chose the drunk-driving court system. However, even though she used a good program well and stayed clean until the program ended—without transition planning, employment counseling and social skill-building, and without community support from friends who did not use substances, Robin landed in the court system again a year later. She simply could not change a lifetime of ruin in six months.

It grieves me to report that her options were limited: she was incarcerated for three months. Released to the street and now homeless, my middle class little sister, who grew up in a

prosperous and caring Oklahoma family, walked ten miles from the state prison to her hometown with no money and no real friends to turn to. Having lost all her possessions, she lived in her car for many days, and with a distant friend’s help, finally found living quarters and, eventually, a job.

Today

Today, Robin is a 50 year old woman who is directed to follow extensive court probation guidelines, drive with a “breathalyzer” before starting her car for the next ten years, attend weekly AA meetings, and pay a number of fines over a lengthy time period—all while maintaining employment. Of course, to keep employment, Robin must not disclose her past. Robin’s fear of imprisonment, alongside structured requirements from the court, helps hold her addiction at bay. Her shame and desperation has pushed her back into serious and necessary work in the local AA program and has prompted her to begin making amends to her family. She is only beginning to attain the diverse skills needed to sustain employment, especially in learning to work with others, manage depression, and make healthy friends in her community. She hopes to reunite with her son some day. We believe that the little “boss” in her is still giving her the courage to continue.

We Still Worry

At home in Oklahoma, each person in my family worries about Robin’s future and wishes to help or support her in the best way possible. At the same time, we have learned that we must let her make her own choices and that “rescuing” or “enabling” does not help. Robin is an addictive personality who happened to be born at a time when few knew how to prevent such problems. Today, in my home, my husband and I talk honestly with our daughter about addiction in our family and the toll it has taken. We also teach her to appreciate and take “one day at a time.” Words cannot describe how tough it is to lose someone this close to you to the disease of addiction. Robin really is my “little sister” and I wish so many good things for her. But, this is her life, not mine. As much as my heart aches for her, I have come to realize that I must let her go to work it out for herself.

I'm Raising My Grandchild ... Because of Drug Abuse

Anonymous Contributor, Ponca City

This story is true. The names and some circumstances have been changed. At the insistence of the Academy, the contributor will remain anonymous.

My Childhood

In my childhood, I can remember having friends who had a relative “who drank.” If they were a happy drunk, then fond, indulgent family lore was shared about them. If they weren’t, they were spoken about in whispers, and family gatherings held a tension borne of never knowing what was going to happen with the drinker. The word “alcoholic” was reserved for poor, unshaven men you saw on the street as you drove by.

My family was loving and hard-working, with high moral standards. We didn’t have a relative who drank—or so I thought. We were actively involved in church activities, with my father sitting on the board of deacons. So, it was a life-altering event when I learned that my gentle giant of a father was indeed an alcoholic who had chosen to stop drinking in order not to lose his family. Over the years, my respect for his strength and character continued to grow, as I realized what it had taken for him to transform his life.

My Husband

It has been said that many girls tend to marry their fathers—and I did. He too was a gentle, loving man who had been a dear friend for some years. But there was a key difference—he was still drinking to quiet demons that were unknown to me. Eleven days after we married, he took his life after drinking a bottle of vodka and taking a bottle of Valium. He left two children, a girl 14 and a son 15, and a note telling me he was certain I would take care of them. I later learned there was a long history of substance abuse in his family, and his children had already started down that road.

During the next 20 years, I enjoyed a great life, with terrific friends; a fulfilling, dynamic career; travel; and the occasional contact with my stepchildren. In 1996, I chose to retire early so that I could enjoy a less strenuous schedule and pursue some other interests.

Both children had been to the depths of addiction, but both were trying to put their lives back on track. With very little family of my own remaining, I met with them and proposed that we celebrate the fact that we had maintained ourselves as an unrelated family by becoming a legal family. In 1997, I adopted both adult children.

My Children

My son had chosen not to have children and pass along what he considers flawed genes. My daughter, however, had one son, during her drug years, and she was now a single mother trying to get an education, work, and care for this sweet little boy, Michael. At three, he met his only grandmother (me) and showed me the blanket his grandmother had sent when he was born. The look on his face when he realized that the person who sent the blanket was the person he was talking to will warm my heart forever.

Years passed with family Christmases and visits back and forth. As he got older, Mike would come to stay with me at holidays and during the summer. It was a time we both treasured, and we have lots of memories from the wide variety of things we shared then.

Sadly, both my son and daughter continued to have drug relapses but would then recover enough to keep working and maintaining somewhat normal lives. My daughter graduated from college after many years of night and correspondence study, and my son had kept the same good job for 10 years.

The Law Won

In March, 2002, though, things started to unravel with a frightening momentum. My son was arrested after a standoff with police who were called because he had abused his wife during a drinking/drugging bout. When I would not pay his bail, he remained in jail for several months.

At the same time, my daughter's live-in boyfriend left, and she spiraled quickly downward. Over the memorial weekend, she called to ask if Mike could spend the summer with me so that she could go into rehab. Since he was already scheduled to be here for a month, I said, of course.

By August, I could not find her, and it became clear that I needed to make some decisions about school and longer-term arrangements for him to live with me. The counselors were a godsend in helping the two of us through those early times, and Mike continued in therapy there for many months. Much of that counseling was focused on giving him other options than drugs and alcohol to ease his pain. We still do "booster shots" of therapy when needed. Because of genetic and behavioral factors, he has a 95% chance of becoming an addict.

I'm A Parent - For The First Time At 60

In September of that year, I went to a "grandparents raising grandchildren" conference. I learned the heartbreaking fact that 12% of children in Oklahoma do not live with either parent—they live with grandparents, aunts and uncles, family friends, neighbors, foster care. I found that the majority of the grandparents I talked to were in my same leaky boat—having been cast there by a sea of addiction. They came from a cross-section of society, economics, cultures.

The adjustment for both of us was enormous. One of the biggest losses was letting go of the fun grandmother/Mike on vacation mode we had always known. It just doesn't work when there is homework to do. He had been used to only sporadic supervision, and very little restriction. I had been accustomed to privacy and quiet and being totally in charge of my schedule.

I had never raised children, and my friends can tell you about the meltdown I had the first year over "book socks." This has been, without a close second, the biggest challenge I have ever faced, and I had weathered some doozies during my professional years.

The Victims of "Victimless Crime"

Three years later, Mike is still with me. His mother has now lost her job, her home, her car, and we hear from her infrequently. Mike is 10 inches taller. He is very bright, but extremely immature for his age, and he probably has some residual brain damage from his mother's drug and alcohol use during pregnancy.

I am delighted to say that his only real addiction so far is computer games. He has attended private schools, but they have the same problems with substance abuse that the general population experiences, and so far he has avoided those temptations. He works Saturdays to earn some spending money, and overall is a good kid.

However, he is doing very poorly in school, has bouts of uncontrollable anger and a poor self-image (like most abandoned children). I have returned to a "day job" in order to meet Mike's needs without further eroding my retirement savings. We both have had to deal with the lives we knew being ripped out from under us. It has been a slow, often painful, journey together, to find a place where we can live easily with one another, but we work on it one day at a time.

A great deal has been written about the by-products of substance abuse, and the toll they take on our society—crime; violence; disease; greater tax burden to fight drug lords and prisons to lock them in; a foster care system that is struggling; and death. But I believe the greatest, most far-reaching, cost is in the lives touched by each addict, particularly their children.

Even with loving relatives, these children are scarred and damaged in ways that will affect their entire lives and their children's lives.

Federal Drug Wars

George Will Washington Post Writer's Group

Exasperated by pessimism about the “war on drugs,” John Walters, director of the White House Office of National Drug Control Policy, says: Washington is awash with lobbyists hired by businesses worried that government may, intentionally or inadvertently, make them unprofitable. So why assume that trade in illicit drugs is the one business that government, try as it might, cannot seriously injure?

Here is why: When Pat Moynihan was an adviser to President Richard Nixon, he persuaded the French government to break the “French connection” by which heroin came to America. Moynihan explained his achievement to Labor Secretary George Shultz, who said laconically: “Good.”

Moynihan: “No, really, this is a big event.”

Shultz, unfazed: “Good.”

Moynihan: “I suppose that you think that so long as there is a demand for drugs, there will continue to be a supply.”

Shultz: “You know, there’s hope for you yet.”

Walters understands that when there is a \$65 billion annual American demand for an easily smuggled commodity produced in poor countries, and when the price of cocaine and heroin on U.S. streets is 100 times the production costs, much will evade even sophisticated interdiction methods. And, Walters says, huge quantities of marijuana are grown domestically, for example, in California, Kentucky and West Virginia — often on public lands because the government can seize private land used for marijuana cultivation. And particularly potent strains of the drug are grown

indoors. Marijuana possession, not trafficking, accounts for most of the surge in drug arrests since 1990. Critics suggest an armistice on this front in the \$35 billion-a-year drug war.

Marijuana’s price has fallen and its potency has doubled in the past eight years. So say David Boyum and Peter Reuter in their new book, “An Analytic Assessment of U.S. Drug Policy,” from the American Enterprise Institute. They say that although the number of people incarcerated for drug offenses on any given day has increased from 50,000 in 1980 to 450,000 in 2003, the inflation-adjusted prices for cocaine and heroin are half of what they were 25 years ago.

So, should there be an armistice on this front, too? Walters responds that the bulk of the demand for illegal drugs is from addictive users. Of the 19 million users, 7 million are drug-dependent. Marijuana use is a “pediatric onset” problem: If people get past their teens without starting, Walters says, the probability of use is “very small” and the likelihood of dependence “much less.”

Use of marijuana by youths peaked in 1979, hit a low in 1992 and then doubled by the mid-’90s. The age of first use of marijuana has been declining to the early teens and lower. Often, Walters says, the “triggers” for use are “cultural messages” — today, for example, from rap music. Nevertheless, teen marijuana use has declined 18 percent in the past three years.

Because marijuana is, unlike heroin and cocaine, not toxic — because marijuana users do not die from overdoses — its reputation is too benign. The 5 million users in the 12-to-17 age cohort are, Walters believes, storing up future family, school and work problems and putting their brain functions at risk with increasingly potent strains of marijuana. Many of these strains — and perhaps one-third of the total U.S. marijuana supply —

come from Canada. A few years ago police estimated that there were 10,000 growers in the Toronto metropolitan area.

Last year 400 metric tons of cocaine were seized worldwide, but at least 200 entered the United States. However, some seizures, by causing abrupt shortages in some metropolitan areas, cause addicts to seek detoxification. Walters says that breaking the French connection did that in New York in 1972. Even Prohibition, he says, for all its bad effects, changed behavior: After repeal, per capita alcohol use did not return to pre-Prohibition levels until the 1960s.

Walters says the data do not support the theory that society has a “latent level of substance abuse” — that if one problem declines, another rises commensurately. And he thinks indifference to drug abuse, which debilitates the individual’s capacity to flourish in freedom, mocks the nation’s premises.

Having studied political philosophy at the University of Toronto with the late Allan Bloom, Walters describes the drug war in Lincolnian language: “There are certain requirements of civilization - to keep the better angels of our nature in preponderance over the lesser angels.”

Fighting terrorists, he says, is necessary even though it is like seeking a needle in a haystack. Illicit drugs - millions of pounds marketed to millions of Americans — are at least not a needle-in-a-haystack problem.

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Illegal Drugs in Oklahoma 2005

U.S. Drug Enforcement Administration,

State Facts

Population: 3,460,097

Law Enforcement Officers: 8,401

State Prison Population: 29,200

Probation Population: 30,269

Violent Crime Rate

National Ranking: 16

2004 Federal Drug Seizures

Cocaine: 83.7 kgs.

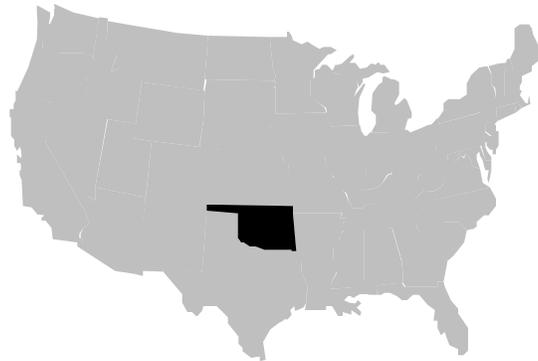
Heroin: 0.0 kgs.

Methamphetamine: 4.8 kgs.

Marijuana: 433.8 kgs.

Ecstasy: 4,237

Methamphetamine Laboratories: 404



www.dea.gov/pubs/states/oklahoma.html

Drug Situation:

Methamphetamine, which is produced in Mexico and the Southwest United States and locally produced, remains the principal drug of concern in the State of Oklahoma. Cocaine, particularly crack cocaine, is a significant problem in the urban areas of the state. Oklahoma also serves as a transshipment point for drugs being transported to the eastern United States via Interstates 40 and 44. Interstate 35 also provides a critical north-south transportation avenue for drug traffickers.

Cocaine:

Cocaine continues to be readily available throughout Oklahoma. The cocaine is transported from Texas and Mexico via commercial airlines and motor vehicles. Mexican polydrug traffickers dealing in marijuana and methamphetamine bring some of the cocaine into the state. Much of the cocaine HCl is converted into crack cocaine for sale at the retail level. Cocaine is distributed primarily by Mexican and African American traffickers. The majority of the cocaine purchased in the Oklahoma City area is transported in by local suppliers who travel to large cities in Texas and return to distribute the product.

Heroin:

Black Tar heroin is available in limited quantities near the metropolitan areas in Oklahoma. It is rare to encounter brown or white heroin, though in a very few instances, “white” heroin from Colombia has been seen. Recently, brown heroin of high potency (66%) was encountered in the Oklahoma City area. Demand for heroin has declined in recent years. The majority of heroin traffickers in Oklahoma receive their heroin from Mexico. Most of the heroin transported into Oklahoma is concealed in hidden compartments in passenger vehicles.

Methamphetamine:

Methamphetamine is the primary drug of choice in Oklahoma. Caucasian males and females are equally the primary users. Most of the methamphetamine in the state is brought in by Hispanic organizations via motor vehicles, commercial airlines, and mail delivery services. An increase in the amount of crystal methamphetamine has been seen over the past year.

Local small “mom and pop” laboratories continue to be a significant problem throughout Oklahoma. Approximately 30% of local laboratories use the Nazi method and produce only ounce quantities or less at a time.

Club Drugs:

The state of Oklahoma is seeing an increase in the abuse of club drugs, such as MDMA and GHB. MDMA is found at rave parties in eastern and central Oklahoma. The majority of the MDMA seen in Oklahoma comes from the West Coast, Nevada, and Texas. A small number of seizures have involved MDMA originating in Canada.

Marijuana:

Marijuana is readily available in all areas of Oklahoma. Marijuana is the main illegal drug of abuse in the state. Marijuana imported from Mexico is prevalent and is usually imported in combination with other illegal drugs being transported to Oklahoma and other states north and east. The majority of the marijuana is imported from the southwest border via passenger vehicle and occasionally in freight vehicles. Mexican “Sensimilla”, usually found in “pressed/brick” form, is the most common type of marijuana seen in Oklahoma, particularly in urban areas.

Domestically produced marijuana is also available in Oklahoma, though not as readily in recent years. Oklahoma, along with several other southern states has endured severe drought conditions over the past three years. This situation has affected the local production of marijuana.

Other Drugs:

The most popular pharmaceutical substances abused in Oklahoma are Vicodin, Lortab, propoxyphene, alprazolam, hydrocodone, Ultram, diazepam, Hycodan, Demerol, Dilaudid, and Percodan. Much of the diversion is through fraudulent prescriptions, doctor shopping, pharmacy break-ins, and hospital thefts. OxyContin is also increasing as a pharmaceutical drug of abuse in Oklahoma.

DEA Mobile Enforcement Teams:

This cooperative program with state and local law enforcement counterparts was conceived in 1995 in response to the overwhelming problem of drug-related violent crime in towns and cities across the nation. Since the inception of the MET Program, a total of 436 deployments have been completed nationwide, resulting in 18,318 arrests. There have been three MET deployments in the State of Oklahoma since the inception of the program: Duncan, Ardmore, and El Reno.

Other Enforcement Operations:

The number of Operation Pipeline interdictions are increasing within the state of Oklahoma. California and Texas are most often reported as the domestic states of origin. Since the state of Oklahoma is traversed by numerous Interstate Highways, interdictions are common in all areas. Seizures of illicit drugs traveling through Oklahoma en route to their destinations north and east are routine, as well as seizures of large amounts of currency en route south and west.

DEA Regional Enforcement Teams:

This program was designed to augment existing DEA division resources by targeting drug organizations operating in the United States where there is a lack of sufficient local drug law enforcement. This program was conceived in 1999 in response to the threat posed by drug trafficking organizations that have established networks of cells to conduct drug trafficking operations in smaller, non-traditional trafficking locations in the United States. As of January 31, 2005, there have been 27 deployments nationwide, and one deployment in the U.S. Virgin Islands, resulting in 671 arrests. There has been one RET deployment in the State of Oklahoma since the inception of the program, in McAlester.

Drug Courts/Treatment Centers:

There are currently Twenty-two drug courts operating in the state of Oklahoma with eleven more in the planning stages.

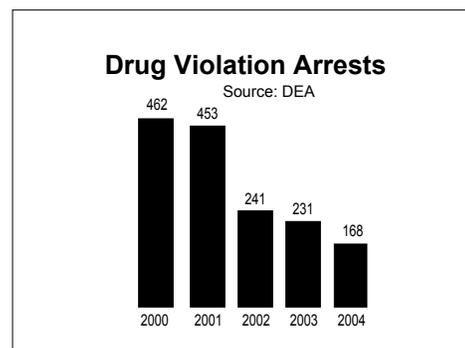
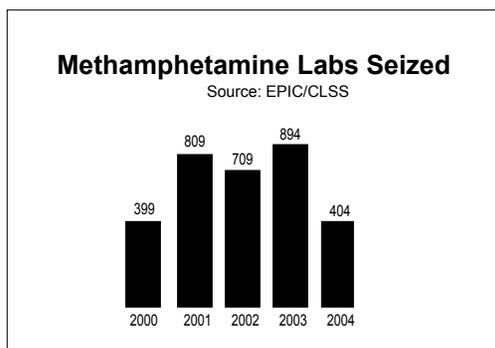
According to the Oklahoma Department of Mental Health and Substance Abuse Services, there were 212 drug and alcohol treatment centers operating in the state of Oklahoma during 2001.

Current Laws Regarding Criminal Sanctions and Precursor Chemicals:

Over the past couple of years the Oklahoma Legislature has passed numerous laws regarding methamphetamine and its precursor chemicals. These include additional penalties for manufacturing methamphetamine in the presence of minors; possessing or distributing methamphetamine in the vicinity of schools, public parks, public pools or on a marked school bus; and for tampering with anhydrous ammonia equipment. Any possession of anhydrous ammonia in unapproved containers is considered prima facie evidence of manufacture. Any possession of three (3) ingredients such as iodine, red phosphorous and ether is considered prima facie evidence of intent to manufacture methamphetamine. The average lab manufacturing sentence in the state is approximately 20 years. House Bill 2316 passed both the Oklahoma House and Senate in May 2002 and went in to effect on July 1, 2002. This new law puts a 24 gram limit on all cold medicines containing pseudoephedrine or ephedrine. The charge carries a five year maximum sentence. If a retailer knowingly distributes pseudoephedrine, ephedrine, or phenylpropanolamine with the knowledge that it will be used to manufacture methamphetamine, the sentence carries a maximum of ten years incarceration. House Bill 1326, effective July 1, 2003 requires state registration (mirroring Federal Law) for the handling/distribution of products containing Pseudoephedrine at both the wholesale and retail levels.

New Legislation:

House Bill 2176 was presented to the Senate in March 2004 and is expected to be signed into law by Governor Brad Henry within the next few months. This Bill calls for Pseudoephedrine to be included as a Schedule V controlled substance.



Drugs & Alcohol in Workplace By Sector

US DHHS, Substance Abuse and Mental Health Services Administration.

Source: US Department of Health and Human Services Substance Abuse and Mental Health Services Administration. (1996). Drug Use among U.S. Workers: Prevalence and Trends by Occupation and Industry Categories. Rockville, MD: US Department of Health and Human Services.

Construction

Almost every aspect of our lives is touched in some way by the construction industry, and America's builders enjoy a long and rich history of designing and erecting landmarks recognizable the world over. Clearly, construction workers who abuse alcohol and other drugs are dangerous not only to themselves, but also to their colleagues and the general public. Safety in the construction industry is paramount, and for this reason many construction firms across the country are challenging themselves to build better workforces by proactively addressing workplace substance abuse and diminishing its potentially disastrous consequences.

A Federal government survey revealed that the construction industry has some of the highest rates of alcohol and drug abuse. Among full-time construction workers between the ages of 18 and 49, the rates of substance abuse among different types of personnel within the construction industry are at the accompanying table.

The good news is that more and more construction companies, ranging from large international corporations to relatively small local contractors, are implementing drug-free workplace programs as a way to ensure productive workforces and safe workplaces — company features that ultimately result in increased profitability and success.

Health Care

Despite fairly widespread belief, the health care industry is not immune to workplace substance abuse. Health care industry workers who abuse alcohol and other drugs threaten the safety and well being of not only themselves, but their colleagues and a countless number of patients. By keeping America's hospitals, clinics and other health-related establishments free of substance abuse, industry administrators work to ensure the health of their staff and clients and further their company's reputation as a provider of high-quality services in which patients and their loved ones can place their trust.

A Federal government survey revealed that more than 4 percent of nursing home employees and more than five percent of hospital and other health services employees report heavy drinking.

The good news is that more and more health care industry employers, ranging from large hospitals to small clinics, are implementing drug-free workplace programs in order to ensure a safe working environment for their employees and high-quality care for their clients.

Hospitality

In the hospitality industry, customer satisfaction and retention are crucial, and providing excellent customer service is key to achievement. In today's world, customers displeased with an establishment's quality of service can simply take their business elsewhere. As a result, industry employees who abuse alcohol and other drugs threaten their company's profitability in addition to the general safety of

Drugs & Alcohol in Workplace

Percentage of current illicit drug use: Someone who has used illicit drugs at least once in the last month; Percentage of past drug use: Someone who has used illicit drugs at least once in the last year; Percentage of heavy drinking: Five or more drinks on five or more occasions in the past month.

	Current Drug Use	Past Drug Use	Current Heavy Drinking
HIGH TECH			
Computer Scientists/Analyst.....			2.4
Computer Programmers/Operators.....	3.6	10.4	2.7
Computer and Data Processors	6.1	13.5	16.2
HOSPITALITY			
Food Preparers	16.3	27.6	16.3
Grounds Keepers.....	11.4	21.0	9.8
Janitors.....	13	20.6	10.3
Maids	7.9	12.8	3.6
Waiters/Waitresses	15.4	28.9	12.1
RETAIL			
Apparel and Shoe Stores.....	3.9	12.3	1.5
Auto Supply Stores and Gas Stations.....	11.2	22.2	13.2
Department Stores.....	5.7	13.1	3.5
Eating and Drinking Places.....	16.3	28.0	15.4
Furniture and Appliance Stores	14.4	20.2	6.2
Grocery Stores	9.3	17.2	5.8
Other Retail Stores.....	5.9	12.8	4.7
CONSTRUCTION			
Construction Laborers.....	12.8	25.4	19.9
Construction Supervisors.....	17.2	25.9	12.7
Other Construction Workers	17.3	23.4	20.6
TRANSPORTATION			
Truck Drivers (light).....	—	18.9	15.1
Vehicle Repairers.....	—	17.0	14.9
Truck Drivers (heavy).....	—	16.4	13.3
Bus Drivers.....	—	13.6	6.7
MANUFACTURING: Durable Goods			
Electrical Machinery.....	5.6	10.3	2.7
Lumber and Wood Products	8.9	15.8	12
Machinery.....	6.7	12.7	7.3
Metal Industries.....	6.8	21.4	10.0
Professional Equipment.....	7.7	16.0	7.3
Transportation Equipment.....	4.8	13.4	8.2
MANUFACTURING: Non-Durable Goods			
Apparel Products.....	6.8	11.5	3.8
Chemical Products.....	3.6	9.6	9.5
Food Products.....	10.3	18.4	8.3
Paper Products.....	8.0	12.7	5.3
Printing and Publishing	11.7	24.6	7.2
Rubber and Plastic Products	2.5	11.5	4.1
Textile Products.....	3.9	10.2	6.1
WHOLESALE			
Durable Goods	9.4	16.4	8.4
Non-Durable Goods	6.9	14.8	11.8
Groceries.....	7.7	21.5	9.8
Misc. Wholesale Trade.....	8.3	12.2	8.2
HEALTH CARE			
Physicians, Dentists, Optometrists.....		19.8	
Nurses and Nursing Aides	5.5	12.8	2.8
Dental and Health Aides	2.8	9.9	2.3
Therapists.....	4	7.2	3.5
Clinical and Laboratory Tech	4.3	8.9	2.2
GENERAL SERVICES			
Business and Repair Services.....	11.1	19.8	9.7
Finance, Insurance, Real Estate	5.4	14.6	4.5
Personal Services	10.3	19.3	5.8
Professional and Related Svcs.....	4.2	11.1	3.1
Public Administration.....	3.7	8.8	7.2

themselves, their coworkers and their patrons. By making the country's hotels, eating and drinking establishments and the many businesses associated with their operations free of substance abuse, industry employers ensure increased profitability for their enterprises and further America's reputation as a welcoming destination for travelers on business or leisure.



A Federal government survey revealed that the hospitality industry, which includes hotel/motel companies, eating and drinking places and those companies related to them and their operations, experiences some of the highest rates of alcohol and drug abuse.

From large multinational corporations to small locally owned hotels, motels and restaurants, hospitality industry employers across the country are implementing drug-free workplace programs to ensure productive workforces and safe workplaces — company features that ultimately result in increased profitability and success.

Manufacturing

Both domestically and worldwide, American products have long been associated with quality. In today's marketplace, manufacturing industry employers uphold this leading position by carefully balancing technical machinery and human talent. Clearly, manufacturers who abuse alcohol and other drugs threaten not only their colleagues and clients, but also America's well-established reputation as a producer of top-quality wares. By keeping the nation's factories and workshops free of alcohol and drugs, industry employers work to ensure that the label 'Made in America' continues to symbolize the spirit of high-quality craftsmanship that has for so long characterized the nation's manufacturers.

A Federal government survey revealed that workplace substance abuse is a significant problem in both the non-durable and durable goods sectors of the manufacturing industry. Roughly 15 percent of workers in both sectors admit to having used illicit drugs in the last year and about 7 percent report current heavy alcohol use.

From large multinational corporations to relatively small businesses, manufacturing firms across the country are implementing drug-free workplace programs to ensure productive workforces and safe workplaces - company features that ultimately result in increased profitability and success.

Retail

In the exposure-oriented industry of retail, success stems from customer satisfaction and loyalty, quality products, competitive pricing and excellent customer service. In today's fiercely competitive marketplace, shoppers displeased with a business's quality of service can simply take their business elsewhere. Thus, retail workers who abuse alcohol and other drugs threaten not only the general security of themselves, their coworkers and their patrons, but also their company's profitability. By making America's shops alcohol and drug free, industry employers increase not only the security and well being of the nation's consumers, but also the profits of their individual enterprises.

A Federal government survey revealed workplace substance abuse is a significant problem in the retail industry. The good news is that more and more retail industry employers, ranging from large multinational corporations to small locally owned shops, are implementing drug-free workplace programs to ensure productive workforces and safe workplaces - company features that ultimately result in increased profitability and success.



General Services

Many service employers wrongly believe that substance abuse is a problem only in industries that have “safety-sensitive” positions-jobs requiring the operation of vehicles, machinery and tools. However, the general services industry pays a high price for substance abuse. It is the nation’s largest employer of people in “security-sensitive positions”-jobs through which employees have access to financial records, maintain confidential information or are privy to a company’s ideas or product plans. Mistakes made by employees impaired due to abuse of alcohol or other drugs have far-reaching consequences. In order to ensure the security and success of their enterprises, America’s service employers must have workplaces that are alcohol and drug free.

The good news is that more and more general services industry employers, ranging from large international corporations to small locally owned businesses, are implementing drug-free workplace programs to ensure productive workforces and safe workplaces - company features that ultimately result in increased profitability and success.

High-Tech

In America’s dynamic high-tech industry, employees regularly shift large quantities of information, data and money with the simple click of a mouse. Accuracy is critical, and the smallest of mistakes can have far-reaching consequences. Employees impaired due to abuse of alcohol or other drugs are a danger to companies determined to succeed in today’s electronic world, where a fast pace of growth and unstructured schedules may allow problems to go undetected and become serious threats to employee health and company profits. By making the country’s high-tech workplaces free of alcohol and other drugs, employers help ensure that America maintains its status as a leader in the worldwide technology revolution.

The good news is that more and more high-tech employers, ranging from long-time industry giants to small start-ups, are implementing drug-free workplace programs to ensure safe workplaces and productive workforces — company features that ultimately result in increased profitability and success.

Transportation

The transportation industry affects almost every aspect of our daily lives. Whether by road, rail, water or air, America’s vast transportation networks are in use day and night moving people and goods to and from points across the country. Regrettably, alcohol and drugs are a factor in a significant percentage of transportation-related accidents each year. This alarming reality has serious consequences for employers

and employees within the industry as well as members of the general public who rely on transportation systems. As a result, the US Department of Transportation (DOT) has mandated that all industry employers maintain alcohol- and drug-free workplaces. By complying with governmental regulations and proactively addressing the issue of substance abuse, transportation employers help ensure success for their commercial enterprises and increase the level of safety for all travelers nationwide.

To address the rising rate of substance abuse in the US and the general safety of all people who travel within the country, Congress passed the Omnibus Transportation Employee Testing Act of 1991. The Act requires transportation industry employers to establish and maintain alcohol- and drug-free workplace programs that incorporate both alcohol and drug testing.

Regarding their employers' efforts to prevent workplace substance abuse, transportation industry workers report:

- 76.1 percent provide workers with information about alcohol and drugs.
- 73.6 percent have written policies about employee alcohol or drug use.
- 52.9 percent provide access to Employee Assistance Programs (EAPs) for employees who have drug or alcohol problems.

Transportation workers report that the following types of drug testing are prevalent throughout the industry:

- At Hiring (62.7%)
- Random (52.5%)
- Upon Suspicion (48.9%)
- Post-Accident (58.8%)

From large international corporations to relatively small local contractors, transportation firms are implementing and maintaining drug-free workplace programs to ensure productive workforces and safe workplaces - company features that ultimately result in increased profitability and success.

Wholesale

The wholesale industry is a fundamental step along the road to delivering products to America's consumers. As a result, workplace errors have potentially far-reaching consequences. The selling of large quantities of goods gives rise to numerous safety and accuracy concerns, and industry employees who abuse alcohol and other drugs jeopardize themselves, but their coworkers, their customers and their business. By making the nation's wholesale establishments alcohol and drug free, industry employers help keep their vital link in America's consumer chain strong.

From large international corporations to relatively small local establishments, wholesale companies are implementing and maintaining drug-free workplace programs to ensure productive workforces and safe workplaces - company features that ultimately result in increased profitability and success.

The Perspective of a Corporate Executive

Ed Farrell, Tulsa

Ed Farrell spent 25 years in Oklahoma's private sector as a senior executive with manufacturing, retail and energy companies before retiring in Tulsa. He was CEO of Tulsa-based StairMaster, president of Oklahoma City-based Oklahoma Natural Gas Company and founding president of the Oklahoma Alliance for Manufacturing Excellence. He is an Academy Board member.

During 2005 there has been extensive news coverage about substance abuse in high profile workplaces and the role of mandatory random testing.

Pilots and Alcohol

In June two America West airline pilots were convicted of being drunk in the cockpit in July 2002 after a long night binge. The damning facts came from alcohol tests administered three hours after security screeners reported reasonable suspicion of alcohol impairment. The pilots were fired at that time.

It is easy to endorse firing for such risky behavior because most air travelers expect to be protected from impaired pilots. Three years later the prompt alcohol test results delivered clear evidence for conviction and the pilots expressed remorse publicly. The widespread publicity sent a message to other pilots who choose to drink during layovers that the party must stop at least eight hours before the next flight time.

Baseball and Home Runs

Steroid use in Major League Baseball passed its peak in 2005 and the Players Association reached agreement with the Commissioner to permit testing protocols that had been long resisted. Most people seem to have an understanding that random screens deter drug use by athletes and increase the integrity of sports competition.

The deterrence effect is seen in the reduced number of home run production in 2005. What happens to players who get caught in the

screening? The first time they are suspended, fined and sent to a rehabilitation program. Subsequent failures result in banishment. In baseball it is three strikes and you are out! For the airline pilots there was a more severe punishment.

... one strike and you are out! ...

More Testing - For Others?

Since it is easy to endorse testing protocols for others, not ourselves, there are regular calls to extend testing. A recent example is the call for testing participants in high school athletics and extra curricular activities. Public policy makers, civic and industry leaders and the public will continue to debate what the benefits might be.

Objections from the untested will be vociferous, especially from the politically powerful. Employee objections have traditionally had strong support by collective bargaining units. The Major League Baseball Players association held out until overwhelmed by public sentiment in 2004 and 2005. Typical objections are that drug tests are unnecessary, unreliable, expensive, time consuming, intrusive, invasive, demeaning, illegal, and unconstitutional and will be used unfairly against certain individuals or groups.

Testing Not New

Drug testing in the workplace is not a new phenomenon. Drug screening has been a part of certain occupations since 1980. In 1991 it became more widespread as Congress passed the law requiring companies regulated by the United States Department of Transportation to randomly test employees in safety sensitive jobs. Occupations affected included pilots and engineers on planes and trains, long haul truckers, mass transit drivers, tugboat captains and pipeline operators. Federal regulations require testing for marijuana, opiates, amphetamines, cocaine and PCP, but it is wise to include other widely abused substances, such as, alcohol and prescription drugs.

There are many employees who have personally experienced mandatory random testing for alcohol and certain drugs, both legal and illegal. By some estimates one-third of American workers are subject to random testing and most accept workplace testing as a routine part of the job.

When an organization has decided all its constituencies will benefit from a drug free workplace, drug testing must be among the policies that affirm compliance and communicate commitment. Implementation does require expert and experienced help because each of the typical objections above is based on elements of legitimate concern.

The courts have repeatedly upheld the legality of random workplace testing done right. The balance between individual rights and the common good is delicate and complex. A written policy must be reviewed against federal and state law to insure fairness and protect against any legal challenges. It defines the program elements, what the tests will identify and the consequences of failure.

Other outside experts provide sample collection, laboratory testing and medical review to interpret test results. Many competent certified contractors are available. Typically testing costs about \$50 per employee and about one in two hundred are returned positive. Opponents claim that testing all employees wastes resources, pointing to the cost of \$10,000 per failure. But, of course, the testing is for the few people who do abuse alcohol and drugs, just as the locks on our homes are not for most people.

There are more organizations that test job applicants than those testing current employees. A mandatory test on each new job applicants protects the workplace. As word quickly spreads, fewer abusers will apply.

For those organizations that test the existing workforce, universal random testing is essential to overcoming initial employee denial and anger. There can be no exclusions for VIPs or other employee groups. While federal regulations require testing only for safety sensitive jobs, exclusions for anyone quickly undermine integrity

and acceptance. While the random call is always intrusive, employees have been known to create some solace for the person called with informal work group lotteries. This extra curricular fun is a signal of acceptance.

Testing Programs

The mandatory random testing program must be effectively paired with an employee assistance program. Supervisors should be trained on signs and symptoms of substance abuse and on how to refer employees to assistance programs. Most organizations spend countless time and considerable resources helping people deal with the problems that are part of life. Benefit programs deliver life insurance, health insurance, retirement savings and paid time off. The Family Medical Leave Act and Worker Compensation laws require additional benefits. Medical plans can include counseling for a range of non-physical problems, like smoking cessation and other chemical dependency issues. It is very important for employees to understand that help is available to overcome dependencies, if they seek assistance.

What should happen to an employee who tests positive on a random screen? One strike and you are out! The employee forfeits the job because help to overcome dependencies is available to all, if assistance is sought before a failed test. Employees who seek assistance on their own are the most successful in completing rehabilitation while those who have agreed to rehab after a failed test typically do not succeed.

Drug Free Workplace

Choose a drug free workplace and experience fewer accidents, absences, mistakes and employee theft. Watch employee morale improve because a workplace that is alcohol and drug free is safer and more secure. People appreciate leadership that addresses problems, rather than looking the other way. It is motivating to be part of a team whose members can be counted on to perform. It's not about self centered individuals pursuing personal gratification at the expense of the rest. It has always been about team victories.

Play ball!

Drug-Free Workplace Programs

Calvina L. Fay, Drug Free America Foundation

www.sarnia.com/groups/antidrug/argument/street.html

According to the National Institute on Drug Abuse (NIDA), approximately 74 percent of the nation's drug abusers are employed and approximately 10 percent of the American workforce abuses drugs and/or alcohol on their jobs.

Drug abusers are costing American businesses a lot of money and eroding their bottom lines. The United States Department of Labor estimates that drug abusers cost an employer \$9,600 per abuser per year. The ability of American businesses to compete on a local, national and even a global basis is endangered by drugs in the workplace.

The cost of drug abuse is experienced through a higher rate of accidents, absences, workers' compensation claims, tardiness, use of sickness benefits, and medical benefits usage. According to national sources, it is estimated that:

- *Sixty-five percent of all accidents on the job are linked to drug and/or alcohol abuse.*
- *Three times as many sickness benefits are used by abusers.*
- *Drug abusers are five times more likely to file a workers' compensation claim.*
- *Drug abusers are sixteen times more likely to be absent than non-abusers.*
- *Drug abusers are tardy for work three times more often than non-abusers.*
- *Two and a half times more medical benefits are used by substance abusers due to more illness, off-the-job injuries and claims by family members.*
- *Drugs account for as much as eighty percent of losses due to theft in the workplace.*

The findings of a national study released in April of 1996, by the U.S. Department of Health and Human Services (DHHS) found:

The highest illicit drug usage among workers is in construction, food preparation, and service jobs; Heavy drug use was found among writers, designers, artists, and athletes; Lowest rates of drug use were found among police officers, administrative support jobs, teachers and child care workers; and Unmarried workers were twice as likely to use illicit drugs or consume large amounts of alcohol.

Employers can ill afford to ignore these facts. According to the American Management Association, 81 percent of major U.S. firms are doing something about the problem. They are implementing proactive drug- and alcohol-free workplace programs that are having a positive impact on their bottom lines. One other significant finding in the study released by DHHS is that drug usage among full-time employees dropped from 16.7 percent in 1985 to 7.3 percent in 1993. These proactive workplace programs may be part of the reason for the decline of drug use noted in the study. Still a 7.3 percent of usage is nothing to brag about.

The anti-drug and alcohol programs vary from company to company but, have some common components. The approach is a comprehensive one utilizing a mixture of five major components:

1. *A written policy that requires drug- and alcohol-free employees;*
2. *Employee education about the policy and awareness about the negative consequences of drug and alcohol abuse;*
3. *Supervisor training in drug and alcohol detection, intervention, and documentation;*
4. *Employee assistance programs; and*
5. *Drug testing.*

The findings of a study recently released by Houston's Drug-Free Business Initiative indicate that employers believe that the benefits of drug and alcohol free programs are far greater than the costs. The 2-year study involved 180 employers from various industries and of varying sizes and had two major objectives:

1. *To develop an understanding of factors that influence and inhibit the implementation of drug control strategies, especially in small businesses; and*
2. *To determine if either drug testing or employee assistance programs (EAPs) affect organization performance.*

The findings of the study indicate that whether employers implement drug testing and/or EAPs is strongly related to perceptions of cost-effectiveness. Well over half of the respondents indicated that the benefits of drug testing outweighed the cost. The breakdown of various forms of testing indicated that 58.5 percent believed random testing, 65.5 percent believed reasonable cause, and 74.3 percent believed pre-employment testing was cost effective.

Just under half of the employers felt that the benefits of an EAP outweighed the cost. When asked to select one strategy over the other, 41 percent stated that it was more important to conduct drug testing than have an EAP. Only 8 percent thought that it was more important to have an EAP than to test. However, 52 percent thought drug testing and EAPs were of equal importance.

Interestingly, more than half of the responding employers in the study supported stronger governmental regulations about drug testing. This could be interpreted by some as an indication that employers desire the legal protection afforded them when operating drug testing programs under governmental regulations.

An attempt was made in the study to collect data on actual, performance indicators over a four year period. A "scientifically valid" methodology was applied in the analysis of the data. This is the first time this type of approach in studying drug-free workplace strategies has ever been attempted by any research study. The study revealed a number of problems inherent to employers with respect to gathering data pertaining to workplace productivity.

While the study was unable to provide conclusive evidence, its findings strongly suggest that testing impacts productivity in a positive manner. The data suggest that random testing, in combination with pre-employment testing, appears to reduce injuries and workers' compensation claims and expenditures. Pre-employment testing by itself, appears to have a strong positive effect on productivity.

The attitudes of employers captured in the HDFBI study reinforced what is commonly believed - that one of the best returns on investment that an employer can expect is when he or she invests in a comprehensive drug-free workplace program. Drug use is detected and deterred with proactive programs, especially those that consist of consistent testing. This results in fewer accidents and injuries, less absenteeism and tardiness, and higher productivity - a definite improvement to the bottom line.

Workplace Drug Problems? Proactive Businesses Needed

Mary Mélon, Publisher, The Journal Record Publishing Company

Prying into employees' private lives certainly wasn't the intention when we instituted a drug policy at The Journal Record three years ago. The intention was simply to protect our business and keep our employees safe.

Our policy includes pre-employment screening, random screening and screening with reasonable suspicion. Our parent company has not put a company-wide policy in place – though I have given my endorsement to a corporate policy due to ongoing proof that it is one important method of keeping drugs out of the workplace.

I clearly remember announcing the policy to our staff and asking them to sign an acknowledgment that they had read and understood the policy. There were some nods of approval in the group, but just as many blank stares.

I felt a bit like Big Brother and wanted desperately for the staff to understand that I was not passing judgment, but merely needed a method for keeping dangerous drug usage out of the workplace. I don't know if the majority of my staff understood or not, but have found that the benefits of having a policy in place far outweigh the risks.

Sadly, we have been faced with positive drug tests from both the random and reasonable suspicion screens. I have heard all kinds of stories and have learned more about symptoms of drug use than I ever thought I would need to know.

Unsure at first of where to go for help – I even “googled” Methamphetamines to learn about the drug that is used in epidemic proportions in Oklahoma. It is still amazing to me that humans would put such toxic substances into their bodies and then drive company vehicles and operate other heavy machinery –but, it is happening every day.

I have come to depend on the advice of a drug testing lab and count on these professionals to guide me through the rough spots that come with a positive test. They have assured me again and again that consistency is the key to success with a drug policy and that the pay-off will be fewer positive results.

The National Drug-Free Workplace Alliance has issued a number of studies measuring the cost of drug use on American businesses. Each year, billions of dollars are lost in productivity, increased health problems and workplace accidents. Something I have seen first hand is a contradiction to the myth that drug users are not able to hold down jobs. In fact, seventy-four percent of all current illegal drug users and heavy alcohol users work full time.

Loss of productivity is a given with drug and alcohol use. Alcoholics and problem drinkers are absent from work four to eight times more than average, while drug users are reportedly absent an average of five days per month. In addition, their quality of work suffers and they are nearly four times more likely to be involved in workplace accidents.

The National Council on Compensation Insurance reports that thirty eight to fifty percent of all workers' compensation claims are related to substance abuse.

A major improvement in Oklahoma's recently passed Workers' Compensation legislation allows for drug testing any time an employee has sustained a work-related injury or the employer's property has been damaged. This is great for business, though having a policy and testing program in place could potentially alleviate employee's injury and employer's property damage.

Public Schools and Drugs

Lloyd Snow, Superintendent, Sand Springs (OK) School District

I suspect any school administrator could compile a lengthy text of personal anecdotes associated with student drug use. In fact, in my book there would be multiple chapters describing beautiful children that tragically lived a short life as a result of use, abuse, and misuse of both legal and illegal drugs.

The misery, tragedy, and trauma to families, schools, and communities is never forgotten when a young life is taken by drugs. The car wrecks from driving while intoxicated. The accidental overdoses of painkillers. The alcohol poisoning that started so innocently. The “crack” that was so cool until it was in control. Thank God, for the most part, death is not typically the situation we are faced with most of the time.

In fact, believe it or not, most of our current challenges and concerns with student drug use is the number of students that are recreationally using at times outside of the school day. These young folks are generally able to recognize and abide by our very strict no tolerance rule at school. But, too many of our kids fully take advantage of a culture and community that easily provides quick, feel good, Hollywood like fixes to the many distractions and stresses of growing up in a “hip hop” world.

I think it would be helpful to describe how most suburban schools manage students that are in possession of or under the influence of a controlled substance. Not too many years ago this student would be expelled for the current and succeeding semester. In essence, we were “washing our hands” of the situation. It didn’t make sense but that’s what was expected and done in the community. Remember, we are a reflection of you!

I was delighted when we began to recognize and realize that there was a better way. We finally figured out we could and should take a longer view

of the impact of denying a youngster an education along with the obvious downside to not helping a teenager at a critical time in development. Alternative education was established by the legislature in the early 90’s and statutes were enacted that required schools to provide a continuing educational opportunity to students that were under suspension. Consequently schools began to develop options and additional safety nets to serve kids that were at risk.

Most districts will begin with a parent conference when a student is suspended as a result of a drug violation. If the facts are not questioned (due process is often requested by parents) there will be a plan established to keep the student on track with the curriculum and insure that family/individual counseling begins. More often than not students will be removed from their regular classes and placed either into an “in school intervention program”, an alternative education site, or a home placement with a structure in place to maintain their class work.

The home placement, very candidly, is always our last recommendation and only permitted if the parent insists. It is the least effective and the most problematic from almost every angle. If the student and parents embraces counseling the alternative placement can be shortened substantially. Proactive and realistic parents working with the school tend to have the most success with getting the student re-entered into the regular school program the fastest. Plus, repeat offenses are much less when parents take full responsibility and command of the family crises.

No surprises there!

In fact, the whole notion of loving engaged parents being the best “anti drug” strategy on the market is maybe a bit trite but from my perch powerfully appropriate and successfully proven.



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School policy concerning managing student drug use is working. It is effective. Or is it? I have already said we have more safety nets. Our drug related incidents at school are down. Rarely do we see death or addiction. All is well. Not so fast. As inferred earlier I am convinced we have a social acceptance of drug use. Too many under age parties in homes of good folks using bad judgment. Too many kids have access along with cultural acceptance. Too many unlimited messages from media and friends that a quick fix is an okay fix to any problem.

So where are we on public policy as it relates to kids, community, culture, and drugs?

Well, let's think back to when I first began teaching. Students and faculty were allowed to smoke in designated areas at many public schools. Roll the clock to where we are now. Public policy has dramatically changed. Tobacco is taxed heavily, very few public buildings allow smoking, and even folks who smoke more often than not do so in private! More importantly our culture has made smoking an unacceptable health practice.

Does that mean students do not smoke. Obviously not, but I think our cultural messages are clear and we have given students and people another reason to quit. There are numerous opportunities for smokers to access resources to help them quit or even better yet never start! They range from employers to federally funded projects. Could education be a part of our progress in this cultural dilemma of smoking? What does that suggest with the use, misuse, and abuse of legal/illegal drugs?

What would happen if we were to truly provide mental health experts, social workers, and multiple interventions for all of our children and young families? In my humble opinion, our early childhood teachers and experts quickly discover families and students that struggle. Often times, there is an apparent drug usage connection. Even though I have stated there has been significant improvement in the school environment we are still stuck in a reactive response world. Becoming more proactive, at the very start of the educational experience, almost from every perspective would bring a more likely positive result. And, it would be significantly more cost effective from the long

view. In our world of policy and culture we tend to apply band-aids on top of band-aids on our society hurts. What if we truly intervened early and successfully? Is it doable? Yes, if we changed our strategy and made a genuine commitment to change processes of what, how, when, where, and why drugs permeate our world.

If I were King and could magically have the power and resources at hand to prevent illegal/legal drug use, abuse, misuse, and addiction I would do the following;

1. *Add significantly more mental health/ counseling resources to public education at all levels.*
2. *Provide community resources with easy access by families*
3. *Eliminate punishment as our first response (where it makes sense)*
4. *Re-work the criminal code to reflect more common sense in adjudication and finally and most importantly,*
5. *Give parents opportunities to be better parents by creating parenting classes. They could be designed in partnership with schools. They could include all kinds of creative incentives that would appeal to parents. I am convinced, generally speaking, even the worst parents have a love for their child even if they are unable to take care of themselves much less their child!*

Being proactive in managing issues associated with drugs is not easy and cannot be done overnight. Our country and world has changed the way we look at smoking. It has taken years. It has saved lives and will do so for future generations. We can do the same with drugs. It can be done but not without a price. It would be a price most folks would pay if they have ever been to a family/ friend/community funeral caused by drugs.

And, by the way, there are few families that are blessed to not have some very personal drug related problems or challenges.

Alcohol's Three Strikes at OU

Clarke A. Stroud, Vice President, University of Oklahoma

Clarke Stroud is the University Vice President for Student Affairs and Dean of Students. He was born and raised in Denver, Colorado and came to OU 18 years ago (in 1986).



announcement of the policy, the staff of Student Affairs worked with student groups and national fraternities and sororities to implement the new policies, which went into effect on January 18, 2005, the first day of the spring semester.

He received his Bachelor of Arts in Public Administration and his Master of Education from the University of Oklahoma. After graduation, Clarke joined University Housing and Food Services as a Center Coordinator and was promoted to become the Oklahoma Memorial Union Administrator where he directed the renovation and revitalization of the Union. He currently serves as University Vice President for Student Affairs and Dean of Students.

Introduction

The alcohol poisoning death of 19-year-old University of Oklahoma student Blake Hammontree at the Sigma Chi fraternity chapter house on September 30, 2004, shocked and saddened the OU family. President David L. Boren acted swiftly, announcing the action taken in a news conference that day: he immediately suspended all Sigma Chi social activities, closed the Sigma Chi chapter house and created an advisory group to discuss the problem of underage drinking and the use and abuse of alcohol on the OU campus. Further, he stated that he would publicly announce a comprehensive plan to address the problem by December 1.

On December 1, 2004, President David Boren announced a broad set of initiatives aimed at combating student alcohol abuse. In developing the policy, Boren sought the guidance of university alumni, students, faculty and staff as well as health professionals and community leaders who reviewed hundreds of pages of research findings as well as best practices at other universities. He said that he would continue to assess the policy and seek input from the advisory group. Upon Boren's

The new policy addresses the problem of the underage and binge drinking with a three-pronged approach: environment, education and enforcement. It is a multi-faceted problem that is addressed with a multi-dimensional approach.

Environment

Alcohol is no longer allowed in the residence halls or in fraternity chapter houses. (OU's sororities were already dry.) The University strives to maintain a healthy, safe living environment for students, and the majority of residence hall and fraternity residents are under the age of 21. The goal of the policy is to reduce illegal and binge drinking.

The new policy was posted throughout the residence halls and fraternity chapter houses notifying residents that they were entering an alcohol-free living environment. Additionally, Student Affairs, OU's Center for Student Life, and the university's Housing and Food Services staff met with fraternities, sororities, housing residents and student organizations and their advisers to explain and discuss the new policy.

The new policy also changes the way campus-affiliated student organizations may host events at which alcohol is served. Groups may only host events with alcohol on Fridays or Saturdays, and they face strict guidelines on their responsibility to provide appropriate transportation for guests who attend such events. The Center for Student Life staff is developing event-planning documents and adviser information packets that will educate groups on their responsibilities related to the new

policies and assist them in developing plans for their events.

The University has expanded its SafeRide program. Introduced in the fall of 2005, SafeRide provided bus transportation on a route through the campus area and designated areas within Norman on Thursday through Saturday nights from 10 p.m. until 2 a.m. Effective January 20, 2005, SafeRide was expanded to also include taxi service to locations not served by the bus route. Students call 325-RIDE, and a dispatcher determines where they are located and to where they need a ride and assigns a bus ride or dispatches a taxi depending on the destination. At the end of the Spring semester, SafeRide provided convenient, safe transportation home to an average of 240 OU students per weekend.

Unregulated summer recruitment conducted by fraternities is now strictly prohibited. All fraternity recruitment activities are now registered with the Center for Student Life, and alcohol is prohibited at any recruitment event or activity. Registered activities may be attended by members of Interfraternity Council or University staff and are monitored by alumni members of the organization.

President Boren also directed the Greek system to enhance the University's statement on prohibited hazing activities. Fraternity and sorority officers will sign a pledge to abide by this policy and report violations. It will also be provided to pledges/associate members who will sign a statement promising to report violations. This statement on prohibited hazing activities will also be given to the pledge's parents/guardians, who will be urged to report any violations.

Education

Effective Spring 2005, all students new to the University of Oklahoma were required to complete a mandatory online alcohol education program. New students were notified as soon as the program was available and several times thereafter during that first semester that they must complete the training. Those who did not complete the program

by the April 1 deadline faced an enrollment hold until they completed the training.

Initially, the university contracted with MyStudentBody.com and used this nationally developed alcohol education program for the mandatory training component. Currently, Student Affairs is partnering with the OU Health Sciences Center's College of Public Health to create the university's own Web-based alcohol education program.

Additionally, IFC, Panhellenic, Housing and Food Services, and Health Services will provide alcohol education programs on a continuing basis.

The University has established a formal relationship with licensed alcohol counselors for immediate student referrals.

Enforcement

Because the policy was not designed merely to be punitive, ultimately the University hopes to change behaviors. However, the University is committed to aggressively addressing any incidents of underage or excessive drinking. All such incidents are subject to the university's new 3 Strikes Policy, and the Student Code of Conduct and Responsibility (www.ou.edu/studentcode/) was amended by the Regents to include the new policies. To ensure that all of OU students understood the new policy and the consequences for violating it, the new sections of the Code were published in five consecutive issues of *The Oklahoma Daily* in January.

The 3 Strikes Policy addresses illegal and excessive drinking and provides mandatory minimum sanctions for students who engage in this type of drinking. The purpose of the policy is to send a clear message to OU students who engage in illegal or excessive drinking that their behavior will not be tolerated.

A student's decision to drink illegally or excessively will result in sanctions that are incrementally more severe with each strike and

may ultimately lead to suspension from the university. Copies of the 3 Strikes Policy and Sanctions are attached.

The policy also provides an anonymous reporting mechanism. Historically problems are reported by concerned students, neighbors, friends and parents. A new Hotline (325-5000) provides an anonymous, confidential method of reporting suspected violations of the University's alcohol and hazing policies.

Goal of the Policy

In December President Boren said, "Our goal is to have at OU a policy to curtail alcohol abuse by students which becomes a national model of best practices for other colleges and universities to follow. These policies send a strong signal that alcohol abuse will not be tolerated at the University of Oklahoma."

Boren appealed to others for help. He said, "Obviously, the university cannot solve the problem by itself. There is a national epidemic of alcohol abuse by underage drinkers. In our own state, teenage drinking among high school and junior high students is above the national average.

Last year, nationally, among those under 25 years of age, over 1,400 deaths of college students occurred that were directly related to alcohol abuse. "(Citation: *Task Force on College Drinking supported by the National Institute on Alcohol Abuse and Alcoholism – which references a 2002 study by Hingson for this statistic.*)

It is going to take the help of parents and university leaders all across the state and indeed all across the nation for us to be successful."

Boren concluded, "No program, no matter how broad, will completely eliminate the problem, but if we can dramatically reduce harmful and dangerous binge drinking, it will be well worth the effort."

The University of Oklahoma THREE STRIKES POLICY



Definition of a Strike

A "strike" is the University's official recognition of a student's or organization's violation of the University's alcohol policy. Nothing herein shall waive a student's right to due process. A strike is a final University disciplinary action which finds the accused guilty of an alcohol-related offense. A student or organization may be charged with an alcohol-related violation based on the following:

1. A conviction, deferred sentence, or a plea that has the effect of conviction of an alcohol related¹ offense of which the University is made aware; or
2. A University finding or allegation that a student or organization may have committed an alcohol-related violation prohibited by the Student Code. Such violations include, but are not limited to, the conduct prohibited by Title 16 of the Student Code of Conduct, the Student Alcohol Policy, incident reports and citations.

Upon notification of the foregoing, or any other violation reasonably related to alcohol, the University may charge the student pursuant to the Student Code and the student shall be entitled to an appropriate hearing as defined by the Student Code. Whether by decision of an appropriate disciplinary body, administrative official, or by a negotiated settlement, any final University disciplinary action² resulting in a finding of guilt for an alcohol related violation shall be considered a strike.

Reporting Mechanisms

The University may act on any reliable information it receives. Although not an exhaustive list, the University may be notified of prohibited conduct in the following ways:

1. A police report from the University of Oklahoma Police Department;
2. A police report from the Norman Police Department;
3. Reports from other law enforcement or security agencies that are received by the University;
4. Notification by a University official that an alcohol violation occurred; or
5. Any other information deemed reliable by the University that comes to the attention of a University official.

The University, upon notification, may investigate the information received to determine if the conduct constitutes a violation prior to taking action. Nothing herein shall waive a student's right to due process.

INDIVIDUAL SANCTIONS

Any offense by an individual student remains part of the individual's record until graduation. If a student is suspended after the 3rd offense and is readmitted to the University of Oklahoma, the student is readmitted with 2 strikes.

1st Offense

- Parent/Guardian notification via return receipt certified mail.
- \$75.00 fine.
- Satisfactorily complete a defined alcohol education program.
- Censure. The notation of Censure shall be removed upon graduation from the University of Oklahoma subject to completion of disciplinary sanctions.

2nd Offense

- Parent/Guardian notification via return receipt certified mail with a follow-up telephone call.
- \$150.00 fine.
- Satisfactorily complete an approved alcohol counseling program .
- Satisfactorily complete 20 hours of approved community service.
- Disciplinary probation. The notation of Disciplinary probation shall be removed upon graduation from the University of Oklahoma subject to completion of disciplinary sanctions.

3rd Offense

- Parent/Guardian notification via return receipt certified mail with a follow-up telephone call.
- Automatic suspension.

ORGANIZATIONAL SANCTIONS

Organizational sanctions will be administered based on the possession and use of alcohol in an organization's residence facility or the illegal or prohibited use of alcohol at an event which was endorsed, organized, or sponsored by the organization when in either case the organization knew or should have known of such use and failed to take appropriate action. Any offense by the group remains part of the organization's "3 Strikes" record for a period of three calendar years.

1st Offense

- At the discretion of the University and after considering all relevant information, the University will impose a minimum fine of \$500.00 or a per capita rate of \$1.00 to \$20.00 based on the organization's membership at the time of the offense, which ever is more appropriate.
- 100% of the organization's membership must complete a defined alcohol education program.
- An aggregate community service requirement for the organization of 10-25 hours per capita based on the organization's membership at the time of the offense. It is at the discretion of the



University as to whether pledges or associate members will be included in fulfilling the requirements of the sanction.

- Censure: A written reprimand for violation of specified regulations, including the possibility of more severe disciplinary sanctions in the event of the finding of a violation of any University regulation within a stated period of time. This type of action does not create new restriction for the organization.

2nd Offense

- At the discretion of the University and after considering all relevant information, the University will impose a minimum fine of \$1,000.00 or a per capita rate of \$5.00 to \$20.00 based on the organization's membership at the time of the offense, which ever is more appropriate.
- 100% of the organization's membership must complete a defined alcohol education program.
- An aggregate community service requirement for the organization of 10 to 25 hours per capita based on the organization's membership at the time of the offense. It is at the discretion of the University as to whether pledges or associate members will be included in fulfilling the requirements of this sanction.
- Disciplinary Probation: Exclusion from participation in privileged or extracurricular University activities set forth in the notice for a period of time specified. Other conditions of the probation may apply to any other activities of the organization in the University community, except those which would affect organization's academic pursuits.

3rd Offense

- At the discretion of the University and after considering all relevant information, the University will impose a minimum fine of \$1,500.00 or a per capita rate of \$10.00 to \$20.00 based on the organization's membership at the time of the offense, which ever is more appropriate.
- 100% of the organization's membership must complete a defined alcohol education program.
- An aggregate community service requirement for the organization of 10 to 25 hours per capita based on the organization's membership at the time of the offense. It is at the discretion of the University as to whether pledges or associate members will be include in fulfilling the requirements of this sanction.
- Organizational Suspension: The organization will be suspended for a minimum of one year. University approval is required before the organization will be reinstated.

End Notes

¹ Alcohol offenses and misconduct shall include, but shall not be limited to, minor in possession; public intoxication; manufacture, use or possession of false identification; driving under the influence, driving while intoxicated, actual physical control and involvement in a crime while under the influence. Student Affairs, by and through the Office of Judicial Services, shall determine if a charge is alcohol related; however, the final determination shall be made by an appropriate disciplinary body or administrative official.

² A final disciplinary action shall be a decision to which no further right of appeal exists in the Student Code.

My Platform

Jennifer Berry, Tulsa, Miss Oklahoma 2005

Jennifer Berry, Miss Oklahoma 2005, is a senior at The University of Oklahoma, majoring in Elementary Education.

She is a member of the Student Oklahoma Education Association, recent Committee Board member of the University's Think If You Drink alcohol education program and studies with the highly acclaimed University of Oklahoma School of Dance.

In 2005, Jennifer was a guest performer with the Tulsa Opera along with five other School of Dance students. Jennifer received the University of Oklahoma's Presidents Honor Roll in 2004 and 2005 and the Dean's Honor Roll in 2002 and 2003.

In 2001, Jennifer graduated from Jenks High School. While in high school, she was a member of the National Honor Society. She was also active in Student Council and Key Club a community service organization and a member of the Varsity Pom Squad. Jennifer served as President of the Family, Career and Community Leaders of America as a senior.

When Jennifer was thirteen years old, she created a successful Summer Dance Workshop with two of her friends acquiring over one hundred students within three summers. Jennifer taught ballet throughout high school, instructing students from ages four to eighteen.

Jennifer's love for dancing and interest in the Miss America Organization eventually led her to the Miss Oklahoma Pageant. In 2001, she received a non-finalist talent award when she was just seventeen years old. The following year, Jennifer was a



Top Ten Semi-finalist and a preliminary swimsuit award winner. In 2003, Jennifer placed third runner-up and received a preliminary swimsuit award.

In 2004 Jennifer received third place in the Kiwanis Club Community Service Award, preliminary interview award and once again placed third-runner up. After competing for five years, Jennifer captured the title competing as Miss Grand Lake. She took home preliminary swimsuit; talent and interview awards along with the first place Kiwanis Club Community Service Award.

At the adolescent age of fifteen, Jennifer lost a friend in an alcohol related accident. Knowing first hand, her death could have been prevented, Jennifer was immediately motivated to save others from losing their lives to a senseless decision.

She became an avid volunteer and spokesperson for Mothers Against Drunk Driving (MADD).

When she was eighteen years old, Jennifer spoke to DUI offenders as part of their rehabilitation through the Victim's Impact Panel. She is a member of Project Under 21 and served on the very first Student Committee Board for the University of Oklahoma's Think If You Drink program. Jennifer spoke to hundreds of incoming college freshman regarding the dangers of alcohol.

She has also spoken to hundreds of elementary age students regarding good decision making skills and creating healthy lifestyles.

Jennifer is the daughter of Tom and Kay Berry. She has one sister, Kim and a brother-in-law Josiah.

Another Look at “Firewater”

*Lee Hester, PhD, Director of American Indian Studies, University of Science and Arts of Oklahoma
and Director of the Howard Meredith Indian Humanities Center*

Despite the fact that the U.S. Government has taken responsibility for Indian health care through the Indian Health Service, there are enormous disparities between Native Americans and other segments of U.S. society. American Indians are 1.1 times as likely to die before reaching their first birthday, 1.6 times more likely to die between one and four years of age, 1.4 times as likely to die between five and fourteen, and twice as likely to die between fifteen and twenty-four when compared to the rest of the U.S. population.¹ The ratio of American Indian death rates to those of the overall population for other age groups continue at these elevated levels until age sixty-five. The statistics are even worse when compared only to the White population. From age twenty-five to age forty-four, American Indians are more than twice as likely to die as whites. Every year from age five to age fifty-four Indians are at least 1.5 time as likely to die as Whites. About the only good news is that Native Americans who manage to reach seventy-four can expect to live somewhat longer on average than the rest of the population. Death rates from that age on are somewhat lower than either that of Whites or that of all races.²

In the area of health care, the real key is *why* Native Americans experience such high death rates when compared to other Americans. Age-adjusted mortality rates comparing Native Americans and all U.S. races show that American Indians have a 440 percent greater chance of dying of tuberculosis, 430 percent greater chance of dying of alcoholism, 165 percent greater chance of dying by accident, 154 percent greater chance of dying from diabetes mellitus, 50 percent greater chance of being killed, 46 percent greater chance of dying from pneumonia or influenza and a 43 percent greater chance of committing suicide.³ Unfortunately, even this mass of statistics isn't quite sufficient to truly define the problem. For example, though tuberculosis is far more prevalent

among Native Americans than among the general populace, it isn't one of the major causes of death for any age group. Though the rate of tuberculosis mortality is shocking when compared the rest of the U.S. population, the actual number of deaths is fairly small.

The real culprits⁴ behind the startling death rates are accidents (the number one cause of death between ages one and forty-four), suicide (the second leading cause of death between ages fifteen and twenty-four and fourth leading cause from twenty-five to forty-four), homicide (third leading cause of death between ages one and forty-four) and chronic liver disease/cirrhosis (second leading cause of death between ages twenty-five and forty-four). In general the ranking of these causes is the same for the U.S. population as a whole, though the rates are greatly exaggerated for American Indians. The real anomalies are suicide and chronic liver disease/cirrhosis. These causes were actually *ranked* higher among Native Americans in various age groups than among the populace as a whole. When one considers that the main cause of chronic liver disease/cirrhosis is alcohol abuse; that many accidental deaths are alcohol related (e.g. drunk driving fatalities); and that alcohol often plays a role in suicide and homicide, a trend begins to appear. Unfortunately this trend is one which many would like to ignore. It has led to the common stereotype of the “drunken Indian,”⁵ a stereotype that is not only unjust but has led to bad scholarship and bizarre policy recommendations.

Probably the most famous example of bad scholarship in the area of Indian alcohol use is the study⁶ that suggests, wrongly, that Indians metabolize alcohol more slowly than other racial groups.⁷ Unfortunately, in exposing the shortcomings of this study and exploding other myths concerning Indian alcohol use, some researchers have gone a bit too far. Phillip May⁸

explodes the myth that alcoholism is the number one health problem among American Indians by equivocating between *alcoholism* and *alcohol abuse*. As he says, “More accurately, alcohol abuse and alcoholism combine to be the leading cause of mortality.” This is certainly comforting.

Recommended solutions to the high alcohol related mortality rate sometimes suffer from the desire to avoid stereotyping Indians as problem drinkers. One study⁹ suggests that alcohol related accidental deaths like those involving car crashes or pedestrian hypothermia can be reduced by bringing the alcohol to the Indians — eliminating prohibition on those reservations that still have it. Barring that, they suggest carpools for patrons and reflector stripes for pedestrians might help. The closest that the study comes to suggesting a decrease in consumption is a recommendation to limit the hours of operation of bars near reservations. Prevention, treatment and rehabilitation are mentioned only in passing and only in the final sentence. Though it is impossible to prove that the desire to avoid stereotyping was behind the choice to linger on solutions to the final as opposed to the proximal causes of death, it certainly seems likely. The fact that the same volume of the *Journal of the American Medical Association* that carried this study also carried an article¹⁰ against stereotyping Indians as drunks is suggestive.

Avoiding stereotypes doesn't make the problem go away. Alcohol is arguably the number one killer of Native Americans. Dropping prohibition or busing Indians to bars is merely treating a symptom. It might help to alleviate some of the accidental deaths but only at the risk of increasing the longer-term health problems like cirrhosis. To truly end the problem, the drinking should be curbed. In the search for causes we are aided by those that have exploded the myths. It is clear that there is no cause for drinking that is unique to Native Americans. Indians drink for the same reasons that other people do.¹¹ Swinson and Eaves¹² summarily state that, “People who have high personal motivation toward drug-taking tend to originate

from groups which commonly produce inadequate, insecure, tense members, who are subject to little in the way of effective controls against deviant behavior.” Though rather disingenuously put, this statement must be taken seriously. Forrest¹³ provides other reasons saying, “Identity and role confusion are precursors to alcoholism and alcohol abuse.”

In quantitative studies, many different instruments have been used to test various psychological factors. Among these is “Locus of Control” (LOC). “Though early studies of LOC using the Rotter scale had conflicting results, newer studies using the Levenson scale have shown a correlation between alcoholism and external LOC¹⁴ as well as a correlation between a shift to internal LOC and treatment success.¹⁵ This is extremely significant, since we have also seen a link between external LOC and poverty in the work of Theodore Sarbin during our examination of the causes of poverty. A study comparing LOC of Indians and non-Indians in Oklahoma showed that Native Americans generally had a much higher external LOC than Whites.¹⁶ This study showed a LOC “Powerful Other” of 24.13 for Indians as compared to 20.46 for Caucasians and an LOC “Chance” of 26.71 versus 20.92. Clearly Native Americans tend to feel that they do not control their own lives.

Many of the problems facing Native Americans seem to be related to an external locus of control. Poverty and alcoholism are related directly, with standardized studies of LOC showing a strong correlation. In addition, the commonsensical nature of such explanation as well as the power of the explanation is obvious. People who believe they have little or no control over their own lives might despair of escaping their fate, take no positive action, and could well end up seeking solace in drugs or alcohol. Even standard education theories cite motivation, in particular the efficacy of the education in meeting the goals of the student. If the student's destiny is controlled by outside forces, or if the student believes it is so, then why bother?

In our examination of U.S. policy, we should be on the lookout for laws and policies that take control of Indian life out of their hands; or which would lead them to believe that control had been wrested. Directly harmful policies should also be examined not only for their harm, but as further reason for an external locus of control among Native Americans. Other policies that would be in line with the causes outlined previously, such as dispossession, should also be noted.

End Notes

¹ Statistics in this paragraph are taken from, U.S. Indian Health Service, *Trends In Indian Health—1994*, (Washington D.C.: Department of Health and Human Services, 1994), Table 4.10, p 55.

² *Ibid.*, 55.

³ Indian Health Service, *Trends in Indian Health*, *Ibid.*, 5. These figures, indeed all of the figures taken from *Trends in Indian Health* are overly conservative, as reported in U.S. Indian Health Service, *Regional Differences in Indian Health*, (Washington D.C.: Department of Health and Human Services, Division of Program Statistics, 1994), p 5. In reviewing data by region, the IHS found that the Oklahoma, California and Portland region statistics were skewed by underreporting of Indian race on death certificates. Such underreporting has the effect of lowering statistical mortality rates. If these regions are removed from calculation, the alcoholism death rate jumps to 630 percent that of the general populace and all the other mortality rates take similar jumps. The lower rates cited herein from *Trends in Indian Health* were chosen because they represent the lowest possible figures.

⁴ Analysis of data presented in *Ibid.*, 46-50.

⁵ Robert F. Berkhofer, Jr., *The White Man's Indian*, (New York: Vintage Books, 1979), 30, notes that if there is a third major White image of the Indian after the contradictory Noble/Savage stereotypes then a "...degraded, often drunken, Indian constitutes the essence of that understanding."

⁶ D. Fenna, *et al.*, "Ethanol Metabolism in Various Racial Groups", *Canadian Medical Association Journal* 105 (1971), 472-475.

⁷ A number of studies have shown that American Indians actually metabolize alcohol as fast or even faster than non-Indians. Including: L. Bennion, L., & T.K. Li, "Alcohol metabolism in American Indians and white", *New England Journal of Medicine*, 284 (1976), 9-13. J.J. Farris, & B.M. Jones, "Ethanol metabolism in males American Indians and

whites", *Alcoholism: Clinical and Experimental Research*, 2 (1) (1978), 77-81. T.E. Reed., H. Kalant, R.J. Griffins, B.M. Kapur, & J.G. Rankin, "Alcohol and acetaldehyde metabolism in Caucasians, Chinese, and Americans" *Canadian Medical Association Journal*, 115 (1978), 851-855. J.M. Schaefer, "Firewater myths revisited", *Journal of Studies on Alcohol*, 9 (1981), 99-117. A.R. Zeiner, A. Paredes, & L. Cowden, "Physiological responses to ethanol among the Tarahumara Indians", *Annals of the New York Academy of Sciences*, 273 (1976), 151-158. All originally cited by Phillip A May, "Alcohol policy considerations for Indian reservations and border town communities", *American Indian and Alaska Native Mental Health Research*, 4 (3) (1992), 5-59.

⁸ Phillip A. May, "The Epidemiology of Alcohol Abuse", *American Indian Culture and Research Journal*, v 18, n 2 (1994), 122-123

⁹ Margaret M. Gallaher, *et al.*, "Pedestrian and Hypothermia Deaths Among Native Americans in New Mexico", *Journal of the American Medical Association*, v 267, n 10 (1992), 1345-1348.

¹⁰ Carol Chiago Lujan, "Alcohol-related Deaths of American Indians, Stereotypes and Strategies", *Journal of the American Medical Association*, v 267 n 10 (1992), 1384.

¹¹ Though there certainly are differences in drinking style which exacerbate the problem. See Deborah Jones-Saumty, Larry Hochhaus, Ralph Dru and Arthur Zeiner, "Psychological factors of Familial Alcoholism in American Indians and Caucasians," *Journal of Clinical Psychology*, (Brandon VT: Clinical Psychology Publishing Company), v 39, n 5, 1983 and Ray Stratton, Arthur Zeiner and Alfonso Paredes, "Tribal Affiliation and Prevalence of Alcohol Problems," *Journal of Studies on Alcohol*, (New Brunswick: Publication Division of the Rutgers Center of Alcohol Studies), v 39, n 7, 1978.

¹² Richard Swinson and Derek Eaves, *Alcoholism and Addiction*, (London: Woburn Press, 1978), 77.

¹³ Gary G. Forrest., *The Diagnosis and Treatment of Alcoholism*, (Springfield: Charles C. Thomas Publisher) revised, 2nd ed. 1978. As quoted in his *Alcoholism and Human Sexuality*, (Springfield: Charles C. Thomas Publisher, 1983), 366.

¹⁴ Deborah Jones-Saumty, *et. al.*, 788.

¹⁵ David Caster and Oscar Parsons, "Locus of Control in Alcoholics and Treatment Outcomes," *Journal of Studies on Alcohol*, (New Brunswick: Rutgers Center of Alcohol Studies), v 38, n 11, 1977, 2093 and *passim*.

¹⁶ Deborah Jones-Saumty, *et. al.*, 787.

A Prevention of Youth Access to Alcohol Act *Thad Balkman, State Representative, District 45, East Norman*

Thad Balkman was born October 23, 1971 in Long Beach, California and graduated from Brigham Young University with a degree in Political Science. In 1994, Thad and his wife Amy moved to Norman, where he has lived ever since. Thad graduated from the University of Oklahoma College of Law. While at Law School, Thad was active in the Student Bar Association, serving as the Second Year Class President. He is a licensed attorney and is currently of counsel with the Lee & Wells law firm.



single year! Nearly as startling is the fact that young people 18 and younger account for almost 1,200 of those arrests.

Binge drinking has other devastating effects. Alcohol is involved in 90% of campus rapes, according to Columbia University's National Center on Addiction and Substance Abuse. It is involved in two-thirds of college student suicides and 95% of violent crime on campus.

According to national experts, beer is the drink of choice in most cases of heavy drinking, binge drinking, drunken driving and underage drinking. Surprisingly, our laws provide stricter penalties for any retail store or person who sells liquor to a minor than those who sell beer to minors.

For example, it's a felony to serve liquor to a minor and license revocation is mandatory, but when those same offenses involve 3.2 beer, it is nothing more than a misdemeanor and a possibility of license revocation.

Don't we all understand that beer is just as deadly as any alcoholic beverage? The same level of accountability should apply.

Knowing that research shows that alcohol-related fatalities are caused primarily by the consumption of beer (80 percent) and knowing that drunken driving is the nation's most frequently committed violent crime, killing someone every 30 minutes, it makes sense that our penalties should be just as tough when someone illegally sells or provides beer to a minor as when they sell or provide liquor.

Thus, I authored the Prevention of Youth Access to Alcohol Act in the 2005 Session. This bill was the product of a coalition of bipartisan legislators

Beer

It begins even before their first day of high school. It worsens as each school year goes by. By college, it has reached epidemic proportions. What is it? Beer consumption by minors. The statistics are sobering:

- The median age at which American youths begin drinking is 15.9 years.
- In the 30 days prior to an alcohol-use survey, more than one in five persons aged 12 or over had engaged in binge drinking.
- In the two weeks prior to national alcohol survey, 11 percent of eighth graders, 22 percent of tenth graders and 29 percent of twelfth graders had engaged in heavy drinking (over five drinks in a single sitting).
- According to a 2001 college survey, a full two out of five college students are binge drinkers.

Too Much Beer

Oklahoma is experiencing a growing epidemic of alcohol abuse by our teenagers. In 2002, 3,307 Oklahomans under the age of 21 were arrested for DUI. That's right: Not 30, not 300 but more than 3,000 of our kids were arrested for a DUI in a

and health organizations, including the Oklahoma Department of Mental Health and Substance Abuse Services, the Oklahoma State Medical Association and the Oklahoma Nurses Association. Others involved in this effort include the Oklahoma Institute for Child Advocacy, the Oklahoma Conference of Churches and MADD. In addition, various restaurant and hospitality operators provided input into this legislation.

The bill contained a package of reforms designed to cut down on underage access. The legislation eliminated drown nights (sales of unlimited beers for a fixed price), increased fines and penalties for serving beer to minors, increased the length of license revocation of retailers who habitually sell beer to minors, and punished minors who attempt to buy beer by revoking their driver's licenses.

Unfortunately, due to powerful lobby groups, including the Restaurant Association, both of the bills containing the Prevention of Youth Access to Alcohol Act failed to make it out of committee. This was an extremely frustrating blow to everyone who worked so hard on this issue. There were those who used the "anti-business" argument which was frustrating because it's only anti-business if your business is illegally selling beer to minors. It was also frustrating because there were responsible business owners who supported the legislation including the Bricktown Association in Oklahoma City as well as TapWerks Pub. If a responsible business does not want to have a drown night or happy hour but their less responsible competitor does, they have no choice but to hold one themselves. When responsible businesses come to the Legislature asking for help, the Legislature should answer the call.

In the end, we had no choice but to settle for a bill that only addressed drown nights and happy

hours, and even then, the final bill applies to very few establishments. While I am hopeful that this legislation will help curb binge drinking, and saving one life or one less DUI is worth it, I am concerned that this legislation needs to be broadened to apply to more establishments to truly have the impact I am trying to achieve. Armed with the knowledge that an alcohol survey of four colleges indicated that binge-drinking levels are associated with ease of access to alcohol and price or special promotions, it is clear that eliminating drown nights and happy hours could have a significant impact on binge drinking and all the dangers associated with it.

But shortly after session, there was some hope. I was thrilled to learn the United Kingdom's leading association of pubs and bars voluntarily ended cheap and free beer specials. I wrote a letter to the Oklahoma Restaurant Association, asking its members to do the same. I explained that their counterparts in Britain took this action without legislation, prodding or mandate, and I asked them to show the same leadership and do the right thing. As of today, nothing has happened. I have not even received a response.



Binge drinking, drunken driving and other alcohol-related problems are a growing phenomenon. Left unchecked, these problems will continue to hurt and kill our sons and daughters. With our children's health and safety at risk, and unfortunately far too often their lives, the Prevention of Youth Access to Alcohol Act is an important step in preventing the next needless death.

I am hopeful my colleagues in the Legislature will support me in my efforts by passing the Prevention of Youth Access to Alcohol Act next session. Please join me in this fight by demanding that the Legislature address this issue.

Alcohol: The Dangerous Legal Drug

Ben Brown, Deputy Director for Substance Abuse, ODMHSAS, Oklahoma City

Mr. Ben Brown is the Deputy Commissioner for Substance Abuse Services at the Oklahoma Department of Mental Health and Substance Abuse Services. he is a long-time and eloquent spokesperson for the dangers of alcohol abuse.

The illicit drug methamphetamine grabs much of our headline news today. We read about clandestine labs, people addicted to methamphetamine and methamphetamine's link to robberies and other crime.

But in Oklahoma, and virtually every other state in America, there is another drug – a “legal” drug – that is far more deadly and causes far more damage to our society.

That drug is alcohol.

In Oklahoma, more than 130,000 adults and 15,000 adolescents need treatment for alcohol abuse. The problem is so pervasive that Oklahomans needing treatment for alcohol abuse outnumber those needing treatment for drug abuse nearly eight to one.

Of the 18,000 people receiving state-funded substance abuse treatment in fiscal year 2004, more than 60 percent listed alcohol as a top drug of choice.

Each year, Oklahoma taxpayers spend billions of dollars dealing with the lingering effects of substance abuse – primarily alcohol abuse— either directly through costs related to health care, public safety and property loss, or indirectly through costs associated with lost productivity.

In 1998, a Governor's Task Force on Substance Abuse found that substance abuse alone is responsible for 85 percent of homicides, 80 percent of prison incarcerations, 75 percent of divorces, 65 percent of child abuse cases, 55 percent of

domestic assaults, 50 percent of traffic fatalities, 35 percent of rapes and 33 percent of suicides in Oklahoma.

More recently, a study completed this spring by the Oklahoma Governor's and Attorney General's Blue Ribbon Task Force found that substance abuse is responsible for direct costs of \$1.4 billion annually in Oklahoma. These direct costs are the costs associated with prisons, jails, prosecution, etc. But that isn't all. Substance abuse has an additional “indirect” economic impact of up to \$4.4 billion annually, accounting for nearly all of the state's foregone productivity in the areas of untreated or undertreated mental illness, substance abuse or domestic violence/sexual assault issues.

Beer is Main Culprit

Certainly, hard liquor and wine are abused by Oklahomans. But probably the most deadly alcoholic drink of all is beer. Signs promoting beer are everywhere, from neighborhood grocery and convenience stores to lakeside marinas. Nowadays, the typical marquee ad readily promotes excessive drinking, encouraging consumers to purchase a “30 pack” or a “24 pack,” rather than a mere six pack. In total, beer accounts for nearly 70 percent of alcohol consumption in the United States. Of this amount, underage and adult excessive drinking account for half of all beer sales, with underage drinkers responsible for 20 percent of beer sales.

Underage Drinking: A Critical Health Issue

Underage drinking is a critical public health issue in America. Teenagers, especially, are lured to beer because it is cheap, easily accessible and socially acceptable.

It is no surprise that adolescents seem so anxious to purchase beer when they are bombarded with advertising telling them they will be hip, cool and athletically successful, if only they drink beer.



According to a report released by the Center on Alcohol Marketing and Youth at Georgetown University, from 2001-2003, 91 percent of 12- to 20-year-olds viewed an average of 779 product ads for alcohol on TV. Over this same period, they saw only nine ads to discourage drinking. Alcohol ads outnumbered industry “responsibility” ads by nearly 32 to one.

And beer is surprisingly easy to get. Nearly 40 percent of junior high school students and 73 percent of senior high school students nationally report that beer is “fairly easy” or “very easy” to get.

In July, a Mothers Against Drunk Driving project found that nearly one in five youths sent into bars and liquor stores across the nation, in cooperation with law enforcement, was able to purchase alcohol without providing identification.

Not only are there increased risks in the short-term for adolescents who consume alcohol – including traffic crashes, violent crime, burns, drowning, suicide attempts, fetal alcohol syndrome, alcohol poisonings and high-risk sexual behavior – if an underage drinker makes it out of adolescence and into adulthood, the long-term

physical and biochemical effects put these drinkers at risk for the rest of their lives. Research suggests that early use of alcohol by teenagers may contribute significantly to dependence on alcohol and other drugs later in life, with 40 percent of children who begin using alcohol before the age of 13 becoming alcoholics at some point in their lives.

Unfortunately, binge drinking, the most prevalent form of underage drinking, is as common as it was in the early 1990s, indicating that efforts to combat the phenomenon have so far failed. According to a study by the Oklahoma Department of Mental Health and Substance Abuse Services, 44 percent of Oklahoma high school students reported having one or more drinks of alcohol within the past 30 days. Thirty percent reported “binge” drinking (having five or more drinks in a row, within a couple of hours).

Binge drinking inevitably gets worse in college. Every year, 6,530 students drop out of Oklahoma’s colleges and universities because of problems related to alcohol. This costs state institutions more than \$11 million in tuition revenue. That likely is the “tip of the iceberg” in terms of costs for these campuses and surrounding communities.

Steps are being taken to crack down on underage drinking, including fining store clerks who sell alcohol to minors and the eliminating college “drown nights,” but much more needs to be done.

Young people who abuse alcohol are playing Russian roulette not only with their lives, but also with the lives of friends, neighbors and loved ones.

Alcoholism: A ‘Family’ Disease

Alcoholism affects a wide circle of people close to the alcoholic, but it afflicts families, in particular. Nationwide, more than 9 million children live with a parent dependent on alcohol and/or illicit drugs, and more than half of all adults have a family history of alcoholism or problem drinking.

In addition to wrecking family systems through divorce, poor health and dysfunctional patterns of



behavior, alcohol abuse also is a contributing factor to domestic violence and child abuse/neglect. Nationally, substance abuse contributes to seven of 10 cases of child maltreatment and accounts for some \$10 billion in government spending on child welfare. In Oklahoma, substance abuse is associated with 65 percent of all child abuse cases.

In a related vein, nearly 250 babies are born with Fetal Alcohol Syndrome (FAS) and another 1,000 are born with Fetal Alcohol Effects (FAE) every year in Oklahoma. These two conditions are devastating developmental disorders that ultimately will cost state taxpayers billions of dollars in terms of increased health care, special education and criminal justice costs.

For women who are pregnant or trying to conceive, steering clear of alcohol can prevent a lifetime of heartache. Even a small amount of alcohol consumed during pregnancy can result in a child born with FAS or FAE. Today, physicians and most substance abuse treatment providers push for zero tolerance, recognizing that both FAS and FAE are totally preventable. If a woman even thinks she's pregnant, the best advice is to not drink – PERIOD.

Summary

Alcohol abuse impacts virtually every segment of our society. ODMHSAS is making strides to provide greater access to treatment through innovative new programs to treat pregnant and parenting women, as well as adolescents, and expanding drug and DUI courts throughout Oklahoma. However, much more needs to be done as thousands of Oklahomans who need substance abuse treatment never receive it. Thousands of others end up in prison or become involved in our criminal justice system.

As our state's substance abuse treatment providers, we know that treatment works. Treatment for alcoholism is cost-effective, both in terms of saving taxpayer dollars and helping people to become productive, taxpaying citizens, and is as effective as treatment for diseases such as diabetes and heart disease.

Stopping the cycle of addiction is our top priority and, we believe, the most effective way to improve quality of life for Oklahoma's future generations.

New Mexico and Alcohol

This section describes the DWI program initiated by the Governor's office in January 2004. The New Mexican, Staff and Associated Press wire reports, January 25, 2004. It is followed by a summary of actions taken as of 2005.

2004 Proposals

Though 30-day sessions are usually reserved for legislators to craft the state budget, Gov. Bill Richardson is proposing a very ambitious DWI package.

The proposals include increasing jail time for some offenders, making it a criminal offense to refuse a breath test, giving judges the opportunity to seize vehicles of repeat drunken drivers and creating harsher laws for any adult who provides alcohol to minors.

The governor's proposed legislation would:

- Increase the basic penalty for killing an adult while driving drunk or recklessly from six to 15 years in prison (third-degree felony to a second-degree felony).
- Increase the basic penalty for causing great bodily harm to an adult while driving drunk or recklessly from three to nine years in prison (third-degree felony to a second-degree felony).
- Increase the penalty for causing injuries that are not life-threatening or cause temporary impairment or disfigurement to an adult while driving drunk, recklessly or fleeing police from a maximum of 364 days to three years in prison (misdemeanor to a third-degree felony).
- Make a two-year sentence mandatory for each prior DWI conviction for anyone who kills or injures an adult or endangers a child while driving drunk. This would be in addition to any other charges stemming from a crash.
- Create a new crime of providing alcohol to minors punishable by 18 years in prison if the minor kills or causes great bodily harm to himself or other minors while intoxicated. This crime would carry a mandatory minimum of 12 years in prison and would be a first-degree felony.
- Create a new crime -- a second-degree felony - - of providing alcohol to minors, punishable by 15 years in prison if an adult is killed, nine years if an adult suffers great bodily harm.
- Create new felony crimes of providing alcohol to minors if they are involved in any crash, even if no one is injured.
- Create a new crime of driving drunk with a child in the vehicle or allowing a child to be transported by a drunken driver. Punishment could be three years if child is uninjured, 18 years if child is killed or suffers great bodily harm -- a first-degree felony -- and nine years for lesser injuries -- a second-degree felony.
- Create a new law on refusal to submit to breath- or blood-alcohol tests. Refusal would be punishable by sentences ranging from a maximum 180 days for first offense to maximum three years in prison for sixth or subsequent offense. (Such refusal now constitutes violation of the state's implied-consent law; it leads to automatic administrative revocation of a license but is not a criminal offense.)
- Provide for forfeiture of a vehicle after a second DWI conviction.
- Provide for vehicle forfeiture for driving drunk on revoked license.

Drug Testing: Forensic Toxicology at the Forefront

Thomas C. Kupiec, Ph.D.

The term “drug testing” rolls off the tongue of every American - with little thought to the science and procedures involved. Dr. Kupiec’s text is a “primer” on drug testing and should be understood before we discuss the specifics of testing and how prevalent it should be.

Dr. Thomas Kupiec is the Director of Laboratories and CEO of Analytical Research Laboratories (ARL) in Oklahoma City, Oklahoma. Dr. Kupiec’s vision of entrepreneurial research is manifested by his contributions at ARL, which include supplying technical expertise and business development in the pharmaceutical and forensic fields. His professional experience includes Associate Director of the Workplace Drug Testing Division of NWT, Inc, Senior Research Chemist in Toxicology, FAA and Senior Forensic Chemist at the Oklahoma City Police Department.

Perspective

Through the ages, man has systematically identified and utilized a number of herbs and plants for medicinal purposes. Advances in technology have facilitated more sophisticated pharmaceutical drugs and products. However, an unforeseen consequence of pharmaceutical progress has been the issue of drug diversion and abuse.

The use of drugs and chemicals for their mood altering qualities is not a novel concept, and historical precedent exists in the use of coca leaves (cocaine) and poppy (opium) for their respective properties. At present, abuse of prescription and illegal drugs has almost reached epidemic proportions.

Currently, most industries incorporate a drug testing policy, whereby, employees are periodically tested for illicit use of drugs; a

prime example being the Department of Transportation.

Forensic Toxicology

Drug testing is a part of Forensic Toxicology. The three major areas of Forensic Toxicology include (1) Workplace Drug Testing, (2) Postmortem Forensic Toxicology and (3) Human Performance Toxicology.

Workplace Drug Testing

Introduction of workplace drug testing programs is relatively recent, and the goal of these programs is to serve as a deterrent to drug abuse. Some potential benefits of a drug free workplace include enhanced productivity, decreased liability, and generally a safer working environment.

Urine is the most common specimen used for workplace drug testing, although in the future, it may be replaced to some extent by oral fluid (saliva), which is less invasive and more indicative of recent use. Some laboratories utilize hair to test for the presence of drugs, because with repetitive use, drugs may remain in hair for several months. However, environmental contamination is a possible detractor to more widespread applications of drug testing in hair.

Post-Mortem Toxicology

Postmortem forensic toxicology is an essential component in the elucidation of the cause and manner of death. Various biological specimens are tested for the presence and quantity of drugs.

Blood is the most commonly tested specimen, and for some drugs like ethanol, the concentration of the drug in blood will permit extrapolation on the degree of impairment.

Other specimens used include urine, liver, kidney, brain, lung and vitreous humor. The window of detection of a drug is contingent on drug chemistry, and the nature of the specimen being analyzed. In general, drugs are detectable in blood for a shorter period of time compared to urine. Drug associated deaths can be due to lethal overdose, impairment related, or due to poly drug interactions.



This 5-panel test is commonly referred to as the “NIDA-5” and was established by the National Institute on Drug Abuse. Other drugs that have the potential for abuse include benzodiazepines (e.g. Xanax, Valium, Ativan), methadone, hydrocodone, oxycodone, MDMA etc.

In the past few years, Methamphetamine production has spread throughout the country with law enforcement scrambling to stifle its lethal effects.

Methamphetamine can be produced with over the counter drugs like pseudoephedrine, and household chemicals like lye, ammonia, lithium from batteries etc.

Human Performance

Toxicology

Human performance toxicology deals with the effect of drugs on physical and mental performance. Drugs have been known to impair judgment, reaction time, perception and psychomotor performance.

The Department of Transportation (DOT) routinely conducts simulated research on the influence of ethanol and other common drugs on the performance of individuals.

Establishing the legal driving impairment limit for ethanol (usually 0.08%) is another example of the applications of human performance toxicology. Based on their effects on humans, drugs can be broadly classified into stimulants (e.g. cocaine, methamphetamine/amphetamine, MDMA), depressants (e.g. benzodiazepines, barbiturates, alcohol) and hallucinogens (e.g. marijuana, LSD, PCP).

NIDA-5

The drugs that are most commonly tested for in the forensic setting include: Opiates (Morphine, Codeine), Amphetamines (Methamphetamine, Amphetamine), Cannabinoids (Marijuana/THC), Cocaine (Cocaine, Bezoylecognine) and Phencyclidine (PCP).

Clandestine meth labs are highly flammable and constitute a public health hazard costing thousands of dollars annually in medical expenses due to exposure, destruction of property, and clean up costs. Additionally, owing to its low cost of preparation and simplicity, meth labs have been operating in houses, garages and even in the trunks of automobiles.

Regulation of some common ingredients (pseudoephedrine) and mass media campaigns directed at schools and the public about the realities of drug abuse are examples of some measures utilized to combat this menace.

Testing Methods

Most laboratory drug testing protocols usually involve two separate testing methodologies.

Screen Testing

The initial screening test is extremely inclusive and sensitive, for example an

immunoassay, and will test positive for a number of non-specific compounds that may have structural similarity to the drugs of interest. This test is also referred to as a “Presumptive Test”, because conclusions on drug presence or quantity are not completely definitive.

Confirmatory Testing

The second test or the confirmatory test is very specific in identification of the drug of interest, and is usually based on a chromatographic separation with a mass spectrometric detection. As an example, a screening test for methamphetamine may result in a false positive because of pseudoephedrine (a legally available drug); however, the confirmatory test is more accurate and can discriminate between the two structurally similar drugs.

The quantity of drug present is also an important factor, and there are reporting guidelines and cutoffs established by the Substance Abuse and Mental Health Services Administration, more notably known as SAMHSA. These cutoffs are set to discern inadvertent exposure from intentional use. As an example, ingestion of poppy seeds may set off a positive result for opiates (heroin, morphine etc) on a routine drug screen, if cutoffs are not sufficiently representative of true drug use.

Quality

Quality assurance (QA) and Quality control (QC) are two ongoing and significant operational components of a drug-testing laboratory. As part of the quality assurance process, laboratory drug testing protocols are based on written and regularly reviewed Standard Operating Procedures (SOPs).

Quality control processes incorporate the concomitant testing of the specimen with negative and positive control samples i.e. samples without any drug and samples with known concentration of the drug respectively.

These QA/QC processes constitute a critical internal system of checks and balances, and are especially significant in legal matters.

Beating The Test?

A disturbing phenomenon that has developed over the past few years is the adulteration or intentional manipulation of samples in order to obfuscate the analytical process. Common examples of adulteration include dilution of the sample, the addition of bleach or other chemicals to degrade the drug, and additives that invalidate the test.

Some drug testing laboratories have developed specific tests to check for adulterants and masking agents. Another observable trend is the growing use of herbal drugs and nutraceuticals such as Ginseng, Ginkgo and Ma Huang etc. Some of these products contain ephedrine and related alkaloids, which may lead to false positives on some screening tests.

Future of Testing

Although drug testing has proven benefits, some concerns remain especially with regards to environmental exposure, cutoffs and reporting limits.

Laboratory protocol needs to be sufficiently robust to permit accurate detection, quantitation and reporting. Certain specimens such as hair present unique challenges because of environmental contamination, lack of satisfactory controls and interpretation hurdles.

Innovative analytical technology combined with further developments in oral fluid testing are some of the exciting new areas on the drug testing horizon.

The future holds promise for more accurate and less invasive testing programs, in the fruition of the ultimate goal of a drug free workplace.

Drug Testing in Schools

Dr. Garland Keithley, Superintendent, Enid Public Schools

Dr. Garland “Kem” Keithly has served as Superintendent of Enid Public Schools for more than two decades. He received his bachelor’s degree from Central Missouri State University and his master’s degree from the University of Missouri at Kansas City. He earned his education specialist degree from Pittsburg State University in Kansas. In 1977, he earned his doctorate from the University of Missouri, Columbia.

Enid Public Schools officials are implementing a drug testing program this fall (Sep 2005) that will give students another reason to stay drug free.

Administrators hope it also will help those students who fall short of the goal.

The program, made possible through a donation from a local foundation, will test students who participate in extracurricular activities for the following substances: alcohol, illegal drugs and unlawful performance-enhancing substances. It is expected to affect at least 1,300 of the district’s 2,000 eighth- through 12th-grade students.

Board members say the policy was adopted to assist students who might not otherwise get the help they need.

“We understand that our district is not immune to social problems that other schools across the country face,” David Meara, Board President, said. “We know that there are students at Enid High who use drugs, and we want to help them. We also want to give students another reason to say ‘no.’ This is about self-control and parent control, not school control.”

Representatives from the Champlin Foundation approached school officials in November 2004 about providing seed money for a drug testing program. The four-member, non-profit board, which also has funded projects such as the city’s public swimming pool, offered \$25,000 to cover

first-year costs. As a condition of the project, the foundation asked that the board decide within six months whether or not to adopt a policy.

School board members, interested in the proposal, established a study committee that included parents, teachers, students, administrators and coaches. They agreed to study a number of topics ranging from policy procedures and forms to testing costs and types.

“We knew it was important for us to develop the policy in a collaborative manner,” Dr. Garland Kem Keithly, Superintendent, said. “A violation of this policy will affect many people, indirectly and directly – the student, parents, teammates and coaches. We wanted to make sure that all perspectives were represented on the committee.” According to members, they immediately agreed that they did not want the policy to be punitive in nature. Instead, they wanted to give students a reason – even an excuse when pressured – not to use drugs. They wanted the policy to – “protect the health and safety of students,” not to serve as a way to “catch” students who may be using illegal substances.

The legality of the issue had to be considered as well. The school’s attorney advised that, as found in a Supreme Court case involving Tecumseh High School, students who participate in school-sponsored extracurricular activities can be subject to drug testing. The entire student body, however, cannot be governed under such a policy because school attendance is mandatory. Extracurricular activities are considered a privilege.

After months of meetings and several reviews by the school’s attorney, committee members recommended a policy to the Board of Education in mid-May. It was unanimously approved, with no opposition voiced by those in the audience.

The policy requires students, as well as their parents or guardians, to sign a testing consent form before participating in extracurricular activities. School officials will conduct orientation sessions to educate students on the sample collection process, privacy arrangements and other drug testing procedures.

A baseline test will be required of all activity students. Using resources provided by the company hired, at least 40 students per month will be randomly selected for subsequent tests. They also may be tested for reasonable suspicion, through personal observations related to appearance, speech or behavior.

Random tests may be administered up to 12 times per year, using a list of students in off-season or in-season activities. Positive tests, using the same urine sample, will be confirmed with a second and different type of test. A third test, conducted by another laboratory, can be requested by the student and his or her parents at their own expense. Results of all tests will be handled in a confidential manner that protects the privacy of students.

If a urine sample registers positive for alcohol or drugs, a private conference will be scheduled with the student, his or her parent or guardian, a school abuse counselor and/or the principal.

For the first offense, the student will be suspended from participation in all scheduled scrimmages, games, competitions or performances in all extracurricular activities for 10 school days. The consequence may be reduced by five days if the student shows proof that he or she has received an evaluation from the school's substance abuse counselor or another certified drug/alcohol counselor in the community, which can be arranged at the family's expense. The student also must provide documentation that proves he or she is following the counselor's recommendations.

Law prohibits districts from requiring treatment. A choice of treatment and punishment must be presented, as the committee members learned through their extensive research.

"Our main focus is to provide assistance to students by being proactive to their needs," Bill Mayberry, Athletic/Activity Director, said. "We feel this policy provides motivation to students to make the right choice when presented with difficult decisions."

For the second offense within the same school year, another private conference will be called with the athletic/activity director and activity coach/sponsor also in attendance. Students will be ineligible to participate in activities for 40 school days. The consequence can be reduced to 20 days if the student attends weekly counseling sessions with a drug counseling professional.

For the third offense within the same school year, following another private conference, the student will be suspended from participation in all extracurricular activities including all meetings, practices, scrimmages, games, competitions and performances for 88 school days. The penalty may carry over to the next school year, if necessary.

Students who fail a drug test may appeal the decision, if the superintendent is contacted within five calendar days. The superintendent or a designee will determine whether the original finding was justified. If a student refuses to submit to a drug test, an 88-day suspension from extracurricular activities will result.

School officials are currently accepting bids from drug testing companies. The district will require companies (1) to provide employees to oversee the urine collection process, (2) to provide tests that screen for a minimum of nine substances and (3) to have a turn-around time that does not exceed 72 hours, among other criteria.

After the first-year seed money has been exhausted, Keithly hopes another non-profit organization or a corporate sponsor will step forward to assist with future costs. School officials believe it will be a program worth preserving.

"It's not a problem that we want to ignore," Keithly said. "One student using drugs is one student too many."

Drug Prevention & Treatment in Oklahoma Indian Country

B. J. Boyd & Levi Keehler, Cherokee Nation Behavioral Health Services

B. J. Boyd is a clinical psychologist, Director of Prevention Programs for Cherokee Nation Behavioral Health Services and Project Leader for the Cherokee Nation Anti-Methamphetamine Coalition. An alumnus of Oklahoma State University in Stillwater, Dr. Boyd is an enrolled member of the Cherokee Nation and originally from Gore, OK.

Levi Keehler is a clinician, prevention specialist, and Methamphetamine Prevention Coordinator for Cherokee Nation Behavioral Health Services. He also represents Cherokee Nation Health on the Cherokee Nation Anti-Methamphetamine Coalition. An alumnus of Northeastern State University in Tahlequah, Mr. Keehler is an enrolled member of the Cherokee Nation and originally from Stilwell, OK.

Treatment and prevention of drug abuse and dependency for American Indian populations in Oklahoma presents several interesting challenges. As with any Indigenous population, there are cultural considerations that must be taken into account. Oklahoma is home to 39 federally recognized tribes, each with its own linguistic, cultural, and historical background.

Further, many Oklahoma Indians trace their ancestry from more than one tribe and may culturally identify with only one or with all of their tribes. Degree of acculturation may be more important to know about a given Indian person than blood-quantum, as many mixed-bloods are culturally very Indian in their outlook, customs, and beliefs. Spiritually, some Oklahoma Indians may follow traditional

tribal spiritual tradition while some (even among strong traditionalists) belong to mainstream Christian denominations. Others still are affiliated with the Native American Church.

In addition to culture, geography must also be considered. Most Oklahoma Indians are neither reservation dwellers nor are they “urban Indians” in the conventional sense (i.e., Indian people who are relocated from their tribe’s current geographical location).

The communities in which Oklahoma Indians live (even those with a very high proportion of Indian residents) are rural and all fall under municipal, county, and state jurisdiction. Residents are just as apt to interface with programs and services of these entities as those provided by the Indian Health Service, Bureau of Indian Affairs, Indian Child Welfare, or tribally run agencies. Providers of treatment, prevention, or outreach services that wish to work with Indian communities must therefore be prepared to navigate multiple systems.

Ethical considerations are also important, cultural competency being chief among them. Providers of services should take great care to ensure they conduct themselves in a culturally sensitive and appropriate manner when working with Indian individuals or communities. Consideration of the cultural, political, and geographical factors outlined above are a good place to start. Also,

because so many Oklahoma Indians live below the poverty level, it is important to consider the impact of poverty on daily living. A review of the relevant literature on prevention and treatment for American Indians is also a good idea.



Although this area of research is somewhat limited, it is nevertheless a valuable tool in designing interventions for Indian populations.

Furthermore, providers must be aware of the long history of exploitation, oppression, and discrimination that Oklahoma Indians have experienced at the hands of outsiders. It is a common experience in Indian Country to have been surveyed and studied with no direct benefit to Indian people or to have government sponsored or grant-funded programs introduced only to disappear again within a few years when funding priorities, personnel, or policies are changed.

Providers should take care not to attribute legitimate cultural mistrust to dysfunction or pathology, to avoid forming exploitative relationships with the communities or individuals they serve, and to design programs with an eye for long-term sustainability. Where the latter is not likely, providers should be open from the outset about the length of time the services they are offering will be available.

Effective treatment practices for Indian people with drug abuse and dependency problems run the gamut of professional, peer-supported, and traditional Indian healing practices. Individual and group therapy provided by addictions counselors, licensed therapists, and psychologists can all be effective if provided in a culturally competent manner. There exists among both practitioners and Indian people the idea that practices developed in Western health and social sciences are not applicable to American Indians.

However, when applied in a culturally sensitive manner, many of these methods can be effective. Where these have failed, the problem may lie not with the practice, but the cultural competence of the practitioner.

Twelve-step programs (i.e., Alcoholics Anonymous, Narcotics Anonymous) are also a viable approach for Indian people, particularly with their emphases on developing a community of



support and on spiritual development. In recent years the “wellbriety” movement put forth by White Bison, Inc. has been embraced by many Indian communities and individuals.

The White Bison model incorporates traditional Indian spiritual and cultural practices into the Twelve Steps to make it more relevant for American Indian people. Depending on an individual’s level of acculturation and the extent to which their own tribal traditions match with those used in White Bison, this may be an effective form of treatment for Indian people who abuse drugs or alcohol.

Some Indian individuals may wish to seek help from a medicine person or traditional healer. They may use this as their sole form of treatment or may wish to combine traditional tribal practices with mainstream treatment methods. Providers should remember to allow for this as part of culturally competent treatment. Likewise, Indian people who attend Christian or Native American Church services may wish to rely on their religious beliefs in addition to other forms of treatment.

Confusion often exists regarding the eligibility of Oklahoma Indians for certain treatment services. The Indian Health Service and tribal health agencies are charged with providing services to Indian people who lack other resources to secure treatment. Unfortunately, this has often been misinterpreted as meaning that IHS and tribes are solely responsible for the healthcare of Oklahoma Indians. It is not uncommon for Indian people in Oklahoma to present to state, county, or private agencies for help only to be told they are ineligible and must seek help from an Indian agency. Public

Yu Can at Yukon

Casey Worthen, Director, Yu Can Coalition, Yukon Public Schools

Casey Worthen has been the Director of the Student Assistance Program for Yukon Public Schools since September 1990. She is also the Director of the Yu Can Coalition, an anti-alcohol, tobacco and other drugs coalition. Casey earned a BA in Elementary Education from Pan American University in Edinburg, TX; and received a Masters in Guidance and Counseling from The University of Central Oklahoma. She also holds state and international certifications as a Prevention Specialist. That certification is through Oklahoma Drug and Alcohol Professional Counselor Certification Board (ODAPCCB).

Attending class, hanging out with friends and lobbying state legislators are all part of a typical day during the school year for Yukon Public School (YPS) students involved with the Yu Can Coalition. The anti-alcohol, tobacco and other drugs (ATOD) coalition works toward changing their environment by supporting anti-ATOD laws, offering community ATOD educational classes, providing alternative activities and sponsoring a place for youth to hang out that is ATOD free. The coalition membership includes students, parents, health, ministerial, police, city, state, medical, school and other community professionals.

For the last three years, student and adult members of the Yu Can Coalition have been instrumental in passage of several anti-ATOD laws. In the fall of 2002, Rebecca Newport, Yukon High School senior, complained at a coalition meeting about keg parties that a lot of her classmates were attending on the weekends. Rebecca said, "If you want to do something about kids drinking alcohol, do something to stop the 'keggers' every Friday night". Oklahoma, at that time, did not have a keg identification law. Anyone 21 years of age or older could buy a keg by giving a \$50 deposit. If the authorities busted a keg party, there was no way to trace who purchased the keg for the minors. That

one statement got the ball rolling that ended in the passage of House Bill 1014, the Keg Identification bill.

During that coalition meeting, adult and student members shared information about the problem as they saw it and brainstormed about what they thought needed to be done. One member that was a Green Beret when he was in the Army, suggested a covert operation to 'catch' kids in the act, one person suggested going to the police, another thought going to the City Council and changing the city law was the way to go. After much discussion, it was decided we needed to change the state law to make the fines stiffer against parents/adults that purchased kegs for kids.

State Representative Robert D. Worthen was contacted and asked if he would author the bill. He agreed and asked for us to put together what we thought needed to be addressed. Our coalition worked with other community coalitions in the state, representatives from the State Mental Health and Substance Abuse Services and a lobbyist for the beer industry to give Rep. Worthen the information to write HB 1014.

Yu Can Coalition student members compiled statistics and made buttons to give to state legislators for them to wear in support of HB 1014. They also attended House and Senate committee meetings and the final hearings for the bill on the House and Senate floors. HB 1014 passed both houses with only one dissenting vote. The Governor, Frank Keating, had a public bill signing day that the students attended. The students got to meet Governor Keating and have their picture taken with him.

Each year since has brought other anti-ATOD legislation that our students have supported. They have worked with several state legislators

including their own, Representative Ray Young of Yukon. Freshman student Shannon Sewell commented, "Because of getting to go to the Capitol to work on this bill, I know I want to be a lawyer when I grow up". The students have learned a lot about the legislative process in working with state legislators and their staffs. Tyler Deckard is now a junior and has been active with the coalition since he was in 7th grade. He said, "Working to change laws is a great way to stop kids from drinking and using drugs".

What started out to be something that seemed overwhelming is now expected. The question the students ask at the beginning of each school year is, "what bill are we going to pass this year?"

The youth hang out place, the Coffee House, also came about by listening to what kids had to say at a Yu Can Coalition meeting. Alice Horn, sophomore, was commenting that there wasn't anything for teenagers to do in our town. She said, "we need a place to go that is all ours and has a 'coffee house' atmosphere that we don't have to worry about our parents being there".

The question was asked, "What would that place look like if money was no object?" Many ideas were given. One of the adults suggested having a place that the kids could rock climb. After all the brainstorming, the kids said they wanted a place that had internet access so they could meet their study groups there or work on a paper. They also wanted a place they could watch movies or play Xbox, PlayStation or board games.

Again, it seemed like their request was overwhelming, but there were a lot of adults at the meeting that knew the Yukon community would support a 'hang out' place for the youth of the community.

Three months later a place to accommodate the Coffee House was decided. YPS went into partnership with The First Baptist Church of Yukon and signed a rental agreement. The agreement was for \$1. per year rental, but YPS would be

responsible for all needed renovations. The house was a perfect location, corner of 6th and Main streets, with an adjacent parking lot. What wasn't so perfect was the condition of the house! It had holes in the doors, windows and ceiling, cement floors, one bathroom with a pink toilet, sink, bathtub, and kitchen cabinets that were falling apart. The house exterior was painted hot pink and had no air-conditioning. It didn't seem like a place that teenagers would want to hang out, but it was easy to see its' potential.

The Maintenance Crew for YPS soon became the heroes for the members of the Yu Can Coalition. They worked for three months to make that shambles an awesome get-away for kids.

First, they had to bring it up to building code and make it handicap accessible. A community electrician donated his time to add wiring to accommodate computers. A local plumber updated all the pipes for the two new restrooms and kitchen sink. Community families and businesses donated furniture, games, TV's, tables and money to help out with furnishing the Coffee House.

Three students worked with a local interior designer of BK Designs to make the place more 'kid friendly'. They picked bright colors for the walls and did the painting during their free time. They bought posters for the walls and decided they needed a platform for a second couch in the TV/ movie room to give the effect of 'stadium seating'. One of the students, Sarah Zittercob, said, "Now the place is "fabulous ". She's right!

Yukon Public Schools and the Yukon community through the Yu Can Coalition believe the old saying: An ounce of prevention is worth a pound of cure. That's why they are working to make their community a better place to raise kids. As it turns out, kids have the answers to fighting ATOD's.

The secret that the Yu Can Coalition has found is they listen when kids speak.

Drugs and Crime in Britain

The Economist, April 7, 2005

What influences patterns of drug use, and what does not?

Can the state alter people's drug-taking habits? Politicians certainly think so. A little-noticed bill that will expand and strengthen the nation's drug laws appears to have survived the legislative haggling that takes place before parliament is dissolved for the general election. The war on drugs may be quieter, but it is not over.

The drugs bill lengthens sentences for dealers and allows the police to test people for drugs without charging them first. The aim is to wean Britons off their favourite highs. "Consuming less drugs is beneficial to society," explained Charles Clarke, the home secretary, on January 18th. To that end, the bill criminalises magic mushrooms (at the moment, unprepared ones are legal). Last month, Mr. Clarke also said that some kinds of marijuana may be reclassified to attract stronger sentences.

Will it work?

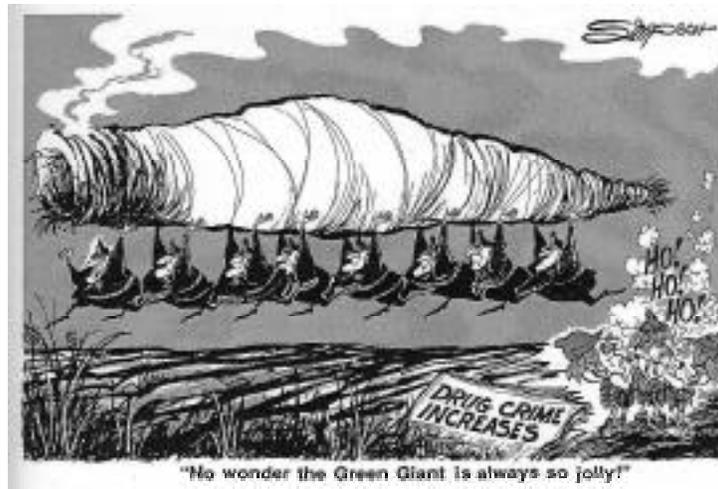
Opponents say that prohibition has little effect on supply or demand. That's wrong: as well as raising prices, it makes quality more erratic. Higher transport and storage costs mean that more potent drugs push out less potent ones.

As the New York politician Fiorella LaGuardia put it in the 1920s: "There may not be as much liquor in quantity consumed today as there was before prohibition, but there is just as much alcohol."

The other effect of prohibition is to make life harder for those with minority tastes. Danny

Kushlick of Transform, a pro-legalisation outfit, points out that pipe tobacco is easy to obtain, though few use it these days. If all tobacco were outlawed, dealers would ignore the niche market and pipe-smokers would turn to cigars and cigarettes. That explains why drugs like LSD can virtually disappear within a few years.

For the more popular drugs, though, legal status matters much less than cost. The average price of a gram of cocaine has fallen from GBP63 to GBP51 since 1999, says the National Criminal Intelligence Service. Ecstasy tablets tumbled from GBP11 to GBP4. Both drugs have lured users away from speed (amphetamines) even though as a Class-B drug it attracts more lenient sentences.



"No wonder the Green Giant is always so jolly!"

Reproduced with permission of David Simpson

Fashion matters even more. Though cocaine's price has fallen, it retains an aura of celebrity that helps sales. It is also a good fit for the modern night-time economy. Ciaran O'Hagan of the Chillout Collective, a harm-reduction group, says that

LSD and (later) ecstasy were suited to the large warehouse parties of the 1990s.

But the current trend is for late-night pubs and bars, which suit cocaine users but are too sedate for pill poppers. Ecstasy use has declined in the past few years even as prices have fallen.

The best deterrent to drug taking is unfashionability—something that is closely associated with endorsement by the government. Mr. Clarke may be missing a key weapon in the war on drugs.

Drugs and Incarceration in Oklahoma: An Arresting Problem

Arthur G. LeFrancois, Professor of Law, Oklahoma City University

It is, by now, received wisdom that American criminal justice policy is subject to a one-way ratchet.¹ Whether this is due to the charms of get-tough-on-crime political rhetoric or deeper institutional arrangements,² it is clear that American criminal justice is committed to incarcerating record numbers of citizens.³ It is unsurprising that Oklahoma's criminal justice policies are marked by the same political pathology.

The driving force behind American criminal justice policy is our effort to criminalize the possession and distribution of drugs. In 2004, 55 percent of federal prisoners were serving terms for drug offenses, while 13 percent were serving terms for violent offenses.⁴ In Oklahoma, the top felony offense for (at least) the last seven years has been drug possession.⁵

In 2003, drug possessors made up 24 percent of Oklahoma's 20,093 felony offenders.⁶ In the same year, drug possessors accounted for 19 percent of the 7,673 persons received at Oklahoma's prisons and drug distributors accounted for 12 percent of the total.⁷ DUI offenders made up another 8 percent.⁸ Nearly 52 percent of all new Oklahoma offenders in 2003 were convicted of drug and alcohol crimes.⁹

It has not always been so. But Oklahoma is now fully engaged in the asymmetries of drug arrests and incarcerations. From 1994 to 2003 in Oklahoma, Uniform Crime Report index arrests (murder, rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft) rose 2.4 percent. Arrests for drug crimes during the same period increased 87 percent.¹⁰

The pressures on any corrections system of such an increase in arrests are enormous. Most obvious is the fiscal strain of trying to accommodate a burgeoning prison population.¹¹

Whether we increase housing space through private or public prisons - or both - at some point our appetite for incarceration becomes unaffordable. Perhaps equally obviously, criminal justice actors have to make decisions about how to allocate limited corrections resources in a world where legislators increase the number of drug offenses and the severity of associated sentences, where federal programs provide substantial monetary incentives to law enforcement to make drug arrests, and where Americans continue to indulge their considerable appetite for controlled substances. Less obviously to some, America's engagement in its drug wars provides another chapter in our troubled chronicle of race relations.¹²

Alluding to the problem's contours is easier than proposing a remedy, which in turn is easier than finding a politically acceptable solution. Possibilities for reform include abolishing some drug offenses (for example, legalizing marijuana use), establishing new criminal penalties (for example, abolishing mandatory minimum sentences), and increasing spending on treatment programs and abstinence efforts. More thoroughgoing reform would seek to regulate drug use as we regulate alcohol use.

The Oklahoma Sentencing Commission has recently made important, thoughtful, and politically acceptable recommendations to the legislature. It has recommended that drug possession offenders be presumptively sentenced to drug court, community sentencing, or probation.¹³ Drug courts and community sentencing provide productive alternatives to incarceration. Probation sentences are either "deferred judgments," which result in an expungement of the (usually first-time, non-violent) offender's record upon successful completion of the non-incarceration sentence, or "suspended sentences," which allow the offender

to serve what would otherwise be a prison sentence under conditions of probation.¹⁴ This recommendation also calls for mandatory treatment programs and funding for expanded substance abuse programs for indigent offenders.¹⁵

Another relevant recommendation is the abolition of mandatory minimum prison sentences for non-violent felonies (except as provided by the Habitual Offender Act).¹⁶ Mandatory minimum sentences reduce the sentencing discretion of courts and increase the lengths of incarceration sentences.

Finally, the Sentencing Commission calls for using intermediate sanctions - rather than revocation - for offenders serving probation sentences.¹⁷ This is essential if we are to maximize the utility of probation (and other alternatives to incarceration), since it is certain that great numbers of drug offenders will relapse.

We must ask what we seek to gain through current criminal justice drug law and policy. If we are trying to make a statement that abusing controlled substances is unacceptable or that law violators will be punished, it is increasingly clear that the statement never will be effective, let alone cost-effective. And as symbols go, it's a rather expensive one. If instead it is the consequences of drug abuse to which we primarily object, we might consider criminalizing those consequences, as we do when we prohibit the sale of alcohol to minors or driving while intoxicated.

And as we work toward creating effective programs and policies designed to disincline people to use illegal substances, we might craft law and policy that reflect the fact that people - particularly in matters seen as private "life-style" choices - make decisions of contestable wisdom with some frequency.

We might want to hesitate before we criminalize a broad range of such decisions, let alone declare war on them.

The great English utilitarian Jeremy Bentham said that punishment should not be inflicted in the following cases.

1. Where it is *groundless*; where there is no mischief for it to prevent; the act not being mischievous upon the whole.
2. Where it must be *inefficacious*: where it cannot act so as to prevent the mischief.
3. Where it is *unprofitable*, or too *expensive*; where the mischief it would produce would be greater than what it prevented.
4. Where it is *needless*: where the mischief may be prevented, or cease of itself, without it: that is, at a cheaper rate.¹⁸

Each of Bentham's criteria counsels serious rethinking of our drug wars' three-pronged strategy of criminalization, arrest, and incarceration.

End Notes

¹ William J. Stuntz, *The Pathological Politics of Criminal Law*, 100 Mich. L. Rev. 505, 509 (2001).

² Professor Stuntz argues that while get-tough-on-crime politics waxes and wanes, a deeper politics of institutional arrangements continues to take us ever-closer to a world where "the law on the books makes everyone a felon, and in which prosecutors and the police both define the law on the street and decide who has violated it." *Id.* at 511.

³ By 2004, a record 2.1 million Americans were incarcerated in state and federal institutions. America's incarceration rate of 726 of every 100,000 citizens is the highest in the world. Crime rates have fallen since 1991, yet the rate of increase in incarceration in the same period was 51%. Federal prisoners have nearly doubled in number over the last decade (an increase of 98%). *The Sentencing Project, New Incarceration Figures: Growth in Population Continues 1* (May, 2005).

⁴ *Id.* at 2.

⁵ Oklahoma Sentencing Commission, *2005 Recommendations to the Legislature 1* (February 24, 2005).

⁶ *Id.*

⁷ Oklahoma Criminal Justice Resource Center, Oklahoma Sentencing Commission, *A report to the Oklahoma Legislature of Statewide Felony Sentencing in 2003 14* (October 28, 2004).

⁸ *Id.*

⁹ *Id.* at 6.

¹⁰ *Id.* at 3.

¹¹ Since 1989, Oklahoma's prison population has increased by more than 100%, and the Department of Corrections budget has grown nearly 200%. *Id.* at 28.

¹² Drug laws and enforcement policies and practices frequently intertwine with issues of racial profiling and with enforcement patterns and punishment distinctions that have disparate racial impacts. See Donna Coker, *Foreword: Addressing the Real World of Racial Injustice in the Criminal Justice System*, 93 J. Crim. L. & Criminology 827 (2003).

¹³ Oklahoma Sentencing Commission, *supra* note 5, at 2.

¹⁴ Oklahoma Criminal Justice Resource Center, *supra* note 7, at 4.

¹⁵ Oklahoma Sentencing Commission, *supra* note 5, at 2.

¹⁶ *Id.*

¹⁷ *Id.* at 1.

¹⁸ Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* 159 (J.H. Burns & H.L.A. Hart eds., Athlone) (1970) (1789).

Drug Court Expansion On Tap

Julie Del Cour, Tulsa World, 5/15/2005

Oklahoma, with the nation's third highest number per capita of offenders behind bars, is about to take a major step toward reducing its addiction to incarceration.

If all goes according to plan later this month, the Legislature will pass and Gov. Brad Henry will sign legislation tripling to 4,800 the number of slots at state drug courts. By diverting carefully screened nonviolent offenders to drug courts instead of sending them to prison, the state could save \$314 million over four years.

"It's time we put up or shut up" about controlling prison spending, said former state Sen. Ben Brown, deputy commissioner for substance abuse at the Oklahoma Department of Mental Health and Substance Abuse Services. That agency operates the drug court program. Drug court expansion, at a cost of \$16 million over the next two years, was the department's No. 1 goal this year.

The expansion isn't only about saving money although the cost difference is dramatic between sending an offender through drug court for \$5,000 versus sending him/her to prison for at least \$16,000.

A new 125-page report by David Wright, the department's chief researcher for justice systems, and data analysts Nancy Warren and Lorrie Byrum, shows how drug courts are turning around offenders' lives, getting them off drugs, into employment and stabilizing families.

A snapshot of the program's success the past three years shows that 2,307 offenders participated, supervised by district courts. Eighty-three percent stayed in the program, a retention rate 12 percent higher than the national rate. From entry to graduation, usually about 18 months, there was an 82 percent decrease in unemployment and a 53 percent

increase in income. There was a 21 percent increase in the number of participants who had children living with them. Substance abuse, as measured by drug tests, decreased as participants progressed through the program.

What stands out is how much less likely drug court graduates are to re-offend, says Terri White, a department management analyst. Graduates were 74 percent less likely to return to prison than successful standard probation offenders and four times, 316 percent, less likely to return to crime than released prison inmates.

It's hard to argue with those statistics, says Brown. Yet, 3,200 people who were qualified for drug court ended up in prison last year because of the lack of drug court slots or other factors such as the reluctance of judges or prosecutors to use drug courts as an alternative to prison.

"Our basic position," said Brown, "is that there are people going to prison who can be safely treated and turned into productive citizens who work and support their families. This expansion is a huge step. The Department of Corrections is growing by 1,000 inmates a year. We can stem the tide particularly with cooperation from the district attorneys and judges who can take a deep breath and say 'this person is salvageable.'"

Receiving \$16 million over two years gives "us time to rev up," White said. Oklahoma has 44 adult and juvenile drug/DUI courts in 32 counties. Expansion means at least 500 more drug court slots in Tulsa County.

A treatment provider network will expand with new money.

Demographically, participants statewide tend to be Caucasian, 65 percent, and male, 68 percent; 70

percent are single. Forty-two percent are employed full-time, 13.2 percent part-time, and 36.2 percent are unemployed. Average monthly income is \$670. About a third of participants do not have a high school diploma but that number is decreasing.

Five offenses accounted for 86 percent of all participants' offenses in 2003. They included drug possession, 44.2 percent, DUI/actual physical control, 26.6 percent, drug distribution, 6.7 percent, other drug crimes, 4.3 percent, and other nonviolent offenses, 4.2 percent. These five offense categories accounted for 54.1 percent of all prison sentences in 2003.

Methamphetamine has overtaken alcohol as the drug of choice used before participants entered drug court. In the past three years, 40 percent of participants statewide had no prior felonies, 22 percent one prior, and 36 percent two or more priors.

The overall cost savings for 2,307 offenders participating in drug court versus going to prison from 2001 to 2004, was \$64.8 million.

Put those figures against the greatly reduced risk of graduates re-offending and the \$16 million investment in court expansion makes eminent sense.

The Legislature often is accused of not doing the right thing when it could and when practical remedies are available. Drug courts began in Oklahoma in 1995. Wright's report shows the program is working: the re-arrest rate for graduates is 19 percent versus a re-arrest rate of 35 percent for traditional probationers and 67.5 percent for prison parolees.

The report and the drug court expansion suggest that Oklahoma can lessen its addiction to incarceration. Getting smart about crime often is as valuable as getting tough on it.



Tulsa County Drug Court

- 33is the average age*
- 61.8%.....were white*
- 68.1%.....were male*
- 49.2%.....were full-time workers*
- \$741average monthly income*
- 33.1%.....did not graduate from high school*
- 26.2%.....were married*
- 59%.....had at least one child*
- 18.6%.....had a chronic mental health condition*
- 14.3%.....had a chronic medical condition*
- 66.1%.....pleaded guilty to drug possession (this offense was the most frequently occurring among drug court participants, accounted for 24.8% of all prison receptions in 2003).*
- 31.6%.....methamphetamine*
- 21.9%.....cocaine*
- 10.5%.....cannabis*

The retention rate for the Tulsa County Drug Court, which includes active and graduate participants, was 83.3% for the period studied. That is higher than the national retention rate for drug courts, which is 67-71%, according to the National Drug Court Institute.

Oklahoma is National Leader in Drug Court Funding

Tim Talley, Associated Press, July 2, 2005 (Tulsa World)

OKLAHOMA CITY - Oklahoma leads the nation in per-capita funding of drug courts following legislative approval of millions of dollars for the specialized courts that provide intensive supervision and treatment for drug offenders, according to a state agency's analysis.

The Oklahoma Criminal Justice Resource Center, which provides research and analysis for the state's criminal justice system, compared funding by 35 states that appropriate money to drug courts after the 2005 Oklahoma Legislature appropriated \$8 million more for its drug-court programs.

The spending plan increased the state's drug-court budget for the fiscal year that began on Friday to \$11.5 million, triple the budget for the previous year, the agency said. At that level, the state will spend \$3.27 per capita for drug courts next year -- more than any other state.

New Jersey ranks second at \$3.10 per capita based on a National Drug Court Institute report published in May, the agency said. The national average is 51 cents per capita. Texas appropriates 3 cents per capita for drug courts, according to the agency.

The Oklahoma Sentencing Commission recommended in February that the state spend more to supervise probationary defendants. Oklahoma spends \$2.04 a day per offender on standard probation supervision, less than half the national average of \$4.37.

The state's drug-court programs spend an average of \$6.37 per participant per day.

"I think it's fantastic. We've seen a lot of success in our drug court system," Rep. Terry Ingmire, R-Stillwater, said Friday.

Drug-addicted defendants can avoid prison by completing drug-court programs that include close supervision and constant drug testing and treatment.

"That's a major step in hopefully getting people's lives back together and put them on the straight and narrow," Ingmire said.

Lawmakers beefed up drug-court funding even though the state is one of the nation's top incarcerators and officials historically have shunned alternative-sentencing programs such as drug courts.

Spending by the 2005 Legislature marked the first time that lawmakers put more money into prison diversion programs such as drug courts than into new prison beds, the agency said.

"It's pretty encouraging. I hope it's a sign of more things to come," said former Sen. Ged Wright of Tulsa, a Sentencing Commission member. Oklahoma has nearly 24,000 inmates in state prisons, many for drug- and alcohol-related offenses.

The added funding will expand 22 existing drug courts and create 10 new courts in the state. Oklahoma now operates 44 drug courts in 39 counties.

Authorities said expanding the program will divert more than 3,000 drug and alcohol defendants from prison in the next year.

A total of 4,765 defendants will be diverted to drug courts in 2006, up from 1,525 last year.

The expansion also will save more than \$38 million in incarceration costs in one year, officials said. The state prison budget totals \$409 million and officials are seeking \$31 million more to provide additional beds during the coming year.

"It's a cost-effective solution," said TOBY TAYLOR of Edmond, who represents the Victim's Compensation Board on the commission.

Ingmire added: "Locking them up and throwing the key away is not working. We're hoping we can divert some of the nonviolent offenders away from prison and still protect the safety of the public."

Oklahoma Needs - More Drug Courts

Julie Del Cour, Editorial Board, The Tulsa World

Before Oklahoma can adopt a rational policy to counteract illegal drugs it must aggressively continue to break its own addictions to incarceration and poverty.

It doesn't take a sociologist to know that the latter often leads to the former and the best strategy for altering the cycle is reducing both.

No single approach will work but smart thinkers have finally convinced the Legislature that putting more funding into prison diversion programs such as drug courts might get some offenders off drugs, back with their families, into the workforce and away from poverty. And, communities are no less safe for the effort.

If a promising trend among drug court graduates continues, as it has over the past three years, Oklahoma could become a model for turning around lives that might otherwise be spent in the prison wasteland or victimizing communities. It's no accident that lawmakers this past legislative session, tripled to 4,765 the number of slots in state drug courts. The cost: \$16 million over two years. The potential: almost \$38 million in annual savings on prison costs.

The infusion of funding quickly catapulted Oklahoma, third in the nation in per capita incarceration, to first in the nation in drug court funding.

Score a victory for the Oklahoma Department of Mental Health and Substance Abuse Services, which oversees the drug court program. And, score a victory for the Legislature, which for the first time put more money into prison diversion programs than into new prison beds and took a giant step toward a rational policy for dealing with nonviolent offenders who use or sell illegal drugs.

Led by Ben Brown, deputy commissioner of substance abuse services, department officials made expansion of their program the agency's No. 1 goal, coming to the session armed for bear. Data, prepared by David Wright, the department's chief researcher for justice systems, showed that over the past three years 2,307 offenders participated in the drug court program that is supervised by district courts.

Eighty-three percent completed the rigorous program, a retention rate 12 percent higher than the national rate. From entry to graduation, on average about 18 months, unemployment among participants decreased by 82 percent and income jumped by 53 percent. Twenty-one percent of the participants with children were living with them instead of having to put their children in foster homes or with other relatives. Substance abuse, as measured by drug tests, decreased as participants progressed through the program. Some participants also showed a greater willingness to improve their lot in life by pursuing a GED, college courses or specialized job training.

What stood out in the data was how much less likely drug court graduates were to re-offend. Graduates were 74 percent less likely to end up in prison than offenders put on standard probation and four times, 316 percent, less likely to return to crime than inmates who were released after completing a prison sentence.

While the drug court statistics were compelling, old habits die hard. When it comes to punishing certain offenders, Oklahomans are much like cell phone users; they prefer more bars even if they cannot afford the cost. So Brown and others showed lawmakers the drug court data and then broke the news that there could have been even more success stories. About 3,200 defendants who were qualified for drug court ended up in prison

last year because of the lack of drug court slots or because of other factors such as the reluctance of judges or prosecutors to use the program as an alternative to prison.

“It was time that we put up or shut up” about controlling prison spending, Brown said. Lawmakers, persuaded by the data and discouraged with coming up with ever more funding for corrections each year approved the appropriation and Gov. Brad Henry enthusiastically signed off on the plan.

The spending plan increases the state drug court budget for fiscal year to \$11.5 million. At that level, Oklahoma will spend \$3.27 per capita for the program. Although almost every state has some type of program the national average for drug court spending is only 51 cents per capita. New Jersey ranks just behind Oklahoma at \$3.10 per capita in spending and our neighbor to the south, Texas, with one of the nation’s largest prison systems, spends only 3 cents per capita on drug courts. Comparisons in funding among the 35 states with drug courts were made by the Oklahoma Criminal Justice Resource Center after the new appropriation was passed.

Oklahoma would spend an average daily cost of \$6.37 per day per drug court participant, a far cry short of the \$16,000 or more per year it spends on housing a prison inmate. Creating more spots to divert about 3,000 carefully screened nonviolent offenders from prison will take several months. But by sometimes next year 4,765 defendants would be diverted to drug courts. The new money will expand 22 of the 44 existing drug courts in 39 counties and create 10 new courts.

As the program builds on its past success drug courts will gain greater acceptance by prosecutors, judges and politicians who can safely tell constituents that getting tough on crime means something besides incarceration. The program also will have to be sold to defendants who sometimes

balk at the intensive and, by necessity, intrusive requirements. Some would rather go to prison than pay the price of freedom. Some fear failure. In short, participants must want to stay drug-free, must want to work and must want to live with and support their families.

Not every offender does.

The program should have particular appeal for women offenders, especially single mothers, who have the added incentive of wanting to raise their children. Oklahoma consistently ranks either No. 1 or No. 2 in the number per capita of female offenders it incarcerates. A high percentage of these women are in prison because of their substance abuse addictions and poverty-ridden existences. Oklahoma must strive to find enough jobs as well as reliable childcare for these women both while they’re in the program and in the years after they graduate.

Employment and self-sufficiency are key components of the program.

Those who oversee the program also must make sure that success stories of drug court graduates are presented to potential drug court participants who can see living proof that people in circumstances similar to their own can survive and thrive from the diversion experience.

And, most importantly, these success stories must be told factually and consistently to the taxpayers picking up the tab, who might otherwise find it easier to fund prison beds instead of prison diversion programs.

Communities convinced that alternatives to incarceration do not threaten citizen safety and can, in fact, free up funds for the state’s myriad needs, are more likely to support other innovative ideas that can lead to a comprehensive and rational approach for dealing with illegal drugs and the people they affect.

The Methamphetamine Scourge

W.A. Drew Edmondson, Attorney General, State of Oklahoma

Drew Edmondson was elected Attorney General in 1994, and in 1998 became only the second Attorney General in Oklahoma history to win re-election without opposition. He was re-elected in 2002 to a third term. Edmondson served as the 2002 - 2003 President of the National Association of Attorneys General after a two year stint as the Chair of the Consumer Protection Committee and Chair of the Southern Region of Attorneys General. Before his election as Attorney General, Edmondson was elected, unopposed, to three consecutive terms as Muskogee County District Attorney in 1982, 1986 and 1990. Edmondson served one term in the Oklahoma Legislature before entering the University of Tulsa School of Law in 1976. His undergraduate teaching degree is from Northeastern State University, Tahlequah, which he attended after graduating from Muskogee Central High School.



Webster's dictionary defines a scourge as "a source of widespread dreadful affliction and devastation such as that caused by pestilence or war" or "a means of inflicting severe suffering, vengeance, or punishment." I can not think of a more accurate description of methamphetamine. Like many other drugs, meth has a way of creeping up on its users and leaving a wake of destruction and suffering. It is potent. It is certainly punishment, and like war, it kills.

So what is this scourge, this thing that has invaded our communities, leaving ruined lives and shattered homes in its wake? Simply and literally put, methamphetamine is pure poison. It's a toxic substance created from a combination of chemicals. Even individually, most meth ingredients should never be put into a human body. For example, you wouldn't drink battery acid for break-

fast or bleach for lunch. You wouldn't sit down to a supper of drain cleaner. But a meth producer might mix all three, along with various other ingredients and then "cook" them in a form for consumption.

It is a recipe for disaster.

As dangerous as it is for its users, meth can also impact people who have never even seen it. Some of us remember the days of junior high science when a lab experiment might require mixing small amounts of controlled chemicals to create a tiny "explosion" in a beaker. It was a relatively safe exercise, supervised by a teacher with some degree of expertise. Meth cooks, on the other hand, are average Joes. For the most part, they know little about the potential reactions that can come from mixing chemicals, yet they do it, right in our backyards. They can blow up a container, a garage or an apartment house, all in the name of creating a deadly concoction. Too often, when a meth lab is taken down, investigators find children's toys and meth-making apparatus in the same room. If these people will put their own children in jeopardy, imagine how little thought they might give you and yours.

Meth is a deadly, vengeful drug, but in Oklahoma, hope is on the horizon. From 1996 through June of 2002, about 4,100 methamphetamine labs were seized in Oklahoma. In 2003 alone, the number of labs dismantled by law enforcement hit 1,300. Some parts of the state were quite simply saturated in methamphetamine and the users who go with it.

In October of 2002, the attorney general's office partnered with the Oklahoma Bureau of Narcotics to file civil lawsuits against six Oklahoma County companies and two individuals alleged to be major

suppliers of pseudoephedrine, a key ingredient in making meth. The lawsuit claimed the companies negligently sold large amounts of pseudoephedrine, often under suspicious or illegal circumstances and that the drug ultimately ended up in meth labs. It was a step toward stopping meth in Oklahoma.

Then, on April 7, 2004, Oklahoma became the first state in the nation to ban over-the-counter sales of pseudoephedrine. Oklahoma law now requires pseudoephedrine to be sold only at licensed pharmacies. Buyers must show identification, and pharmacists must keep a log of buyers.

The results have been astounding. In 2004, law enforcement dismantled 812 meth labs in Oklahoma. Of those, 374 were taken down before the new law took effect. Either way you look at it,

almost 500 fewer meth labs were found to be in existence than in 2003, and the numbers are expected to continue to decline.

Other states have taken notice, and already Oregon, Arkansas, Kentucky, Iowa and Tennessee have enacted similar laws. Twenty-five other states are now following suit, and there is a push to make Oklahoma's law the model for federal legislation that would restrict pseudoephedrine sales nationwide.

We are on our way, but the fight against methamphetamine is ongoing. We must continue to seek out meth in our communities and fight it with the same vengeance it reeks on those it touches. Instead of meth being a scourge to us, we must be a scourge to meth.



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Meth: Who, What, When, Where, Why and How

*John Duncan, Ph.D., Chief Agent, Medical Professional Division
Oklahoma State Bureau of Narcotics and Dangerous Drugs Control*

Introduction

People who become addicted to methamphetamine usually do not undertake its use intent upon causing permanent brain damage. Most have problems already with their brain chemistry, and some suffer from an untreated pre-existing mental disorder. Quite frequently these individuals, who are often most genetically at risk to become substance abusers, began their dangerous use of methamphetamine as a form of self-medication. Methamphetamine fills a void, gives these individuals something that they feel missing in their psyche. But this solution is illusory. The reality is that methamphetamine abuse creates a downward spiral of ever-increasing despair, culminating in significant neurological and psychological damage that is often irreversible and has a far-ranging and deep social impact.

One of the most remarkable clinical features of chronic methamphetamine abuse is the extensive structural and functional effect it has on the limbic, meso-limbic, and pre-frontal cortical areas of the brain. Many of these neurological changes occur on a cellular level, actually genetically restructuring the brain itself. Because of the location and nature of this damage, chronic abusers have been observed to exhibit symptoms clinically indistinguishable from paranoid schizophrenia, even long after ceasing to use methamphetamine. Along with serious psychiatric and psychological problems, behavioral correlates of this neurological damage generally appear as inappropriate emotional responses to stimuli, quite often displayed as intense aggression and violent behavior. This kind of morbidity poses special problems for professionals in medicine, law enforcement, substance-abuse services, and the criminal justice system. In this paper, I will examine the neurological effect of methamphetamine abuse and show how this, in

turn, causes profound changes in behavior.

Finally, I will argue that a more realistic model of treatment is imperative for adequately addressing a methamphetamine abuse outbreak.

Background

While documented cases of amphetamine abuse can be found as far back as 1936 (Grinspoon and Hedblom, 1975), the drug continues to be a very popular drug of choice among abusers. However, not only has the potency of methamphetamine increased by the emergence of newer methods of clandestine manufacture, but also there are significant developments in various psychoactive analogues of amphetamine group drugs available on the street, each with corresponding patterns of abuse.¹

Throughout the last half of the twentieth century, users have progressed from abusing amphetamine to methamphetamine, which is significantly more psychoactive (Nichols, 1994). Furthermore, most methamphetamine marketed illegally is easily manufactured in small 'cottage industry' operations that have come to be called 'clandestine laboratories'. Up until the early 1990's, typical recipes used in clandestine laboratories to produce methamphetamine resulted in the production of a racemic mixture of both dextro- and levo-methamphetamine (Duncan, 2000). Currently, methods used in clandestine laboratories only produce the dextro- isomer, which is stronger. These laboratories, initially sparse in location and number, are being discovered at exponential rates throughout the West Coast and central parts of the United States.

The history of methamphetamine is believed to have begun in 1885, when the German chemist Leuckhart began experimenting with variations of the Benzene ring (Fancett and Busch, 1998). In

many ways, he did not understand that he uncovered one of the most psychoactive molecules yet discovered; for, along with his vast analysis of benzene syntheses, one variation was amphetamine. However, the psychoactive properties of the chemical remained a mystery to Leuckhart, who was only interested in benzene chemistry, and were not discovered until the early 1930s.

In the early 1900's, epinephrine (adrenaline) was the only Western treatment for asthma and could only be administered intravenously. Because of the inconvenience and difficulties associated with the IV route of administration, intense research was underway to find a more efficacious treatment. It was known that a close cousin of amphetamine, found in the ephedra plant (*ephedra vulgaris*), which the Chinese called *Ma Huang*, had been used in their traditional medicine for the past 5000 years as a treatment for asthma and to supply increased energy (Graedon and Graedon, 1991). Therefore, in 1922, K.K. Chen, a pharmacologist working for the Lilly Drug company in Indianapolis, whose hobby was researching traditional Chinese homeopathic remedies, synthesized the active ingredient from *Ma Huang* and named it *ephedrine*. He discovered that *ephedrine* was an effective treatment for asthma; however, since supplies of *Ma Huang* were scarce, chemists embarked on the quest for a synthetic substitute (Fancett and Busch, 1998).

Not until 1933 did the research chemist Gordon Alles discover a novel molecular structure while he was researching synthetic routes of producing ephedrine. This new structure had exciting properties, including efficacious applications in the treatment of asthma. Alles renamed the new substance, known as Alpha-Methyl-PHENYL-ETHYLAMINE. Its new name (now shortened) became *amphetamine*. Under the brand name *Benzedrine*®, amphetamine inhalers and tablets were produced and distributed as the latest and most powerful treatment for asthma (Fancett and Busch, 1998). This over-the-counter preparation became widely popular and was marketed

throughout the United States during the 1930's and 1940's.

Shortly after *Benzedrine*® inhalers were marketed, people began to abuse amphetamine from them in order to get "high." An editorial published in the Journal of the American Medical Association (JAMA) in 1936 described a study that had just been completed by researchers in the psychology department of the University of Minnesota. In this study, a control group of students used *Benzedrine*® (amphetamine) while studying for final exams. Students taking amphetamines scored higher on their exams and reported that the drug "pepped" them up and prevented sleepiness (Fancett and Busch, 1998). The result was the popularization of "pep pills." After the publication of the results of this study, there was a sharp rise in student abuse of amphetamine, which, in turn, led to a 1937 article in *Time Magazine* that warned about the dangers of amphetamine abuse. However, in 1938, an article appeared in JAMA, in which researchers argued that amphetamine was neither addictive nor harmful.

During World War II, the Germans used "pep pills" extensively, especially pilots. These drugs were very effective in keeping flight crews awake and alert on long missions. The British responded by using amphetamines in the same manner. However, while the American public was divided in belief about whether amphetamines were harmful, American pilots are reported to have consumed over 180 million dosage units during the European Theater of WWII (Doweiko, 1999). Roughly 10% of the United States fighting men are thought to have used amphetamines during the war.

In the Pacific Theatre, Japanese soldiers used great quantities of amphetamine. In fact, use was so widespread that many Japanese citizens were given the drug to increase wartime productivity. After the war, massive military stockpiles of amphetamine were marketed to the Japanese people to increase vitality and energy.

Consequently, the consumption of amphetamine in Japan grew exponentially. In fact, in a 1948 study it was estimated that 5% of Japanese males between the ages of 16 and 25 were addicted to the drug (Konuma, 1994).

Meanwhile in the United States amphetamines were widely used in medicine. Specifically, it was believed to treat Parkinson's disease (until 1968), epilepsy, barbiturate poisoning, "psychopathic states," depression, and alcoholism. The drug gained popularity in the United States during the late 1950's and early 1960's as a treatment for obesity. "Pep pills" were readily available throughout the United States. In fact, President John F. Kennedy was known to have a physician inject him several times each day with amphetamine to combat fatigue (Witkin, 1995).

The abuse of amphetamine continued to rise. During the late 1960's in San Francisco, the illicit use of amphetamine gained its strongest foothold (Stalcup, 2000). "Hippies" used amphetamine mixed with LSD to achieve a keener and more euphoric state of altered consciousness. These individuals discovered that intravenous use of amphetamine would produce an intense "high" that diminished over a period of 12-18 hours. According to Stalcup, the typical pattern of amphetamine abuse was as follows: Individuals would inject amphetamine every 2 hours around the clock for 3-6 days, remaining continuously excited and awake (some runs would last up to 12 days); then the user, exhausted and confused, would fall into a deep sleep for 3-4 days. Once awake, the user was normal for 3-4 days, then the cycle would begin again (Stalcup, 2000). During this time, the production of pharmaceutical amphetamine was raging. In fact, prior to governmental rescheduling amphetamine, pharmaceutical companies produced approximately 10 billion amphetamine tablets (Doweiko).

Although it is not clear whether there was a connection between the emergence of illegal clandestine amphetamine laboratories and

governmental regulation, the first clandestine amphetamine laboratory was discovered in Los Angeles, California in 1963 (Duncan, 1987). A chemistry graduate student had revived the old "Leuckhart reaction" to produce amphetamine. However clandestine laboratory activity remained slight until amphetamine was made a Controlled Dangerous Substance in by the US government in 1970. At that time, outlaw motorcycle gangs (mostly based in California) controlled the bulk of clandestine amphetamine laboratories. Initially, this was accomplished by hiring chemistry students to synthesize the drug; however, it was not long before complex chemical equations and processes were eventually "translated" into common recipes that anyone could follow. These early recipes for manufacturing amphetamine (and its stronger variant "methamphetamine") were closely guarded secrets passed down only through apprenticeship and close association.

Clandestine laboratories can be seen as a response to two things: (1) a rapid increase in the demand for illicit drugs, and (2) the interruption of legitimate sources of supply. But this phenomenon was regional: clandestine laboratories during the 1970's were confined mainly to California. Only in the early 1980's was there a significant spread of this kind of criminal activity to other West Coast and mid-western states. Primarily California, Texas, Oregon, Oklahoma and Washington, in that order, became the major areas of clandestine amphetamine/methamphetamine activity (Duncan, 1990). In 1988 and 1989, for example, Oklahoma ranked fourth in the United States on the law enforcement seizure of clandestine methamphetamine laboratories. At that time, law enforcement officers in Oklahoma seized only 63 labs and 71 labs, respectively. Because these early laboratories were much larger, used research-grade chemicals and glassware, and had an average production capability of over 50 pounds of methamphetamine per cook, they were highly vulnerable to interception by regulating the necessary chemicals used in the reaction (Duncan, 2000). As a consequence, state strategies throughout the nation emphasized a strong push for

chemical control legislation. Subsequently, with the bulk chemical sources dried up, clandestine laboratories in many states became a relatively insignificant problem.

But a new method, much less formal, and actually more effective, was in the works in California. In only a few years, information about how to manufacture methamphetamine (i.e. recipes), which was once a closely guarded secret, became ubiquitous. Nowadays, this information can be easily retrieved over the Internet or in a number of popular books. While the older method of production resulted in the chemical d,l-methamphetamine, the newer method produces the stronger and more psychoactive variant, d-methamphetamine. This means that the propensity for users to become addicted to the drug is greater now than in the late 1980's. Furthermore, because the "precursor" chemicals have changed to simple over-the-counter preparations (e.g., pseudoephedrine tablets), criminals usually produce smaller quantities in more clandestine laboratories. It is curious that while the lab operator of the late 1980's was a major supplier of methamphetamine, the "cook" of the late 1990's is much lower on the "food chain" of the drug world. In other words, the social distance between the producer and consumer of illegal methamphetamine has shortened. The newer small labs are easy to operate and can produce small quantities of nearly pure d-methamphetamine in a very short time (less than 4 hours). Even though lab seizures have soared, production capacities for each lab have dropped from the huge average of 27 pounds per week in 1989 to around 1 to 6 ounces per cook in the late 1990's.

Currently there are two major recipes (each with many variants) that have been observed. First is what has become known as the "pseudoephedrine reduction" method. While around 65% of the clandestine labs use this recipe, the remaining 35% have been what are called "Nazi labs" (after the method used by the Germans in WWII). In the "pseudoephedrine reduction" method, cooks use common sinus medicine, red phosphorus (from

matchbook covers), iodine, water, common solvents and acids to produce the finished drug. In the "Nazi method," cooks use pseudo-ephedrine, lithium metal (from camera batteries), and anhydrous ammonia (common fertilizer) in a glass mixing bowl to make methamphetamine. Both of these methods are very easy yet create significant chemical hazards during the process of manufacture. There has been a major outbreak of methamphetamine laboratories in the United States.

An example of the nature of a methamphetamine outbreak can be seen in the small mid-western state of Oklahoma. During the past five years, there has been an exponential increase in the number of illegal clandestine methamphetamine laboratories seized by law enforcement officers there. While there were only 34 labs seized in 1995, 781 were taken off in 1999 and 946 in 2000, 121% increase over the previous year and a 2782% increase from 1995. Only California and Missouri had more lab seizures, ranking Oklahoma third in the nation in the seizure of clandestine laboratories. However, Oklahoma is a small state with only 3.2 million residents; therefore, from a *per capita* perspective, Oklahoma ranks first in the United States in the number of methamphetamine labs seized.

Because of the rapid onset of this phenomenon, the law enforcement infrastructure in Oklahoma has been "swamped." Not only have officers from various federal, state, county, and local agencies been caught without proper equipment and training, but also forensic analysts, prosecutors, courts, and corrections have experienced this rapid influx. Additionally, parallel increases have been seen in the demand for services placed upon substance abuse treatment centers and in other areas of social concern, such as domestic violence and child abuse services.

This indicates that the dimension of the methamphetamine problem goes well beyond law enforcement. For example, a recent study conducted by the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS)

showed that “the rate of stimulant (i.e., methamphetamine) use in Oklahoma is 42% higher than the national rate.” A survey of lifetime methamphetamine use, comparing Oklahoma to the overall United States, shows significantly higher percentages in Oklahoma, with the largest difference in ages 26-34. Accordingly, while the national average for methamphetamine use in this age group is 7.7% of the population, Oklahoma stands at 13.7%. The next highest age group is between 18 and 25, where the national average is 6.5%, and Oklahoma stands at 9.3% of the population. Oklahoma DMHSAS studies further indicate that at least 78% of those requesting treatment are unable to receive it.

Even more frightening than the sheer amount of abuse, methamphetamine abusers are a different kind of drug-abuse concern—they are presenting severe neurological damage. It is clear that the dimension of the methamphetamine problem in Oklahoma goes beyond sheer numbers of clandestine laboratories—a growing segment of its methamphetamine abusers have caused permanent neurological damage, which will lead to further increases in violent crime, spousal abuse, and child abuse.

Patterns of Abuse

Konuma (1994) has described what he calls “methamphetamine dependence syndrome.” According to this model of abuse, it is possible for someone to practice occasional use at the early stages of the syndrome; however, because of the highly addictive nature of the drug and the popularity of IV administration, both psychological and physiological dependence develops fairly quickly. The most common pattern of abuse conforms to a cyclic nature (Konuma, 1994). In this vicious cycle, users repeat a pattern of abuse at intervals of one week to ten days. The first stage, called the “run,” lasts 2-3 days; the second stage, the “crash,” usually lasts 1-2 days; and the third stage is the “craving” period, which lasts for several days. During the “run,” users exhibit insomnia, anorexia, highly obsessive behavior, intense paranoia, fearfulness, unfounded

rage, and violence. This behavior is especially prominent during the “tweaking” period, i.e., when the individual is unable to maintain the euphoric effects of the drug. After the “run,” users exhibit accumulated fatigue, usually indicated by continuous sleep for several days. Finally, during the third phase, users exhibit intense irritability, easily enraged states, and drug-seeking behavior (Konuma, 1994). Further, the “run” has been differentiated by Stalcup as follows: (1) the “rush,” which lasts 5-30 minutes; (2) the “high,” which lasts 4-16 hours, (3) the “binge,” which lasts 3-15 days, and (4) “tweaking,” lasting 4-24 hours (Potter, 1996). Although the period between “binges” may last up to 90 days (Potter, 1996), chronic users use the drug right after they wake up from the crashing phase. As with any drug of abuse, users experience a diminishing intensity of the euphoric effects of methamphetamine over periods of continued use.

Neurotoxic Effects of Methamphetamine

The overall neurotoxic effects of methamphetamine have been known for some time. In fact, much of what we know about the patterns of methamphetamine abuse are the results of studies conducted on the major outbreak in Japan after WWII. But new information about the pernicious effects of methamphetamine continues to be discovered. In 1971, Fibiger and McGeer (1971) showed that prolonged and intense exposure to methamphetamine greatly compromised the dopaminergic system. This effect was also carefully documented in the works of Koda and Gibb (1971, 1973). Similar results echo throughout the literature. Further evidence shows that chronic exposure to methamphetamine is associated with atrophy of dopamine reuptake sites, “consistent with the destruction of nerve terminals” (Wagner, *et al.*, 1979).

Methamphetamine has been shown to be neurotoxic, primarily to the dopaminergic system, and there is strong evidence that this neurotoxicity also affects the 5-HT neurons (Gibb, *et al.*, 1994). While some regeneration occurs after the use of methamphetamine is discontinued, much of the damaged areas remain permanently as structural neurological damage (Axt, *et al.*, 1994).

To fully understand the neurological impact of methamphetamine, it is imperative to consider the mechanisms of action of the drug. Kinetically, methamphetamine causes dopamine vesicles to release all of their stores of the neurotransmitter. Typically, in normal life, dopamine is released in small amounts, generally as a part of a normal-functioning limbic and meso-limbic system, and integral to proper functioning of the pleasure-reward and incentive-salience neuro-cognitive mechanisms. However, in methamphetamine abuse, systemic overload occurs, causing the presynaptic neuron to release the entire store of dopamine into the synaptic cleft. After this massive release, the vesicles in the neuron continue to try to regurgitate more dopamine, in a process analogous to “dry heaves.”

With synaptic saturation of dopamine, methamphetamine also blocks the monoamine oxidase (MAO) reuptake mechanisms (which eventually degenerate), shutting down the cycle of release and reuptake, and forcing repeated binding, release, and rebinding of the dopamine molecules to post-synaptic receptors. This over-saturation causes a continual cascade of neurological stimuli that gradually diminishes over a period of twelve to eighteen hours. Repeated dosing with methamphetamine can prolong the cascade; however, the neurological effect finally reaches a point where the system shuts down and causes the individual to “crash.”

Furthermore, when the molecules of dopamine activate receptor sites in the post-synaptic neuron, G-protein binds and forms a second messenger. This second messenger travels down the axon to the nucleus, where it causes a genetic transcription known as CART (cocaine-methamphetamine regulated transcript). There are two genetic messages sent to the cell in response to this transcription (Stahl, 2000). First, the cell forms more new receptor sites (to facilitate more dopamine stimuli registering). Second, through a process known as “apoptosis,” the neuron “prunes”

away dendritic structure not associated with the dopamine system. Essentially, this interrelated process is saying, “I want more of this chemical, so I need more receivers” and “I don’t want to be distracted by other stimuli, so let’s do away with dendritic structure not associated with this effect.”

It is easy to observe, therefore, that this process describes both functional and structural neurological damage. Functionally, the dopamine neurons are continually depleted and struggle to make more dopamine. Through repeated over-stimulation cellular metabolism is altered—an effect that does not completely return to—“normal” after methamphetamine abuse is discontinued. Structurally, the neuron changes in three ways: (1) the MAO reuptake mechanism deteriorates, (2) the number of dopamine receptor molecules increases exponentially, and (3) there is a necrosis of the dendritic structure not associated with the dopaminergic process. Through these functional and structural processes, severe compromise of the limbic, meso-limbic, pre-frontal cortical areas of the brain occurs.

Behavioral Correlates of Methamphetamine Neurotoxicity

As early as 1956, with the landmark analysis of the Japanese post-war epidemic of methamphetamine abuse conducted by Tatesu (Tatesu *et al*, 1956), there was strong evidence indicting methamphetamine as neurotoxic. By altering the structure and function of the limbic, meso-limbic and pre-frontal cortical areas of the brain, methamphetamine causes significant changes in the individual. While some reversal is often observed after the use of the drug is discontinued, severe neurological damage remains. This neurological damage is most apparent as the insidious behavioral correlates typical to the methamphetamine abuser that have come to be known as “meth psychosis.”

This form of psychosis has been associated with the severe post-war outbreak of amphetamine abuse in Japan (Konuma, 1994). The change in

behavior in “meth psychosis” was differentially characterized as four “types”: antisocial, shiftless and frivolous, explosive, and asocial (Knouma, 1994). Meth psychosis has been characterized as clinically “indistinguishable from acute or chronic paranoid schizophrenia” (Connell, 1958). Further evidence supports the view that this neurological damage endures and is perhaps permanent. Fukui, *et al* (1994), have documented that, in reference to the outbreak in Japan,

“of the METH-related patients visiting psychiatric hospitals, 255 (77.0%) were in a hallucinatory-delusional state. However, 139 cases (42.0%) had not used METH since their last psychotic episode. These individuals visited the psychiatric hospitals because of a prolongation or re-exacerbation of METH-induced psychosis” (Fukui, et al, 1994).

It is easy to see the correlation between the types of neurotoxicity found in methamphetamine abuse and the behavioral responses associated with meth psychosis. First, the dopaminergic system is primarily located within the limbic and meso-limbic areas of the brain. It is well documented that the limbic area is associated with a modular and automatic processing of the “feel” of the environment. Whether the environing world is perceived as generally insidious or “not quite right” is often the result of a precognitive and automatic process closely tied with the function of these areas of the brain. Consequently, when these neurological areas are damaged, as is the case with chronic methamphetamine abuse, the individual may “feel” as if something is wrong, leading to a sense of paranoia. In a way, the damage leads to the individual having a strong “fight or flight” response, except in the case of methamphetamine abuse, this urge is manifested as an unfounded background horizon to everyday activity.

It has been suggested that while schizophrenia is a displacement of the ego-center within experience, paranoia tends to manifest an overemphasis of the “third person” perspective. In this case the “subject-object” separation is reversed, so that the

paranoid individual sees herself as the object and the surrounding world as the subject constantly gazing at her. Clearly, the damage to the limbic areas of the brain can be seen as the catalyst for this paranoid response. With methamphetamine paranoia comes a host of bizarre responses to everyday activities. Primarily, these are inappropriate reactions to environmental stimuli. Methamphetamine abusers tend to exhibit aggressive, explosive, irascible, and violent outbursts without provocation.

Methamphetamine related aberrational behavior does not only affect the quality of life of the abuser, but also “ripples” into the social world – family, friends, co-workers, and finally society at large are all adversely impacted by the mental instability and asocial behavior demonstrated by methamphetamine abusers. Increases in domestic violence typically accompany a methamphetamine outbreak, especially spousal and child abuse. Of course this makes perfect sense: violent outbursts first occur within the family setting. The problem is exacerbated when both partners are methamphetamine abusers (most often the case). Child neglect and physical abuse of children (including sexual abuse) is common when the parents are abusers.

Phenomenology of Methamphetamine Abuse
While the physical effects of methamphetamine abuse are seriously debilitating and cause psychosis, the user experiences a completely different effect. While under the influence of methamphetamine, a user will report feeling euphoria, stronger, smarter, more energetic, and generally as having a tremendous sense of power. The onset of this effect is almost immediate in cases of intravenous administration and is associated with the “rush,” leading to the “high.” If the drug is ingested orally or through the nose, the onset of the “high” is delayed approximately 20-30 minutes and the “rush” is not as intense.

The sense of power begins to fade after about 4 hours, leading to subsequent dosing, which reinitiates some (but never all) of the original

effect. This process continues throughout the “binge,” until the dopaminergic system, along with other physical systems, becomes exhausted and fails to function properly. This period, known by abusers as “tweaking,” is associated with feelings of extreme discomfort, itchy skin, and depression. Users typically become highly irritable during this phase and are prone to violent outbursts. Finally, the user “crashes” and sleeps for several days, until the body’s systems have rested enough to function within normal limits. At this time the user returns to waking life and may begin a new cycle of abuse.

Clearly, the phenomenology of methamphetamine abuse is diametric to the actual psychopharmacological effects of the drug. While the individual feels a sense of power and augmentation of natural abilities, the drug is extensively damaging the neurological system. Furthermore, because methamphetamine is also a sympathomimetic norepinephrine, damage occurs to other systems of the body, especially the cardiovascular system. Severe anorexia, dermatitis, calcium depletion, and depression are also associated with methamphetamine abuse.

Problems in Dealing with Meth Abusers

Everyone who interfaces with methamphetamine abusers is subject to the pernicious effects of the drug. Law enforcement officers, who typically are involved in confrontational relationships, are in the most immediate danger. A simple traffic ticket can explode into a life and death struggle when the perpetrator is a methamphetamine abuser. Undercover drug buys take on an increased complexion of danger and officers responding to the scene of domestic violence often confront a methamphetamine abuser. Medical professionals are also exposed to the violent and paranoid outbursts of methamphetamine abusers.

The problem of dealing with methamphetamine abusers goes deeper into the social infrastructure. Work environments are changed, incidents of “road rage” increase, and general violent crime increases. Substance abuse treatment providers are faced with a new situation—the fact that a chronic

methamphetamine abuser is most always a dual-diagnosis patient, disruptive, unfocused, and not typically responsive to cognitive behavioral therapy. Faced with a new form of drug abuser, the standard “twelve step program” is often not useful with patients who have serious neurological damage. Because of the problems that these individuals have focusing, cognitive-behavioral therapy must begin with heuristic basics—orientation to time and place, simple problem recognition, and focus training are necessary to start the process. This type of therapy alone is insufficient to adequately treat the neurophysiological aberrations common among methamphetamine abusers. Psychiatric evaluation and psychopharmacological treatment are frequently indicated.

This departure from traditional drug treatment is significant and poses unique challenges for treatment workers, corrections personnel, domestic violence workers, and child abuse investigators. Courts are also challenged by a new kind of offender (often violent) that has essentially become a paranoid-schizophrenic.

Summary

The evidence is overwhelming that methamphetamine abuse causes permanent and irreversible brain damage. The nature of this damage is extraordinarily significant, since the behavioral correlates are a recognizable form of mental illness. More than any other drug of abuse, chronic methamphetamine use leads to psychiatric problems that are both expensive and difficult to address. Most often, the social infrastructure, from law enforcement to treatment and from domestic violence services to child welfare services, is ill equipped to deal with the insidious effects of methamphetamine. Only by re-thinking the manner in which these individuals are approached, using new psychopharmacological resources, and breaking ground on innovative treatment methods can an effective and overarching solution be found.

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Endnote

¹ Various forms of amphetamine, methamphetamine, and ring-substituted analogs, such as MDA, MDMA, and others are typically found on the street. All of these variants share potential for abuse and cause neurological damage.

What Is A Meth Lab?

Minnesota Department of Health

Methamphetamine is often made in clandestine labs (also called clan labs or meth labs) in a variety of locations, such as houses, apartments, motels, vehicles, wooded areas, or other buildings. Methamphetamine is made (or 'cooked') from common, easily-available materials, using one of several basic chemical processes.



Meth "recipes" are easy to obtain from other cooks and from the internet. There are hundreds of chemical products and substances that are used interchangeably to produce meth. The substitution of one chemical for another in meth recipes may cause the cooking process to be more hazardous (resulting in fire or explosion) or may result in a finished product with unwanted or dangerous effects.

Different meth recipes also result in finished products with different colors, making meth difficult to describe. Most meth made in Minnesota is made using the anhydrous ammonia meth. The drug made in these labs typically ranges in color from white to light brown. Meth amphetamine imported to Minnesota from other states is most often some shade of pink. Crystal meth, commonly called, "ice," "glass," or "crystal" looks like clear chunks of crystal or ice.

Many dangerous chemical ingredients are used to make meth. The cooking process causes chemicals and methamphetamine to be deposited on surfaces and household belongings. Also, chemical by-products such as toxic phosphine gas may be formed during meth manufacture. This may occur through planned chemical interaction, or by processing errors, such as increasing cooking temperatures too rapidly.

Every meth "recipe" starts with over-the-counter medications that include pseudoephedrine or ephedrine in their contents. The pills are crushed and mixed with other chemicals in the process of cooking meth. Various meth recipes include combinations of volatile organic compounds (VOCs), acids, bases, metals, solvents and salts. Making meth with these chemicals can result in explosions, chemical fires, and the release of toxic gases.

Meth cooking also produces solid and liquid wastes that can contaminate a building and its contents, or the groundwater or soil where they are dumped.

<http://www.health.state.mn.us/divs/eh/meth/lab/index.html>

Meth & America's Counties

MSNBC, July 5, 2005

The No. 1 drug problem for many counties across the country is not cocaine, heroin or marijuana but methamphetamine, according to a survey released Tuesday.

A synthetic drug that's easily manufactured, meth has spread from the West Coast and is moving east, according to the survey by the National Association of Counties.

Of 500 law enforcement agencies surveyed in 45 states, 58 percent cited meth as their biggest drug problem, dwarfing cocaine (19 percent), marijuana (17 percent) and heroin (3 percent).

The highest meth percentages were along the West Coast and Upper Midwest. In the Northeast, on the other hand, only 4 percent of counties rated meth as their biggest drug problem. Forty-six percent cited heroin as the top problem, followed by cocaine at 21 percent.

A form of speed that is usually smoked, snorted or injected, meth quickly becomes addictive.

Robberies, domestic violence links

Other findings indicate how quickly the drug is spreading:

- 87 percent of agencies report increases in meth-related arrests starting three years ago. Arizona, Arkansas, California, Florida, Indiana, Louisiana, Minnesota, Nevada, New Mexico, Ohio, Oregon, South Carolina, Tennessee, Utah, Washington and Wyoming reported 100 percent increases.
- 70 percent say robberies or burglaries have increased because of meth use.
- 62 percent report increases in domestic violence because of meth use.

In a report with the survey results, the association described the spread as an "epidemic ... affecting urban, suburban and rural communities nationwide."

The federal government still considers marijuana the top drug problem in the nation, citing a 2003 survey estimating 15 million people who had smoked marijuana over the last month, compared with 600,000 meth users over the previous month.

The counties association, however, said that "county law enforcement officials have a different perspective on this ranking. With the growth of this drug from the rural areas of the western and northwestern regions of this country and its slow but continuing spread to the east, local law enforcement officials see it as their number one drug problem."

Small and Large Labs

Meth is imported from Mexico, Canada and Asia, the association said, as well as produced in small or large labs across the United States using household ingredients like cold medicines and fertilizer.

"The small lab methamphetamine production and market was originally dominated by motorcycle gangs and local producers chiefly in California and the Pacific Northwest," the association said, "but has grown now to include major producers in Mexico who are responsible for the organized trafficking of meth and by the thousands of small producers in nearly all areas of the country."

"Meth can be manufactured in barns, garages, back rooms of businesses, apartments, hotel and motel rooms, storage facilities, vacant buildings and vehicles," the association said — and even a suitcase.

MSNBC, Updated: 11:46 a.m. ET July 5, 2005. The full report is online at www.naco.org. © 2005 MSNBC Interactive

Behind Oklahoma ... Again!

Rep. Tom Osborne (R, 3rd District, NE) Third District and Errin Hegge

Press Release: June 14, 2005

Washington, D.C.— As the United States continues to experience an unprecedented rise in the use, trafficking, and manufacturing of methamphetamine, Rep. Osborne and several of his colleagues including Rep. Lee Terry fought hard to secure federal sources of funding for programs working to guard communities against the harmful effects of methamphetamine during floor consideration of H.R. 2862, the fiscal year 2006 Science, State, Justice, Commerce Appropriations bill.

“The devastating impact methamphetamine has on our rural communities in the Third District, across Nebraska, and across the United States cannot be exaggerated. Given the vital role federal programs such as Byrne Justice Assistance grants, COPS, and others play in helping local law enforcement officials fight meth production, it is incumbent upon Congress to ensure that federal funding exists to ensure the continued effectiveness of such programs.”

On the House floor today, Rep. Osborne called attention to the escalating problem of meth trafficking from Mexico. “As our nation continues to fight against the ravaging effects of methamphetamine use, it is critical to point out that much of the meth production destroying so many lives does not even occur within our own borders, but is smuggled into the United States from Mexico.

I urge the Drug Enforcement Agency (DEA) to utilize its resources to target Mexican criminal groups responsible for meth production and trafficking, similar to their successful efforts in reducing the amount of pseudoephedrine—an ingredient in meth production—diverted from or through Canada. Lawmakers can regulate the sales of pseudoephedrine within the United States, but until the federal government takes serious action against the international trafficking of methamphetamine, we are facing an uphill battle.” Rep.



Osborne will be working with House Appropriations Subcommittee on Science, State, Justice, and Commerce Chairman Frank Wolf on this issue.

Following his floor discussion, Rep. Osborne later voted to support an amendment offered by Rep. Baird to provide \$10 million in additional funds to the DEA to combat international trafficking of methamphetamine. It would also provide \$10 million in additional funds to the Community Oriented Policing Services (COPS) program to be used for providing training to state and local prosecutors and law enforcement agents for the investigation and prosecution of methamphetamine offenses. The amendment passed by a vote of 260-168.

Also, Rep. Osborne voted in favor of Rep. Terry’s amendment to restore approximately \$286 million to the Edward Byrne Memorial Justice Assistance Grant (Byrne-JAG) program, and thereby, prevent the termination of task forces across the country charged with the responsibility to identify and destroy local, state, and regional drug-related crimes. “Local law enforcement officers are our first line of defense against meth use. Without the Byrne funding grants, Nebraska law enforcement officers have limited or no local resources to help them fight this threat. The \$286 million in federal funds through the Byrne program simply must be restored to the level provided in fiscal year 2005, \$634 million.” The amendment failed by a vote of 175-252.

“Since coming to Congress, I have worked hard to raise awareness about this highly addictive, destructive drug in Nebraska and in Washington. As I travel to schools in the Third District, I speak to middle and high school students and share with them the devastating effects of meth in hopes that we can reverse the growing and dangerous problem of meth in our communities. Meth is too easily accessible and its effects are detrimental to our youth, communities, and way of life in Nebraska.”

Oklahoma's Pioneering Meth Legislation

John Nance, State Representative, District 90, Bethany

Speed, meth, ice, crystal, glass, by whatever name you want to call it, methamphetamine is a scourge on society. Drug abuse is always a concern to government and to the elected officials who must respond with effective and, hopefully, innovative means to combat illegal drug use.

Illegal drug use carries with it problems for communities both large and small.

The methamphetamine problem in Oklahoma is no exception, and it didn't begin overnight. It doesn't take much digging into the statistical evidence to determine that drug abuse is a constant contributing factor to Oklahoma's prison population. In research performed by the Oklahoma Criminal Justice Resource Center, nearly 52% of people sentenced to prison in 2003 were incarcerated due to a conviction for a drug or alcohol offense. Since 2000, there have been numerous pieces of legislation introduced to combat the traumatic effects of meth use. In those early days, before legislators and the public truly understood the impact meth would have in our state, legislation tended to focus on the detection, prosecution and sentencing of meth manufacturers with little focus on the treatment and rehabilitation of the abusers.

Methamphetamine is an extremely dangerous drug. Commonly referred to on the street as speed, meth, ice, crystal, or glass, the drug is a derivative of amphetamine and is an extremely powerful stimulant. The drug produces physiological effects similar to cocaine, only worse because methamphetamine metabolizes much slower than cocaine and has longer lasting effects. When a person abuses methamphetamine, he or she feels an immediate rush. The intense high felt by an abuser is caused by the brain releasing high levels of dopamine in the section of the brain that controls the feeling of pleasure. These effects can last up to 12 hours. Methamphetamine users



develop a resistance to the drug which causes the abuser to use more of the drug each time which in turn leads to chronic abuse. Chronic abuse of the drug has been shown to cause psychotic behavior such as intense paranoia, hallucinations, and out-of-control rages.

As law enforcement started to see increases in meth use, they often came to the Legislature with recommendations on changes in law which would aid in the fight against the drug. In 1999, I authored legislation in an attempt to fight illegal manufacturing of methamphetamine. That legislation made it illegal to possess any detectable amount of pseudoephedrine or other pre-cursor components used to manufacture meth. The new law allowed prosecutors to file charges against a person for intending to manufacture a controlled dangerous substance if the person possessed three or more pre-cursor components used to manufacture the drug. In the case of methamphetamine, this meant that if the police found a person in possession of pseudoephedrine tablets, ether and brake fluid, it was enough evidence to show that the person intended to manufacture meth even though no finished meth product was present. That same year, I attempted to pass legislation to make it a crime to transport anhydrous ammonia in an unapproved container. The use of anhydrous ammonia is one of the two preferred cooking methods used by meth cooks to produce the drug, and reports of anhydrous theft were on a dramatic rise during this time. Even though there was much support for the idea, it took another session before legislation was enacted to make it a crime to possess anhydrous ammonia in an unapproved container.

I mention those early efforts to fight the meth menace to show that even though the Legislature

and law enforcement were working together to combat meth, still more needed to be done. In 2003, I asked for an interim study on ways law enforcement efforts could be enhanced to fight meth. The request was granted and in September of 2004, the House of Representative's Criminal Justice Committee met with more than 40 officials from the Oklahoma Bureau of Narcotics and Dangerous Drug Control, district attorney led drug task forces, physicians and pharmaceutical representatives over a two-day period to discuss the dangers of methamphetamine and possible best practices to address the growing problems in Oklahoma. The meeting was a huge success in that it brought to the table a wide-ranging scope of expertise to discuss the issue.

As a result of the interim study, several recommendations were made to create a holistic approach to the meth menace. The product of these recommendations was House Bill 2176 which I introduced for the 2004 legislative session. The measure began with four basic assumptions. First, we had to stop the cooks from getting the ingredients used to make meth. The one common denominator for the meth cook is pseudoephedrine. Language was incorporated into the bill to add over-the-counter products which contain pseudoephedrine in a tablet form to the Schedule V class of drugs which are regulated by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBND).

While the drugs remain available for over-the-counter sales, they may only be dispensed by licensed pharmacies and only after the customer provides identification and signs a log book noting the sale. Second, we had to make sure that meth cooks stayed behind bars while awaiting trial. We had heard much testimony about the nature of addicted meth cooks whose one consistent driving urge once they got out of jail was to find their next set of ingredients for another "cook." We incorporated language in the bill to allow judges to deny bond for individuals if it could be shown that the person was addicted to methamphetamine. Third, we attempted to stop the source of

anhydrous ammonia by requiring anhydrous tanks to be equipped with a locking mechanism to prevent theft. This language was greatly opposed by the farming community and was later removed from the bill. Fourth, the measure created language to mirror federal regulations by restricting the amount of pseudoephedrine a customer could purchase in a 30-day time period to nine grams and requires a purchaser to present a valid photo identification. The last thing the bill addressed was to make it illegal to sell or market products which are used to mask a drug sample.

All in all, I felt that I had a good working bill to take to the Legislature. We had done our homework and had the support of law enforcement, the medical community and the district attorneys. Then, during Christmas of 2004, a tragic event occurred that made the legislation take on a life of its own. Early on Christmas Eve morning, Trooper Nik Green answered a call to check on a suspicious vehicle on a rural country road. Trooper Green responded to the call and surprised a meth addict in the middle of a "cook." A struggle ensued and during the course of the struggle, the addict took Trooper Green's gun and shot him. Trooper Green left behind a young widow and three beautiful daughters. After this terrible turn of events, I felt a deeper purpose to get legislation enacted to stop this terrible, terrible drug.

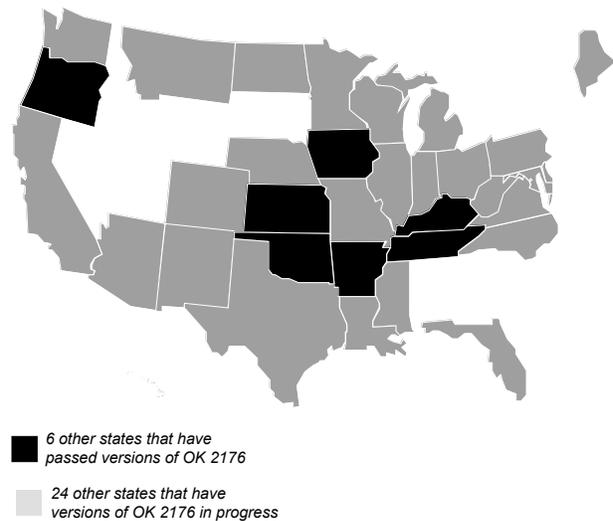
After the tragic death of Trooper Green, the Legislature took swift action in passing **HB 2176** which was by then named the Nik Green, Rocky Eales, and Matthew Evans Act in honor of three Oklahoma troopers who were killed in the line of duty by persons involved in illegal methamphetamine production. The measure, which is now a model for other states, establishes strict guidelines for the sale of certain products containing pseudoephedrine. All of the major components originally asked for were enacted, except for the previously mentioned anhydrous locks. By the time the Act became effective on April 6th, 2004, numerous states were inquiring as to how Oklahoma had been able to enact this far-

reaching legislation. To date, according to the Oklahoma Bureau of Narcotics and Dangerous Drugs Control, more than 35 states have adopted language similar to Oklahoma's or are in the process of doing so.

States that have passed versions of 2176
In the one year since the enactment of HB 2176, the OBNDD has reported an astounding reduction in the number of meth labs seized by law enforcement. Prior to the enactment of HB 2176, more than 1223 meth labs were seized by law enforcement in 2003. During 2004, 812 labs were seized by law enforcement. The reduction is even more dramatic when looked at on a month by month basis. The Oklahoma District Attorney's Council polled the 25 multijurisdictional Drug Task Forces operating in the state and found that prior to the enactment of HB 2176, the monthly average for meth lab seizures was 92 labs each month. After enactment, the numbers dropped to 48 in April, 45 for the months of May and June, dwindling down to 21 lab busts in December 2004.

These illustrations of the dramatic reductions in the number of labs, while encouraging, should not indicate to the public that our work on meth is done. The life altering effects of meth are still around us. Just recently, there have been reports in The New York Times detailing the terrible effects methamphetamine is having on our foster care programs. According to the article, foster care shelters are being bombarded with children who have been taken from meth addicted parents. We in the Legislature must continue to support programs to meet the needs of these children and find effective ways to break the cycle of addiction that plagues their parents. I'll never forget how 20-year law enforcement officials came to me saying that incarceration was never going to break the cycle of addiction and that it was time to try something new. That something new was drug courts. Drug courts are an alternative to the traditional adversarial judicial process in that it allows prosecutors and judges to hold a drug offender accountable without sending the person to prison. Oklahoma is fortunate in that we have been

States Adopting 2176



able to fund and support drug courts as an alternative to incarceration. Drug courts offer nonviolent, felony drug offenders a supervised substance abuse program to help return the offender to the community as productive members of society instead of incarceration. The Oklahoma Department of Mental Health and Substance Abuse Services supervises drug courts, and since the inception of drug courts in 1995, more than 2,300 participants have received services. One interesting factor that has been seen in drug court participants is the offender's drug of choice. In 2004, methamphetamine out-paced alcohol for the first time as the principal drug of choice for those sentenced to drug court.

As I've said previously, the work that has been done to stem the rampant abuse of methamphetamine is not completed. As long as there are drugs and people, drug abuse will continue to exist. We in the Legislature must be willing to listen to new ideas and new concepts to address the needs of law enforcement, substance abuse treatment providers and citizens. If we can all sit down and discuss the issues placed before us, we can ultimately find acceptable solutions to the problems. After all, it was only through a team effort that we were able to enact one of the most significant pieces of law enforcement legislation in the history of the state of Oklahoma.

Oklahoma Leads - Feds Follow

Sam Hananel, Associated Press, June 5, 2005

Following Oklahoma's lead, more than a dozen states have enacted laws to require retailers to sell Sudafed, Nyquil and other medicines only from behind the pharmacy counter.

Now Congress is working on legislation intended to make it tougher for people to get the ingredients needed to manufacture the highly addictive drug.

Retailers once resisted the idea, saying it would inconvenience consumers. Today, stores seem ready to go along with a federal law in hopes of avoiding a tangle of state regulations.

This month, a Senate committee plans hearings on a bill that sharply restricts the sale of cold and allergy pills containing pseudoephedrine. This ingredient is used to "cook" meth in makeshift labs across the country.

"There's a lot of public pressure to do something," said Sen. Jim Talent, R-Mo. He has joined with Sen. Dianne Feinstein, D-Calif., on a bill to limit the sale of cold medicines. "I think retailers - most of them - do not want to sell their products to meth cooks and they know they have to do something," Talent said.

The pharmaceutical industry has not raised major objections. Pfizer Inc., which makes Sudafed, supports a national standard that would put pseudoephedrine behind the counter, said a company spokesman, Jay Kosminsky. "I do think there really is an opportunity for a national consensus on this issue and I don't think there was a year ago," Kosminsky said.

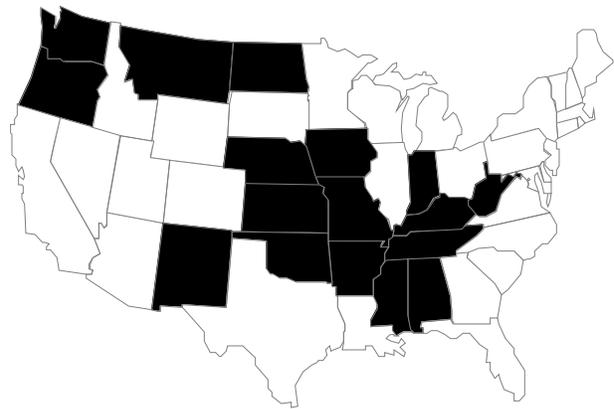
The meth problem is particularly severe in the Midwest, where rural areas provide cover for the pungent chemical odor from meth labs. In Missouri, law enforcement officers seized more than 2,700 meth labs last year - more than any

other state. The Senate bill is modeled on an Oklahoma law that took effect in April. The proposal would require the sale of medicines with pseudoephedrine only by a pharmacist or pharmacy personnel. Customers would have to show a photo ID, sign a log and be limited to 9 grams - or about 300 30-milligram pills - in a 30-day period.

The government can make exceptions in areas where pharmacies are not easily accessible. Kmart, Walgreens, Target, Wal-Mart and other leading retailers have put in place guidelines to move cold products behind pharmacy counters or limit their sales. Last month, the National Association of Chain Drug Stores endorsed a set of principles that includes limiting access to the drugs. "We do think it's time for a federal solution," said Mary Ann Wagner, the association's vice president of pharmacy regulatory affairs. "It's just becoming so complicated when you look at a map across the country and no two laws are anything alike." She said that store employees - not just those in the pharmacy - should be able to sell the medication as long as they are under a pharmacist's supervision.

Meth: A Heartland Problem

(states with greater than 10 lab seizures per 100,000 population)





The Bush administration has not taken a public position on the Senate bill. But John Horton, associate deputy director for state and local affairs for the White House Office of National Drug Control Policy, said early signs show that state laws are having a positive effect.

A report by the drug office last month found a 50 percent drop in the number of meth labs in Oklahoma and Oregon, two of the first states to enact laws restricting the purchase of pseudoephedrine-containing products.

“We know that when we prevent the methamphetamine cooks from getting the ingredients they need to make the meth, that the problem becomes smaller,” Horton said. Horton estimates about one-third of the meth comes from small labs in the United States, while two-thirds is smuggled in bulk from big labs outside the country, mainly Mexico.

Lt. Steve Dalton, supervisor of the Combined Ozarks Multi-Jurisdictional Enforcement Team, an anti-drug police task force in Branson, Mo., said the meth trade is the worst drug problem he has seen. “A federal law is not going to wipe it out, but if we can get away from the cleanup of these meth labs, it’s going to free up a lot of our time and we can target those that are bringing it in from across the border,” Dalton said.

State Anti-Meth Law Survives

By Jim Meyers, Tulsa World Washington Bureau

WASHINGTON -- A key Senate committee approved a bill Thursday to restrict sale of certain cold medicine after the bill's sponsors accepted an amendment by U.S. Sen. Tom Coburn to protect Oklahoma's landmark anti-methamphetamine law.

"This amendment will ensure that a federal 'one-size-fits-all' solution does not water down Oklahoma's successful law," the Oklahoma Republican said. "We can be proud that Oklahoma has set the gold standard in terms of anti-meth legislation. In fact, the federal bill adopts many of the standards already in Oklahoma's law."

Before Coburn's amendment was adopted, the bill by Sens. Jim Talent, R-Mo., and Dianne Feinstein, D-Calif., specifically pre-empted state laws against meth.

Coburn and at least one other Senate Judiciary Committee member objected to that provision. "The Judiciary Committee took a bold step today to combat methamphetamine abuse while respecting state's rights," said Coburn, who agreed to drop a second amendment to strip \$43 million out of the bill. With the Coburn amendment, Talent and Feinstein said their bill now provides a floor on anti-meth legislation. States are free to make stricter laws.

Using the Oklahoma law as a model, the Talent-Feinstein bill would move certain cold medicines containing pseudoephedrine behind pharmacy counters and limit how much one person can buy to 7.5 grams a month. Consumers also would be required to sign a log so retailers could track their purchases.

Oklahoma officials initially had backed the legislation but withdrew their support after learning the automatic pre-emption provision had been added.

Gov. Brad Henry had warned the bill threatened Oklahoma's dramatic success with its law.

The Drug Czar and Marijuana

John Walters, Director of the Office of National Drug Control Policy

(Washington, D.C.)—The Nation's Drug Czar, John P. Walters, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator, Charles G. Curie, joined with scientists and experts from the leading mental health organizations today to alert parents about the danger marijuana poses to their teens' mental health.

"A growing body of evidence now demonstrates that smoking marijuana can increase the risk of serious mental health problems," said Walters, Director of National Drug Control Policy. "New research being conducted here and abroad illustrates that marijuana use, particularly during the teen years, can lead to depression, thoughts of suicide, and schizophrenia. This is yet another reason that parents must stay closely involved with their teens and ensure that they are not smoking marijuana."

A number of prominent studies have recently identified a direct link between marijuana use and increased risk of mental health problems. Recent research makes a stronger case that cannabis smoking itself is a causal agent in psychiatric symptoms, particularly schizophrenia. During the past three years, these studies have strengthened that association and further found that the age when marijuana is first smoked is a crucial risk factor in later development of mental health problems.

A report released today from SAMSHA found that adults who first used marijuana before age 12 were twice as likely as adults who first used marijuana at age 18 or older to be classified as having serious mental illness in the past year than were adults who first used marijuana at age 18 or older.

"Kids today are using marijuana at younger ages, putting them at greater risk," said Charles G. Curie, SAMHSA Administrator. "We have found that the younger a person starts smoking marijuana, the greater the likelihood they have of developing an addiction and serious mental illness later in life."

"Mental health disorders such as depression and schizophrenia contribute to the mortality of our citizens, and suicide is one of the leading preventable causes of death," said U.S. Surgeon General Richard H. Carmona, M.D., M.P.H., F.A.C.S. "As a society we must do everything we can to promote mental health and prevent mental illness—and that includes keeping our kids drug-free. Parents and teens alike must realize the long-term effects marijuana can have on the brain."

Several recent studies have linked youth marijuana use with depression, suicidal thoughts and schizophrenia:

- * Young people who use marijuana weekly have double the risk of developing depression.
- * Teens aged 12 to 17 who smoke marijuana weekly are three times more likely than non-users to have suicidal thoughts.
- * Marijuana use in some teens has been linked to increased risk for schizophrenia in later years.
- * A British study found that as many as one in four people may have a genetic profile that makes marijuana five times more likely to trigger psychotic disorders.

Evidence has recently emerged that some people's genetic make-up may predispose them to be particularly vulnerable to the effects of marijuana on mental health. For instance, a major study out of the



Netherlands concluded that use of the drug "moderately increases" the risk of psychotic symptoms in young people but has "a much stronger effect" in those with evidence of predisposition.

"The nonchalance about marijuana in Europe and the U.S. is worrisome," said Neil McKeganey, Ph.D., Professor of Drug Misuse Research and Director, Centre for Drug Misuse Research, University of Glasgow, Glasgow, Scotland. "Marijuana is the first illegal drug that many young people use and teens don't view it as a serious drug, and when children are exposed only to advice from kids like themselves, the risks seem meaningless. We're starting to see marijuana in a new light given recent research into the connection between marijuana and mental illness."

This new evidence comes with a warning to parents, as they are the most important influence in their teens' lives when it comes to drugs. "Tell your teens the facts and tell them not to use marijuana," said Robert L. DuPont, M.D., President of the Institute for Behavior and Health, Inc., and a leading advocate for the power of parents in preventing drug use. "Take meaningful actions to see that they do not. A vital part of your job as a parent is helping your teen grow up drug-free."

As part of the Office of National Drug Control Policy's (ONDCP) National Youth Anti-Drug Media Campaign, this outreach effort features a compendium of recent research linking marijuana and mental illness and an Open Letter to parents on "Marijuana and Your Teen's Mental Health." The letter highlights some of the new research about the serious consequences of teen marijuana use on mental health and is signed by ONDCP and 12 of the Nation's leading mental health, behavioral health and addiction treatment organizations: American Psychiatric Association; American Academy of Child and Adolescent Psychiatry; American Society of Addiction Medicine; Asian Community Mental Health Services; Association for Medical Education and Research in Substance Abuse; Institute for Behavior and Health, Inc.; National Asian American Pacific Islander Mental Health Association; National Association of Addiction Treatment Providers; National Council for Community Behavioral Healthcare; National Latino Behavioral Health Association; National Medical Association; and the Partnership for a Drug-Free America. The letter begins appearing next week in USA Today and newspapers in the 25 largest cities nationwide, including The New York Times and The Washington Post, and will also run in The Nation, The National Journal, The National Review, The New Republic, Newsweek, Time and The Weekly Standard.

On the Media Campaign's Web site for parents, TheAntiDrug.com, adults can learn more about how marijuana affects the developing teen brain, including the links between marijuana and depression, suicidal thoughts and schizophrenia. Visitors can take a virtual tour of a human brain to learn how marijuana impairs, and even changes, the functionality of the centers responsible for maintaining overall mental health. Parents can also view responses from a qualified psychiatrist on the most common questions regarding marijuana and mental health.

For more information on the ONDCP National Youth Anti-Drug Media Campaign, visit www.MediaCampaign.org.

Medicalization of Marijuana? Supremes Say “Don’t Ask - Don’t Tell”

Fred Barbash, Washington Post Staff Writer, June 6, 2005

Editor’s Comments:

This section was intended to be a “point-counterpoint” debate over the medicalization of marijuana in Oklahoma. Per the June 6, 2005 U.S. Supreme Court ruling, the issue is now more muddled than ever and the role of the states marginalized. To-date 11 states have adopted allowing the medical use of marijuana.

The Supreme Court decision (1) affirms the supremacy of the federal law over state statute (2) allows the federal government to prosecute marijuana users in the 11 states (3) but does not strike down the 11 state laws. This seems to obfuscate rather than clarify and suggest a “don’t ask-don’t tell” policy. Given that it seems non-productive to debate the state policy for Oklahoma. But that is not to say some cannot try!

The Supreme Court ruled today [June 6, 2005] that the federal government has the power to prosecute the use of marijuana for medical purposes even in states that have enacted laws permitting it.

In a 6-3 decision, the court agreed with the Bush administration that the regulation of controlled substances, including marijuana, is the province of Congress without exception.

Nonetheless, the ruling does not strike down laws in California and several other states allowing medicinal use of marijuana. The court was not asked to declare such statutes illegal.

It means, however, that such laws will not protect anyone from federal prosecution should a U.S. attorney or the Department of Justice bring charges or order raids to stop the practice.

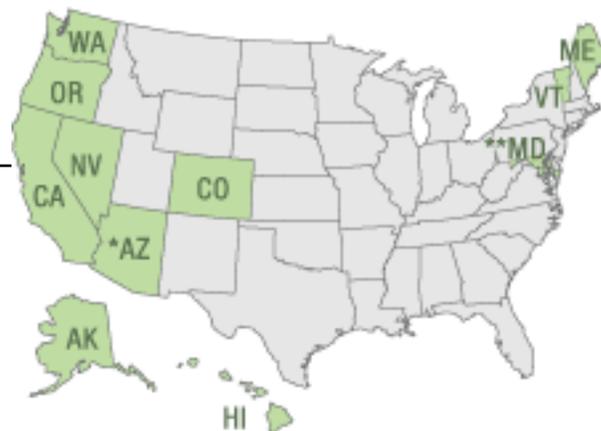
Justice Sandra Day O’Connor, who dissented today, saw the decision as effectively “extinguishing” experiments with medical marijuana laws.

Supporters of medicinal marijuana laws, on the other hand, said they believed that most individuals being treated with marijuana under state laws would be untouched by the ruling.

Daniel Abrahamson, of the Drug Policy Alliance, said that “it will take time for the dust to settle” but that when it does, things will be roughly the same, “an uneasy status quo. . . . States will be able to pass protections for marijuana patients and the federal government will remain free to go after them or not. . . .”

Supporters argued that the Controlled Substances Act, under which the federal government prosecutes drug violations, did not specifically bar limited drug use under a physician’s supervision when sanctioned by state law. Under these circumstances, they said, the federal government’s power to regulate drugs under the Constitution’s Commerce Clause is limited.

The argument by the 11 states relied heavily on two Supreme Court cases within the past 10 years, in which the court limited Congress’s power to



make laws in the name of regulating interstate commerce. The court ruled in 1995 that Congress could not criminalize the possession of guns near schools; in 2000, the court said Congress lacked the authority to give rape victims the right to sue their attackers in federal court. The court said the link between school gun violence or rape — both of which are already illegal under state law — and the national economy was too attenuated.

The Bush administration said that whether or not Congress specifically prohibited medicinal drug use, it has broad power over all aspects of drugs and medicine under the Commerce Clause.

The court agreed with the administration in an opinion written by Justice John Paul Stevens, who said that the Controlled Substances Act of 1970 was a valid exercise of federal power by the Congress “even as applied to the troubling facts of this case.”

Stevens said that Congress’ failure to specifically preclude the practice of medicinal marijuana did not make it exempt from federal regulation.

“We have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole” in the Controlled Substances Act.

Federal law, Stevens wrote, “designates marijuana as contraband for any purpose . . . The mere fact that marijuana — like virtually every other controlled substance regulated by the Controlled Substances Act — is used for medicinal purposes cannot possibly serve to distinguish it from the core activities regulated by the CSA.”

The patients in today’s case were Angel McClary Raich and Diane Monson, Californians who use marijuana as a medical treatment. Raich has been diagnosed with a number of disorders, including cancer, and used marijuana as a form of relief every other hour while she was awake.

Monson has been using marijuana for relief of severe chronic back pain and muscle spasms caused by a degenerative disease of the spine.

On Aug. 15, 2002, deputies from the Butte County Sheriff’s Department and agents from the U.S. Drug Enforcement Agency came to Monson’s home and got into a disagreement over the marijuana, with the deputies arguing that it was being legally used under California’s Compassionate Use Act while the DEA agents demanded that the drug be destroyed, which they ultimately did.

Monson and Raich, who feared prosecution, sued the U.S. government to stop further raids.

The ruling today reversed a decision of the 9th Circuit Court of Appeals.

Stevens said that the appellate court reached a different conclusion only “by isolating a separate and distinct class of activities that it held to be beyond the reach of federal power, defined as the intrastate, noncommercial cultivation, possession and use of marijuana for personal medical purposes on the advice of a physician and in accordance with state law.”

In addition, he said, “limiting the activity to marijuana possession and cultivation in accordance with state law cannot serve to place” the activities “beyond congressional reach.” The Constitution’s Supremacy Clause, he said, “unambiguously provides that if there is any conflict between federal and state law, federal law shall prevail.”

O’Connor was joined in dissent by Chief Justice William H. Rehnquist and Justice Clarence Thomas.

“This case exemplifies the role of states as laboratories,” she wrote.

“The states’ core police powers have always included authority to define criminal law and to protect the health, safety, and welfare of their

Marijuana! Supreme Court Just Says No

Daniel Henninger, Wall Street Journal Editorial Board, June 10, 2005

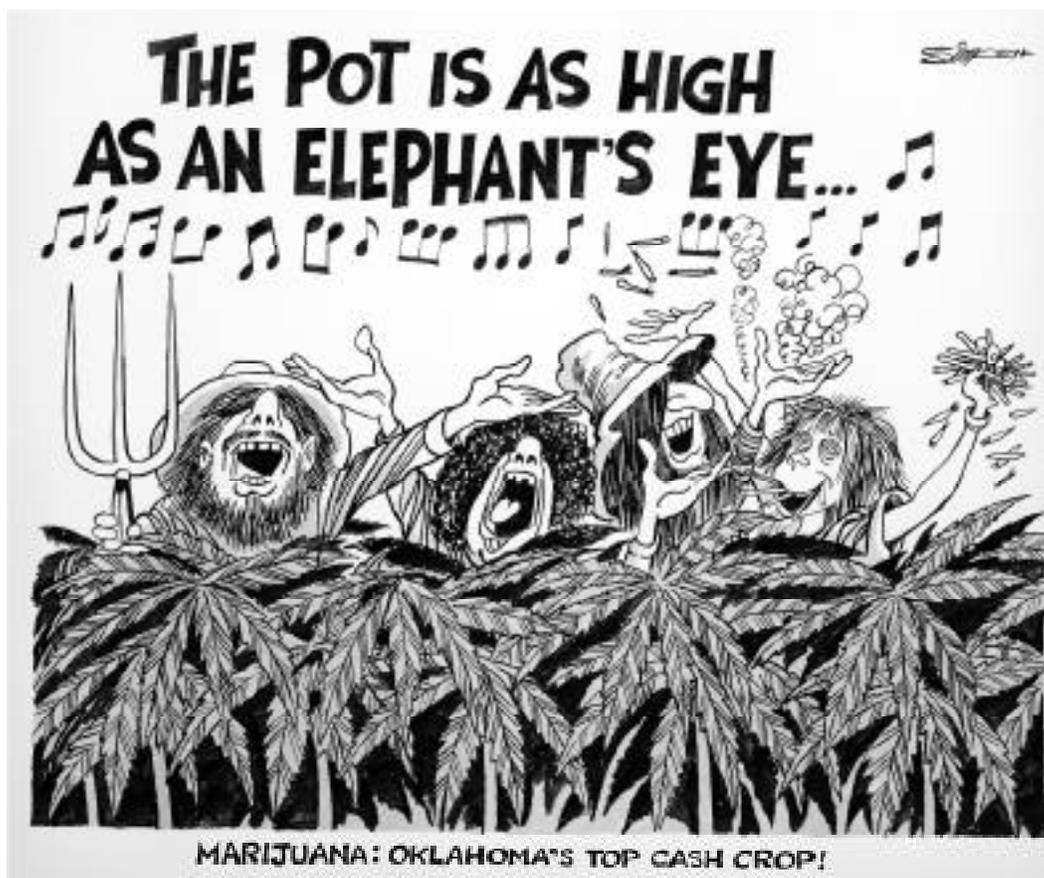
The Supreme Court's liberal bloc—Stevens, Ginsburg, Souter and Breyer—ensured Monday with the support of Justices Kennedy and Scalia that people sick from cancer treatment will have to think first about a house call from the federal drug police before using marijuana to relieve their symptoms. Even the Court's language was unfeeling: "The case comes down to the claim that a locally cultivated product that is used domestically rather than sold on the open market is not subject to federal regulation. Given the . . . undisputed magnitude of the commercial market for marijuana, *Wickard* and its progeny foreclose that claim."

Liberalism to cancer patients: Drop dead.

Meanwhile, dissents on behalf of medical marijuana were written by Sandra Day O'Connor, a cancer survivor, and Clarence Thomas, whose nomination was fought by recreational pot users.

Medical marijuana sounds simple. Cancer patients receiving chemotherapy often endure extreme nausea, and many say that smoking marijuana during chemo makes it bearable. Many of us know sober folks who have done this. So why is this a Supreme Court case? Because this is America, where nothing is so simple that it can't be turned into a federal case.

If the Court's four liberals had ruled in favor of state laws allowing medical marijuana, which federal law forbids, that precedent would have helped conservative efforts to reduce federal clout



Created for the Oklahoma Academy by David Simpson

in other areas, such as environmental authority in the West. Thus Justice Stevens wrote that the Controlled Substances Act, a Nixon-era law, “is a valid exercise of federal power, even as applied to the troubling facts of this case.” Liberals with cancer should take solace in knowing they will be vomiting to save the snail darter.

In his dissent, Justice Thomas, liberalism’s archfiend, noted: “The majority prevents states like California from devising drug policies that they have concluded provide much-needed respite to the seriously ill.” And: “Our federalist system, properly understood, allows California and a growing number of other states to decide for themselves how to safeguard the health and welfare of their citizens.”

This is an abstruse but important legal debate about the Commerce Clause and federal legal power in the 21st century. Liberals, if they wanted to, could recognize that letting the states take the lead on controversial issues involving behavior among consenting adults—both personal and commercial—might abet their beliefs in this day and age. But they won’t. Thus friends sick with cancer must choke down this decision.

Not all cancer patients are interested in the Hundred Years War underway between conservatives and liberals. They probably think common sense should allow Justice Thomas’s “much-needed respite.” The usual tangle of public policy makes that difficult.

American medicine isn’t adept at pain management. Writing in the *New England Journal of Medicine*, Drs. Jane Ballantyne and Jianren Mao said: “The recognition that opioid therapy [such as morphine] can relieve pain and improve mood and functioning in many patients with chronic pain has led experts on pain to recommend that such patients not be denied opioids. Despite this recommendation, many physicians remain uncertain about prescribing opioids to treat chronic pain and do not prescribe them.” They conclude even this article, however, by urging doctors to resist patients’ pressure to greatly increase opioid dosage.

Medical disagreement or confusion about pain treatment is only the start. Doctors with cancer patients also may have visited the Web site of the U.S. Drug Enforcement Administration—the aggressive federal cops. Beneath an image of a DEA police badge, one finds an article: “Exposing the Myth of Smoked Medical Marijuana.”

Studies of physician fear of prosecution have been done, which conclude that prosecutions of honest doctors prescribing such pain-killers are rare. That point was made in news articles the day after the medical marijuana decision. Late last year, I accompanied a patient with extreme spinal pain to the office of a pain specialist whose first words were that if the subject was opiate-based therapy, we should leave. End of conversation.

To address this concern, Congress several years ago took up the Pain Relief Promotion Act. It collapsed amid the controversy over physician-assisted suicide. Most docs already believe that the U.S. system of justice is irrational, and if patients have to share the pain, so to speak, that’s too bad.

Once-in-a-lifetime users of medical marijuana are also collateral damage in the war on drugs. Writing for the majority, Justice Stevens said, with approval: “Congress was particularly concerned [in 1970] with the need to prevent the diversion of drugs from legitimate to illicit channels.” Some argue, including proponents of drug legalization, that a Supreme Court imprimatur for medical marijuana would have no relevance to campaigns to legalize recreational use of this and other drugs. I don’t believe that. There isn’t much self-restraint in our activist politics.

What now? My guess is 99.99% of medical marijuana users won’t get prosecuted. Society’s disapproval of marijuana stays in place, but patients get their drug.

Live and let live.

Benevolent hypocrisy comes in handy in a free country when public politics, as now, often makes sensible solutions impossible.

Medical Marijuana? It's Called Marinol. It's Legal

U.S. Drug Enforcement Administration

- Medical marijuana already exists. It's called Marinol.
 - A pharmaceutical product, Marinol, is widely available through prescription. It comes in the form of a pill and is also being studied by researchers for suitability via other delivery methods, such as an inhaler or patch. The active ingredient of Marinol is synthetic THC, which has been found to relieve the nausea and vomiting associated with chemotherapy for cancer patients and to assist with loss of appetite with AIDS patients.
 - * Unlike smoked marijuana--which contains more than 400 different chemicals, including most of the hazardous chemicals found in tobacco smoke--Marinol has been studied and approved by the medical community and the Food and Drug Administration (FDA), the nation's watchdog over unsafe and harmful food and drug products. Since the passage of the 1906 Pure Food and Drug Act, any drug that is marketed in the United States must undergo rigorous scientific testing. The approval process mandated by this act ensures that claims of safety and therapeutic value are supported by clinical evidence and keeps unsafe, ineffective and dangerous drugs off the market.
 - There are no FDA-approved medications that are smoked. For one thing, smoking is generally a poor way to deliver medicine. It is difficult to administer safe, regulated dosages of medicines in smoked form. Secondly, the harmful chemicals and carcinogens that are byproducts of smoking create entirely new health problems. There are four times the level of tar in a marijuana cigarette, for example, than in a tobacco cigarette
 - Morphine, for example, has proven to be a medically valuable drug, but the FDA does not endorse the smoking of opium or heroin. Instead, scientists have extracted active ingredients from opium, which are sold as pharmaceutical products like morphine, codeine, hydrocodone or oxycodone. In a similar vein, the FDA has not approved smoking marijuana for medicinal purposes, but has approved
- the active ingredient-THC-in the form of scientifically regulated Marinol.
- The DEA helped facilitate the research on Marinol. The National Cancer Institute approached the DEA in the early 1980s regarding their study of THC's in relieving nausea and vomiting. As a result, the DEA facilitated the registration and provided regulatory support and guidance for the study.
 - The DEA recognizes the importance of listening to science. That's why the DEA has registered seven research initiatives to continue researching the effects of smoked marijuana as medicine. For example, under one program established by the State of California, researchers are studying the potential use of marijuana and its ingredients on conditions such as multiple sclerosis and pain. At this time, however, neither the medical community nor the scientific community has found sufficient data to conclude that smoked marijuana is the best approach to dealing with these important medical issues.
 - The most comprehensive, scientifically rigorous review of studies of smoked marijuana was conducted by the Institute of Medicine, an organization chartered by the National Academy of Sciences. In a report released in 1999, the Institute did not recommend the use of smoked marijuana, but did conclude that active ingredients in marijuana could be isolated and developed into a variety of pharmaceuticals, such as Marinol.
 - In the meantime, the DEA is working with pain management groups, such as Last Acts, to make sure that those who need access to safe, effective pain medication can get the best medication available.



The Drug Czar and Legalization

John Walters, Director of the Office of National Drug Control Policy

Recently, Britain went one step closer to legalizing drugs by decriminalizing the possession of cannabis. John P. Walters argues that legalizing drugs will merely trade a crime problem for a public health problem.

Pro-legalization arguments sound persuasive:

- Legalizing drugs would lower prices and eliminate the gangs and organized crime associated with illegal drugs.
- Drug offenders would not flood the prison system.
- Governments could regulate and tax drugs, increasing quality and raising tax revenue. Walters argues that these benefits are mostly illusionary and are easily outweighed by the health costs. He points out that drug abuse alone cost an estimated \$55 billion in 1998, not factoring criminal justice costs. Moreover, deaths directly related to drug use have more than doubled since 1980. When British physicians were allowed to prescribe heroin to certain addicts, the number skyrocketed from 68 in 1960 to over 20,000 in London alone by 1982. Legalizing drugs would increase use, abuse and death according to Walters.

Furthermore, Walters argues that the benefits are illusionary:

- For example, drug legalizers claim that 1.5 million American are arrested for drug crimes, flooding the prisons.
- However, Walter argues that most of those arrested do not serve jail time, and those that do, deserve it.
- Some 24 percent of state prison drug offenders are violent recidivists, while 83 percent have prior criminal histories.

Pointing out a New England Journal of Medicine article in 1999, Walter notes that cocaine use raises the risk of domestic violence by a factor of four. Other studies indicate that up to 80 percent of our child welfare caseload involves substance abusers. Walters asks if society could trust legal drug addicts to work as nurses or even bus drivers? And, what of female cocaine addicts becoming pregnant?

Source: John P. Walters, (director, National Office of Drug-Control Policy), "Don't Legalize Drugs," Wall Street Journal, Friday, July 19, 2002.

Portugal Assesses Softer Approach To Drug Users

Sara B. Miller | Special to The Christian Science Monitor, August 8, 2002

A year ago [2001] Lisbon decriminalized drug use. Views differ on whether the policy is effective.

www.csmonitor.com/2002/0808/p07s01-woeu.html

PORTO, PORTUGAL - In the shadowy labyrinth of cobblestone streets around this port city's 12-century Sé cathedral, heroin addicts have long been selling drugs and shooting up.

Police had hoped that the narcotics-infested neighborhood would change after Portugal's decision to decriminalize the use of all drugs. But a year after the sweeping initiative took effect, they say the scene, and their jobs, have changed little.

"There are no fewer people here today than a year ago," says one of three officers on the night shift, who asked that his name not be used since, officially, the police are in favor of decriminalization.

"The program has a good intention, but it isn't working. They go to rehabilitation and come right back. Or they are at rehabilitation by day and shooting up here at night."

Portugal, a main gateway for drugs entering Europe, has among the highest per capita rates of hard drug use in the European Union, with an estimated 80,000 heroin addicts in a population of 10 million. Decriminalizing drug consumption was intended to attack the problem at its source: With users given treatment and education instead of jail time, police could devote more time and resources to catching traffickers.

While an evaluation to be released later this month by the nation's Institute for Drugs and Drug Addiction points to some positive results over the past year, the frustrations, and the cost of the program, have some critics urging cutbacks.

The program is being watched by other countries in Western Europe, which has rejected the hard-line US approach and moved increasingly to lenient policies toward users.

Just last month, Britain, traditionally an anti-drug bastion, became the latest to follow the trend, announcing that private use of marijuana in small amounts will not result in jail time.

So far, Portugal has gone the furthest, decriminalizing the use – but not sale – of all drugs, from cannabis to cocaine. When users are caught, they are sent to one of the country's 18 newly created commissions staffed with social workers, legal advisers, and psychiatrists. The commission decides whether the user will be sent to a treatment program. Sanctions, such as revocation of passport or a fine for repeated offenses – typically about \$150 – can also be imposed.

The commissions also try to inspire users to look inward for motivation to quit, asking them such questions as: Why do you use drugs? How do you think you could stop the need?

The commission in Porto, which has seen 1,032 users in its first year, according to its president, Eduarda Costa, is in the city's business district. It has the sleek feel of a public relations office, with hardwood floors, top-40 music in the background, and a casually dressed young staff. The hope is that these commissions will serve as a kinder, gentler path to prevention and treatment than the court system did.

According to the national drug institute evaluation, of the 6,000 users who were sent to the commissions in the past year, some 1,600 have undergone treatment at the Prevention and Treatment of Drug Addiction Service, the public rehabilitation center.

“One of the most important things Portugal has learned this year is the importance of dissuasion,” says Elza Pais, the president of the government-run drug institute. “With the commissions, drug users are getting to treatment much faster.”

When the initiative was passed last year, it drew criticism from conservative politicians and some members of the Roman Catholic church. Paulo Portas, former leader of the Popular Party and now the nation’s defense minister, strongly condemned the law, concerned that it would turn the country into a haven for drug trafficking and drug tourism. Under the new program, trafficking is still a crime.

“There has been no indication that more traffickers have come to the country or that drug use or drug tourism is increasing,” says Vitalino Canas, a member of parliament who directed the program last year as the secretary of state under the Socialist government. He says that it is still too early to assess the full impact of the program.

It is unclear whether the program will result in more trafficking arrests. Since the start of the program in July 2001, 1,892 people have been caught for trafficking, about the same number as were caught last year.

Still, at least with regard to drug users, the public has a new perception that something is being done, says Pais. “The sense of impunity has disappeared, since consumers, when caught by the police, are considered very rapidly by [the commissions],” she says. “Before, processes could take as long as two years to be taken to court. Nowadays, within four to five weeks a decision is taken.”

When the new conservative government took office last spring, it threatened to abandon the program, says Danilo Ballotta, an expert at the European Union Monitoring Center for Drug and Drug Addiction in Lisbon. Instead, the program was moved under the health department to fit in line with the philosophy that drug users are patients, not criminals, and no major structural changes were made.

“It is very rare that a new government, of different colors, would take the same program and not change it. I think that shows it is working well and that the people are in favor of it,” Ballotta says. “[The government] realized that it is the trend in Europe – new legislation that softens policies toward drug users, just like in Spain and Italy.”

The government is considering cutting back the program, however.

Officials are studying the possibility of closing down some of the 18 commissions because, although Pais says that coordination between the police and the commissions is growing, not enough users are being sent to the commissions to keep them busy.

And other reductions may be on the way. “Treatment is controlled by outsources, and the problem is the cost,” Ballotta says. “Whenever public money is cut, one of the first places it is cut from is health.”

The decriminalization project is part of a comprehensive anti-drug campaign set to run until 2004, when a fuller assessment will be made. The campaign includes education and prevention programs in jails and in classrooms, from elementary school to college; media initiatives; and information programs in parent associations.

One of the major components is risk-reduction, including needle exchange programs, methadone centers, and street teams of health care workers who drive around drug-infested neighborhoods and distribute information along with clean needles.

According to the national drug institute’s web site, public spending is to increase 10 percent per year until 2004, up to \$1.53 billion.

The program is having an important impact on public opinion, according to the national drug institute’s evaluation.

“We are experiencing a revolution of mentalities,” says Pais, “which facilitates the social integration process so that drug users aren’t marginalized.”

Pandora's Pharmacy

Beyond Medical and Legal: A Religious Perspective of Drug Misuse

A. Theodore Kachel, Tulsa

Once you've opened "Pandora's Pharmacy" you can not selectively close it again. Drug misuse is a part of drug use, and no one is proposing to give up "better living through chemistry" which the Twentieth century has given us. Learning to live with our drug usage in good health, medically, legally, socially, recreationally, and let's add religiously, is the challenge for public policy makers. We shall have to find new ways to live with our widespread drug usage in general if we are to find new means for managing or avoiding misuse. Prohibition will never work for this reason in any long run.



De-criminalization of some substances we have classified as "bad" drugs has already begun in the D.U.I. and Drug Court programs. We know this is the first rational step toward better management of this issue, and so, steps towards the legalization of all psychoactive substances is the public policy problem we face today. Why and how to do so requires us to re-imagine the place of psychoactive experiences in human life. The final framework, often taken-for-granted, is religious and moral, rather than legal or medical. The way you define human nature, biologically, psychologically, and spiritually will largely determine your public policy approach to drug use or misuse.

The human quest for ecstasy is as fundamental a need as the drives to satisfy sexual desire and hunger. It is an organic necessity for sanity and survival. What then is ecstasy? Let us define it by the etymology of the word itself, from the Greek, *ekstasis*, "to stand outside of the self." The proof of this is found in our daily need to sleep and to dream.

The extensive research on sleeping and on dreaming is what persuades me of our brain's need

for regular ecstatic experiences. This need is so basic that each night we necessarily lose our selves in our dreaming. Also this is not an optional quest but a necessity for healthy function during the daytime. (See, J. Allan Hobson. *Dreaming: an Introduction to the Science of Sleep*. Oxford., and Michel Jouvet. *The Paradox of Sleep: The Story of Dreaming*. MIT Press.)

These neurologists report on years of research into the cycles of REM, rapid eye movement, and non-REM sleep which all warm-blooded mammals need each night to maintain the brain's sanity and ability to function during the day's wakefulness. Dreaming is necessary to maintain individuality as well as survival skills. Sleep deprivation as any intelligence service can testify is a direct means for reducing the individual's ability to function when confined and under intense questioning. Deny us our dreaming ecstasy and we lose our humanity.

The analogue for dreaming and drug experience in the history of religions is the ritual quest for mystical, conversionary, Pentecostal, and other extreme spiritual experiences. How did I come to view it this way? First, I did my PhD sociology of religion dissertation at Columbia University by doing field research about psychedelic drug usage of a newly forming religious community. (See, Kachel, *An American Religious Community Using Hallucinogens in 1970*. University Microfilms, Ann Arbor, MI, 1975.) This involved, not only participant observation from 1969 to 1970 of this specific community, but also considerable background research in the history of religions, anthropology of shamanism, ethnobotanical research on hallucinogenic plants, and medical-psychiatric studies of modern therapeutic use and addiction. Widespread usage of psychoactive

substances is ancient, geographically global, and occurred at one time or another in many religious traditions. Yet none of the seven major religious traditions kept this form of religious experience central to their ritual or meditative practices. Today's religious drug usage is restricted to native communities here in the USA, and abroad in Africa and South America, often isolated from the mainstreams of the urban world.



Second, in defining what was the common characteristic of religious experience throughout the history of religions I discovered that the search for ecstatic experience is what all shared, despite considerable variation in content of and the spiritual techniques used to seek it out. Religious communities have developed many ways to do this: prayer and fasting, deep breathing, mediation for long periods of time, automatic speaking in 'tongues,' whirling dances, and/or withdrawals into isolated caves or deserts where the senses are deprived of new experiences. Mystics then report a loss of the personal self and then its replacement by a presence of Ultimate Reality.

The religious community I studied used their psychoactive substances, e.g. LSD, psilocybin, peyote tea, and marijuana, and reported their own version of this loss of self and this emergent presence of a larger Reality. Therefore, as a phenomenon there is no difference in these transpersonal experiences between what comes from the traditional religious techniques and the hallucinogens. But is this natural or healthy way to be religious, to engage in a quest for ecstatic experience as a part of your religious life?

If dreaming is a clue to the human need for regular ecstatic experience for healthy functioning, then perhaps the danger in the waking usage of psychoactive drugs is that you are not physically paralyzed as you are when you are sleeping. Therefore, it is not surprising that a religious usage of these substances where they are focused by

rituals is how their most beneficial effects for the individual as well as the larger community were achieved. These rituals, i.e. **repetitive patterned performance**, moreover, might be religious, therapeutic, educational, and/or sensually playful. In this manner the newly experience energies and their physical and psychological effects would be held together for the individual by other humans sharing or guiding their experience.

Yet dreaming may not offer us complete guidance in what to expect in the waking psychoactive drug states. The best research on dreams is very divided on the meaning of a dream's content.

Scientists and other interpreters range from those who think it is the brain's "garbage dumping" and then "re-wiring" for better survival skills for tomorrow, to others who think the ancients were correct in seeing these irruptions into the individual's un-consciousness as a Presence which was more Real than our ordinary waking experiences of reality. Such "visions" play important roles in the history of religions also. It is clear this "more real" is what religious mystics seek, and confirm in their reports.

Others find a middle ground for their explanation of dreaming content which is focused as Freud did on the individual's deepest lived experiences which are now embedded below immediate self-awareness. In recovering them the individual can heal or ennoble their emotional, spiritual and productive waking life when these dreams are given a meaningful interpretation. Much research by psychiatrist and others before the hallucinogens were made illegal suggested that other possible insight, somatic, and integral therapies could be helped by their usage by a skillful practitioner therapeutically with selected clients.

The deepest, but also, most pressing mystery is why with all the societal effort to stop this

psychoactive drug usage it persists, even if you allow for some cycling of the actual numbers up and down, and appears despite official protests to the contrary, to be on a gradual upward slope in our immediate time in America. Demand has always and consistently exceeded supply, legal and illegal. My speculation is two fold.

The first is not surprising for I believe we are religious social animals. There is a gap in us that rationality does not answer. Whether this gap emerges because of our early and continuing knowledge that we will die, and as Freud insisted the individual's unconscious can never imagined or accept that. Or rather it is revealed simply in our need for daily sleep, where we are caught up in the ritual regularity of night following day on our planet, and this larger rhythm of the universe roots individual consciousness in deeper and more connected ways than we have discovered yet or even imagined in our wildest religious visions.

The second is less ethereal and more psycho-sociological focus on my experience of the 1960's when I did the research, and now watching several generations of American adolescents struggle to graduate from childhood to adulthood without much cultural guidance or ritual forms for safe, unforgettable, and irreversible passage as was always the case before this modern and post-modern era.

Look at what we offer them.

Around sixteen, you can get your driver's license and join the religion of automobile-ing yourself, you girl friend, and others up and down the endless streets to no-where! Wow—no wonder James Dean was a *Rebel Without a Cause*, because there was no there there! Then there is the High School Prom—a ersatz sexual initiation ceremony remarkably unchanged for both “boy-men” and “girl-women” since I had mine in 1955—fifty years ago. Lead Belly's dirty ditty cleaned up as the last song from the dance band—“Good Night,

Irene, I'll [get] see you in my dreams!” A prisoner's lament is what brackets these lost adolescents, or maybe now it has been at least changed to the more obvious “I Can't Get No Satisfaction!” from the Eternal Bad Boys—the Rolling Stones

There is, of course, a deep public policy irony about illegal synthetic drugs, e.g. methamphetamines, LSD, and others, for they were developed and used by the military and intelligence agencies before they became popular in the Streets of America. Now we label them “dangerous” since they escaped from war-making to pleasure-seeking usage. There is no doubt about this danger. Yet, if we are to make sense of it, we also must see today's usage and misuse within the larger social and economic context in which it exists.

It has been said that “You learn to use drugs at your momma's knee!” From our earliest memories since WWII in doctor's offices and in family homes we give pills to our children to ease pain, cure illnesses, and to improve performance in schools. Often they do just as they are supposed, even though controversy remains about even this legal usage. The general point is that it should not surprise us that even those drugs we later label “bad,” may seem “good” to some of us, to relieve pain, real or imagined, to cure our emotional distress, and to enhance our performance in music, art, or truck-driving. We all believe we can handle it.

Then there is the widespread marketing to us all on billboards, magazines, newspapers, radio, television, and in product placements in the movies, of the relaxing or curative effectiveness of various psychoactive or pharmacological substances. Nicotine remains legal, but can only advertise in certain places or times, mainly sporting events, where we seek enhanced performance. Of course, that has led to steroid scandals, too. Wine, beer, and maybe soon liquor advertisements will finally become ubiquitous, and



this common ancient psychoactive substance sustains its lead in death and in disease among them all.

Despite commentary both right and left and up and down this country no one wants to return to prohibition here, although the current White House Drug Czar, John Walters, has a few good things to say about the success of Prohibition as he leads our War on Drugs today in order to win his case for why we will slow down usage if we just keep it up on the present crop of stigmatized substances. On the other hand, perhaps we can not put the Genii back in the bottle after all, because we are “wired for dreams” and various psychoactive drugs may just be another, possibly more controlled way, to benefit from this natural capacity and biological necessity.

So, what shall we do? Let us turn again to a religious frame to consider policy alternatives. Probably one of the most successful legal traditions in the USA is found in the way we constitutionally organized our religious lives in America. Jefferson called it the “separation of church from the state.” Unsurprisingly, he placed it in the First Amendment, saying there: “Congress shall make no law respecting the establishment of religion, or prohibiting the free exercise thereof;” making it the first freedom which underlies all the others.

If we grant for a moment that “we, the people” with our God given “inalienable rights to life, liberty and the pursuit of happiness,” have an organic need for ecstatic experience, then perhaps if we might treat this as a religious need, and then reframe how we deal with drugs that produce a similar ecstatic experience as potentially as deepening and as healing of our spirits if allowed to flourish as we have leaned to allow our religions in America, too.

So, first, we set as a social goal of any new public policy initiatives the removal of absolute legal prohibition of any class of psychoactive substances. We, moreover, recognize that religious

usage does not mean anything goes anymore than we agree to allow polygamy, or animal sacrifices, or drunken orgies in our congregations. This is shifting our frame for thinking to the “free exercise” clause about drug use and misuse.

Next there is the question of how we began to implement the “establishment clause.” How might we prevent an official Brave New World version of religious drug usage which would be simply another form of political or social control of people by the government, or any other large corporate entity? It is the latter pharmaceutical



industry with its belief in the quest for economic success regardless of social costs that today seeks any means necessary to “establish” market control of us through endless promotion of their products by symbolic manipulation of our fundamental sense of self.

What is truly ‘sacred’ about drug usage today in America? Is it not the right to make money off of it, legal or illegal? This is the taken-for-granted ersatz religion of market place capitalism. When it comes to drug usage in the quest for organic ecstasy, and the temporary or enriching release from our selves safely, it is this behemoth which needs to be stopped legally. This is the underlying problem for drug use and misuse in America today. Demand, perhaps, is a real organic need, but

A “Conservative” Case for Decriminalizing Drugs

Gary Krasner, Coalition For Informed Choice

Gary Krasner grew up in the Bronx in the 50's through the 70's. He moved to Queens in 1975 after obtaining a B.S. degree in Psychology from CCNY. Today, Mr. Krasner works as a computer graphics artist by day. By night he runs Coalition For Informed Choice, a non-partisan organization that promotes personal freedom of choice in decisions involving our health. (06/19/04). www.americandaily.com/article/1551)

I thought I would tackle an issue in which conventional political partisans do not line up evenly. There may be as many Republicans who support drug decriminalization as there are Democrats who feel similarly. While those who desire drug decriminalization may be in the minority, we normally don't see this level of cross-party consensus on most issues. On that basis alone, it might seem that this is an issue that has appeal on its merits and represents an efficacious rationale for reforming a failed status quo policy. Despite the low degree of party partisanship, this issue still attracts a good share of shameless sloganeering that decriminalization ‘sends the wrong message to kids’; cheap political grandstanding that drug abuse will increase; self-righteous sermons about the immorality of permitting drug use; embellishments that drugs will be as available as cigarettes or liquor; race peddling by claiming that minorities will be most adversely affected; and misstatements of fact that drug abuse has declined.

Let's examine a common argument from liberal opponents of decriminalization: That drug dealing has devastated their communities and increased crime. Let's admit to some self-evident facts. First, that drug abusers are “criminals” solely as an artifact of the controlled substances laws: Either because they're caught using drugs, or because of the high cost of drugs that forces users to rob, steal, or prostitute themselves. The high cost of drugs is itself solely an artifact of its illicit status!

Let's also admit that drug dealers are not in business to hurt people. They're in it for the money. The harm that drugs do to their clients is an

incidental matter to them. They're on the street corner selling drugs because drugs can be sold at high profit margins, because it's a black market product (no pun). If drugs can be obtained at the pharmacy with a prescription or permit, then drug dealers will be gone from the street. Gang and mob violence over the control of the streets where drugs are sold would also disappear.

White Man in Harlem

It was particularly ironic that former President Clinton rented his office in Harlem, as it was he and other vocal opponents of decriminalization who successfully used race and drugs as a wedge issue solely for political gain. The following vignette also represents how cynical and decadent our body politic and (what amounts to) discourse has become as a result of the current drug policy:

The disparity in sentencing for possession of cocaine is far greater than for heroin. And since the less expensive cocaine is used in a greater ratio by blacks, it has resulted in more convicted blacks going to prison for disproportionately longer periods than for the same offense committed by whites selling or using heroin.

Instead of seeking to resolve this inequity, President Clinton used it as a racial wedge issue. In his campaign for re-election, President Clinton frequently implied—and echoed by black Democratic members of Congress—that the disparity in these drug penalties was created by racially prejudiced Republicans.

In reality, these drug penalties were originally intended to save black and poor communities from the ravages of crack-cocaine. In the early 1980s, (anti-decriminalization advocate) Congressman Charles Rangel and the Congressional Black Caucus were alarmed by the adverse effects that these cheap drugs had on their neighborhoods, and consequently had forcefully lobbied for stiffer penalties for the sale and possession of cocaine.

They got what they wanted. And 10 years later, in a political environment where perception and

preconception are reality, the issue was tailor-made for Clinton.

If anyone doubted that it was nothing more than a wedge issue for Clinton, such doubts were eliminated by the time of his second term as President. Because by then, Congress approved more equitable sentencing guidelines. And the punch-line? Clinton vetoed it(!)—despite the fact that it was a politically safe time (in his second term) for him to enact it.

It doesn't end there. One of the (record number of) white men Clinton pardoned was a man who was convicted for possessing 800 pounds of cocaine, presumably destined for a neighborhood like Harlem. He was pardoned because his father was a large contributor to the Democratic Party.

Clinton had always counted on the African-American community whenever he got into trouble. That move he made into Harlem wasn't his first choice. It was damage control for the fallout from the pardons. But did Harlem really need another "dealer" living there?

Imagine a World...

As a Natural Hygienist, I haven't taken so much as an aspirin in 35 years. My dentist is still amazed that I refused all anesthesia when he installed crowns for me several years ago. So I don't have any pro-drug agenda. My agenda is just good public policy.

Decriminalization of illicit drugs would lead to the following:

- Virtually overnight, the price of formerly controlled substances would plummet. All street crime, money laundering, gang violence, (etc.), and the corresponding corruption in law enforcement that involves drugs, would disappear. The power of organized crime and drug cartels would decline drastically, with beneficial ripple effects throughout our society. The greatest improvement will be seen in impoverished communities. Street dealers will be gone. So will be maximum minimum sentences, that have led to lengthy and costly (to the taxpayers) incarceration of non-violent

offenders, that has exacerbated the breakdown of families and communities.

- Based upon past experience (prohibition of alcohol), we can expect a slight and temporary rise in drug abuse, which would eventually decline and level off, partly because of more robust and better-funded prevention programs (from the billions of dollars saved from drug enforcement that's no longer needed), and also because studies indicate there's a percentage of "addictive personalities" who will seek out drugs whether they're legal or illegal. Most of us, for example, will not use recreational drugs once they're decriminalized.
- People addicted to drugs would be registered with the government and encouraged to detoxify. In the meantime, the substances that we provide addicts will be less potent and free of harmful contaminants. Pharmaceutical companies would make safer substances to wean abusers off of the most addictive and psychoactive substances. Again, the billions formerly spent on drug enforcement could fund all this. (Over \$20 annually at the federal level alone.)

The only way societies have been able to control the transactions of items in great demand was by controlling its legal commerce, and never through total prohibition. Prohibition forces the commerce underground and makes it invisible. It never stops it. Supply inevitably meets demand. Always.

Prohibition also poses special problems for open societies like ours. The regulators operate in the open, while the violators operate in secret, without any rules. The former are vulnerable to bribery; their families threatened; etc. Unless we're prepared to inaugurate a police state, with secret trials, and police, prosecutors, jurists and jurors forced to wear masks to conceal their identities (for their own safety), all notions of effective drug enforcement and interdiction is a false promise.

Let's drop the facade that we may lose "respect for law" or that we risk "tearing apart the moral fabric of our society". We can also ignore the "deadheads" that favor this. Strictly from a rational public policy standpoint, decriminalizing drugs is a no-brainer (no pun)."

A “Libertarian” Case for Decriminalizing Drugs

Milton Friedman, University of Chicago

Editor’s Comment:

Just because one is a Nobel prize winner does not mean that one knows all the right answers. But Dr. Friedman’s arguments are reasoned and rational. Whether or not they are “right” is up to us.



The following is an excerpt from "Friedman & Szasz On Liberty and Drugs." (www.druglibrary.org/schaffer/Misc/friedm1.htm) It is from a 1991 interview on "America's Drug Forum," a national public affairs talk show that appears on public television stations. Randy Paige is an Emmy Award-winning drug reporter from Baltimore, Maryland; Professor Milton Friedman has been a Senior Research Fellow at the Hoover Institution on War, Revolution, and Peace at Stanford since 1977, and is considered the leader of the Chicago School of monetary economics. Professor Friedman won the Nobel Memorial Prize in Economic Science in 1976, and is also the recipient of the National Medal of Science and the Presidential Medal of Freedom by the U.S. government in 1988.

Paige: Let us deal first with the issue of legalization of drugs. How do you see America changing for the better under that system?

Friedman: I see America with half the number of prisons, half the number of prisoners, ten thousand fewer homicides a year, inner cities in which there's a chance for these poor people to live without being afraid for their lives, citizens who might be respectable who are now addicts not being subject to becoming criminals in order to get their drug, being able to get drugs for which they're sure of the quality. You know, the same thing happened under prohibition of alcohol as is happening now.

Under prohibition of alcohol, deaths from alcohol poisoning, from poisoning by things that were mixed in with the bootleg alcohol, went up sharply.

Similarly, under drug prohibition, deaths from overdose, from adulterations, from adulterated substances have gone up.

Paige: How would legalization adversely affect America, in your view?

Friedman: The one adverse effect that legalization might have is that there very likely would be more people taking drugs. That's not by any means clear. But, if you legalized, you destroy the black market, the price of drugs would go down drastically. And as an economist, lower prices tend to generate more demand. However, there are some very strong qualifications to be made to that.

The effect of criminalization, of making drugs criminal, is to drive people from mild drugs to strong drugs.

Paige: In what way?

Friedman: Marijuana is a very heavy, bulky substance and, therefore, it's relatively easy to interdict. The warriors on drugs have been more successful interdicting marijuana than, let's say, cocaine. So, marijuana prices have gone up, they've become harder to get. There's been an incentive to grow more potent marijuana and people have been driven from marijuana to heroin, or cocaine, or crack.

Paige: Let us consider another drug then, and that is the drug crack.

Friedman: Crack would never have existed, in my opinion, if you had not had drug prohibition. Why was crack created? The preferred method of taking cocaine, which I understand was by sniffing it, snorting it, became very expensive and they were desperate to find a way of packaging cocaine...

Paige: The entrepreneurs?

Friedman: Of course, they're entrepreneurs. The people who are running the drug traffic are no different from the rest of us, except that they have more entrepreneurial ability and less concern about not hurting other people. They're more irresponsible in that way. But they're in business and they're trying to make as much as they can. And they discovered a good way to make money was to dilute this crack with baking soda or whatever else--I mean, cocaine, whatever else they do--I don't know the procedure--so that they could bring it out in five dollar and ten dollar doses.

Paige: Let's talk about that more in a minute. But with regard to crack, considering the fact that it's very addictive and considering the fact that...

Friedman: That's very dubious. It is addictive, but I understand from all the medical evidence that it's no more addictive than other drugs. In fact, the most addictive drug everybody acknowledges is tobacco.

Paige: Well, let me rephrase that then. All of the information I've seen on it suggests that it is a drug which is very pleasurable.

Friedman: Absolutely, no doubt.

Paige: And the effect of it is also very short.

Friedman: Yes.

Paige: And it is very expensive because multiple doses cost a lot of money. My question is: If drugs were legalized and if crack cocaine were available at a low cost, could it not be devastating in that it is so pleasurable, I am told, that more people could get it and stay on it for longer periods of time?

Friedman: Well, maybe. Nobody can say with certainty what will happen along those lines. But I think it's very dubious, because all of the experience with legal drugs is that there's a tendency for people to go from the stronger to the weaker and not the other way around, just as you go from

regular beer to light beer. That's the tendency that there is: from cigarettes without filters to low-tar, filtered cigarettes, and so on. But I can't rule out that what you're saying might happen, but, and this is a very important but, the harm that would result from that would be much less than it is now, for several reasons. The really main thing that bothers me about the crack is not what you're talking about, it's the crack babies, because that's the real tragedy. They are innocent victims. They didn't choose to be crack babies any more than the people who are born with the fetal alcohol syndrome.

Paige: As you now, we are already experiencing epidemic proportions of that. One out of every four babies going into one hospital, I can tell you, in Maryland is addicted.

Friedman: But I'll tell you, it isn't that crack babies are necessarily addicted, but they tend to come in at low birth weight, they tend to come in mentally impaired, and so on. But you know that the number who do that from alcohol is much greater. So, the same problem arises there. That's what bothers me.

Now suppose you legalized. Under current circumstances, a mother who is a crack addict and is carrying a baby is afraid to go the prenatal treatment because she turned herself into a criminal, she's subject to being thrown in jail. Under legalized drugs, that inhibition would be off. And, you know, even crack addicts, mothers, have a feeling of responsibility to their children.

And I have no doubt that under those circumstances, it would be possible to have a much more effective system of prenatal care, a much more effective system of trying to persuade people who are on drugs not to have children or to go off drugs while they have children.

Paige: Let us turn to the early genesis of your belief that the drug laws may not be working the way the nation would hope them to. Tell me about the elements that you saw early on that changed your mind or changed your way of thinking.

Friedman: Well, I'm not saying "changed." I would rather say "formed" my way of thinking, because I do not recall at any time that I was ever in favor of prohibition of either alcohol or drugs. I grew up-- I'm old enough to have lived through some part of the Prohibition era.

Paige: And you remember it?

Friedman: I remember the occasion when a fellow graduate student at Columbia from Sweden wanted to take me downtown to a restaurant for a Swedish meal and introduced me to the Swedish drink aquavit. This was a restaurant at which this Swedish fellow had been getting aquavit all during Prohibition; they had been selling it to him. And this was just after the repeal of Prohibition. We went there and he asked them for some aquavit. They said, "Oh, no, we haven't gotten our licence yet." And finally, he talked to them in Swedish and persuaded them to take us into the back where they gave us a glass of aquavit apiece. Now that shows the absurdity of it.

Prohibition was repealed in 1933 when I was 21 years old, so was a teenager during most of Prohibition. Alcohol was readily available. Bootlegging was common. Any idea that alcohol prohibition was keeping people from drinking was absurd. There were speakeasies all over the place. But more than that. We had this spectacle of Al Capone, of the hijackings, of the gang wars...

Anybody with two eyes could see that this was a bad deal, that you were doing more harm than good. In addition, I became an economist. And as an economist, I came to recognize the importance of markets and of free choice and of consumer sovereignty and came to discover the harm that was done when you interfered with them. The laws against drugs were passed in 1914, but there was no very great enforcement of it.

Paige: That was the Harrison Act?

Friedman: The Harrison Act. There was no very great enforcement of it until after World War II, by

which time I had been able to see the harmful effects of price control, of rent control, of other attempts for government to interfere with market things. So, it never occurred to me to be in favor of it.

Paige: Was there any single event, anything you happened to witness that made an impression upon you or was it...

Friedman: No, there was no single event. It was a cumulative effect.

Paige: Of course, you know that there are those who say that when Prohibition was over with, consumption dramatically increased and that it would be a...

Friedman: I beg your pardon, that's simply not true. That's not a fact. What is true...

Paige: It has been argued. That has been argued.

Friedman: You have statistically reported figures in the books on the amount of alcohol consumed. That went up sharply right after Prohibition, but that was "illegal" alcohol consumption. If you take, as I have done, the chart of alcohol consumption before and after Prohibition, alcohol consumption after Prohibition came back roughly to where it was before, and, over the course of the period since then, if anything, alcohol consumption has been going down not in absolute terms, but relative to the population and relative to the growth of income.

For a time, it went up rather slowly, along with income, with one exception. During WW II, it shot way up. But that's what happened during WW I. Of course, you never would have gotten Prohibition if you hadn't had all the young men away in France when the vote was taken, so that the women had an extraordinary influence on it. But the same thing happened during WW II. And then after WW II, it settled down again. And more recently, the consumption of alcohol has been going down on a per capita basis. So, it simply is not true that there was a tremendous increase.

Friedman: So far as drugs itself is concerned, some years ago, Alaska legalized marijuana. Consumption of marijuana among high school students in Alaska went DOWN. The Dutch, in Holland, do not prosecute soft drugs, like marijuana, and they would prefer not to prosecute hard drugs, but they feel impelled by the international obligations they've entered into, and consumption of marijuana by young people has gone down. And, equally more interesting, the average age of the users of hard drugs has gone up, which means they're not getting any more new recruits.

So, the evidence is very mixed. But I have to admit that the one negative feature of legalizing drugs is that there might be some additional drug habits. However, I want to qualify that in still another way.

The Child who's shot in a slum in a pass-by-shooting, in a random shooting, is an innocent victim in every respect of the term. The person who decides to take drugs for himself is not an innocent victim. He has chosen himself to be a victim. And I must say I have very much less sympathy for him. I do not think it is moral to impose such heavy costs on other people to protect people from their own choices.

Paige: For us to understand the real root of those beliefs, how about if we just talk a minute about free market economic perspective, and how you see the proper role of government in its dealings with the individual.

Friedman: The proper role of government is exactly what John Stuart Mill Said in the middle of the 19th century in "On Liberty." The proper role of government is to prevent other people from harming an individual. Government, he said, never has any right to interfere with an individual for that individual's own good.

The case for prohibiting drugs is exactly as strong and as weak as the case for prohibiting people from overeating. We all know that overeating causes more deaths than drugs do. If it's in principle OK for the government to say you must not consume

drugs because they'll do you harm, why isn't it all right to say you must not eat too much because you'll do harm? Why isn't it all right to say you must not try to go in for skydiving because you're likely to die? Why isn't it all right to say, "Oh, skiing, that's no good, that's a very dangerous sport, you'll hurt yourself"? Where do you draw the line?

Paige: Well, I would bet that former drug czar William Bennet, some other folks along those lines, would probably suggest that the present sale and distribution of illegal drugs is, in fact, an enterprise which harms another person and the government has to step in...

Friedman: [Simultaneously] It does harm a great many...

Paige:...to protect the vulnerable.

Friedman: It does harm a great many other people, but primarily because it's prohibited. There are an enormous number of innocent victims now. You've got the people whose purses are stolen, who are bashed over the head by people trying to get enough money for their next fix. You've got the people killed in the random drug wars. You've got the corruption of the legal establishment. You've got the innocent victims who are taxpayers who have to pay for more and more prisons, and more and more prisoners, and more and more police. You've got the rest of us who don't get decent law enforcement because all the law enforcement officials are busy trying to do the impossible.

Friedman: And, last, but not least, you've got the people of Colombia and Peru and so on. What business do we have destroying and leading to the killing of thousands of people in Colombia because we cannot enforce our own laws? If we could enforce our laws against drugs, there would be no market for these drugs. You wouldn't have Colombia in the state it's in.

Paige: Is it not true that the entire discussion here, the entire drug problem is an economic problem to...

Friedman: No, it's not an economic problem at all, it's a moral problem.

Paige: In what way?

Friedman: I'm an economist, but the economics problem is strictly tertiary. It's a moral problem. It's a problem of the harm which the government is doing.

I have estimated statistically that the prohibition of drugs produces, on the average, ten thousand homicides a year. It's a moral problem that the government is going around killing ten thousand people. It's a moral problem that the government is making into criminals people, who may be doing something you and I don't approve of, but who are doing something that hurts nobody else. Most of the arrests for drugs are for possession by casual users.

Now here's somebody who wants to smoke a marijuana cigarette. If he's caught, he goes to jail. Now is that moral? Is that proper? I think it's absolutely disgraceful that our government, supposed to be our government, should be in the position of converting people who are not harming others into criminals, of destroying their lives, putting them in jail. That's the issue to me. The economic issue comes in only for explaining why it has those effects. But the economic reasons are not the reasons.

Of course, we're wasting money on it. Ten, twenty, thirty billion dollars a year, but that's trivial. We're wasting that much money in many other ways, such as buying crops that ought never to be produced.

Paige: There are many who would look at the economics--how the economics of the drug business is affecting America's major inner cities, for example.

Friedman: Of course it is, and it is because it's prohibited. See, if you look at the drug war from a purely economic point of view, the role of the

government is to protect the drug cartel. That's literally true.

Paige: Is it doing a good job of it?

Friedman: Excellent. What do I mean by that? In an ordinary free market--let's take potatoes, beef, anything you want--there are thousands of importers and exporters. Anybody can go into the business. But it's very hard for a small person to go into the drug importing business because our interdiction efforts essentially make it enormously costly. So, the only people who can survive in that business are these large Medellin cartel kind of people who have enough money so they can have fleets of airplanes, so they can have sophisticated methods, and so on.

In addition to which, by keeping goods out and by arresting, let's say, local marijuana growers, the government keeps the price of these products high. What more could a monopolist want? He's got a government who makes it very hard for all his competitors and who keeps the price of his products high. It's absolutely heaven.

Paige: Of course, you know that there are conspiracy theorists who suggest it's there for a reason, and that's because governments are in cahoots with the drug runners; you wouldn't say that.

Friedman: No, it's not. I don't say that at all. You know, over and over again in government policy, good intentions go awry. And the reason good intentions go awry is because you're spending somebody else's money.

Paige: Many would say that a lot of your theories are grounded in the notion of personal interest; if it is in an individual's personal interest to do something, he or she will do that.

Friedman: That's not a theory, and there's nobody who will deny it. Is there anybody who will deny that you can expect every person to pursue his own personal interests? Now those personal interests don't have to be narrow. Mother Theresa is pursu-

ing her own personal interest just as much as Donald Trump is pursuing his. But they're both pursuing the personal interest.

Paige: Some would say that that notion--that personal interest is what propels societies as well as people--is a heartless philosophy and that the underclass would not fare well under that kind of a notion. You've heard that before.

Friedman: Yes, of course. But the evidence is so overwhelming. The only countries in the world in which low income people have managed to get a halfway decent level of living are those which rely on capitalist markets. Just compare the quality of life, the level of living of the ordinary people in Russia and ordinary people in, I won't say the U.S., but in France, in Italy, in Germany, in England, or in Hong Kong. Compare Hong Kong with mainland China.

Every society is driven by personal interest. Mainland China is driven by personal interest. The question is: How is personal interest disciplined? If the only way you can satisfy your personal interest is by getting something that other people want to pay for. You've got to...

Page: Or by forcing down other people's throats at the point of a gun, I suppose.

Friedman: If you can do it.

Paige: At the extreme.

Friedman: At the extreme. But that won't get their cooperation. You may be able to kill them. You may be able to take their wealth. But it won't create any more wealth. So, the only societies which have been able to create broadly based relative prosperity have been those societies which have relied primarily on capitalist markets. That's true whether you take Hong Kong versus mainland China, East Germany versus West Germany, Czechoslovakia before WW II and current. You cannot find a single exception to that proposition.

Adam Smith put it best over two hundred years ago, when he said people who intend only to pursue their self-interest are led by an invisible hand to promote the public interest even though that was no part of their intention. Mr. Ford did not develop the Ford car for the public interest. He did it for his private interest.

Paige: But Adam Smith also saw a role for government, for example, in the administration of justice, didn't he?

Friedman: So do I. I am not a zero government person. I think there is a real role of government. And one of the reasons I object to so many of the things that government has gotten into is that it prevents government from performing its proper role. A basic role of government is to keep you from having our house burgled, to keep you from being hit over the head. And because the larger fraction of our law enforcement machinery is devoted to the war on drugs, you haven't got that kind of safety.

Paige: But, of course, there is clearly the argument that if the police come and pick up a person who is addicted to a drug and does not have the money to buy those drugs, then they're also taking a potential burglar off the street who's going to come and get my house, right?

Friedman: They are, but they'll be more of them coming on, as we know, and besides what are you going to do with them. Are you going to house them? A majority of those people who are arrested are simply arrested for possession, they're casual users.

Paige: However, the sixty-five, seventy-five-year-old woman who looks out her window and sees drug dealers out in the street and she sees them carrying guns and selling drugs thirty feet from her front door has a right to call police and say, "I want these people off the street."

Friedman: Absolutely.

Paige: And police should take them off the street. Correct?

Friedman: Absolutely. But it's a mistake to have a law which makes that the main function of the police. I don't blame the police. I don't blame that woman. I don't blame the drug dealers.

Paige: In what way?

Friedman: We put them in a position where that's the thing to do. When we say to a young man in the ghetto, "Look, you get a reasonable job at McDonald's or anyplace else, you'll make five, six, seven dollars an hour. But on the other hand, here's this opportunity to peddle drugs in the street." Why does the juvenile have the opportunity? Because the law is easier on juveniles than it is on adults.

Paige: But how would you see legalization affecting poor in this country?

Friedman: The poor? It depends on which poor. But in the main, legalization as such would not have a major effect on the poor. It would provide better opportunities for the poor by rendering the inner cities safe and a place where you might have some decent, proper business. It would provide an opportunity to do more to improve schooling. The deterioration of the schooling, which is another case of ineffective socialism, has as much to do with the problems in the inner city as drugs do. Drugs aren't the only thing at work.

But I don't believe that legalization should be viewed primarily as a way to help the poor. Legalization is a way to stop--in our forum as citizens-- a government from using our power to engage in the immoral behavior of killing people, taking lives away from people in the U.S., in Colombia and elsewhere, which we have no business doing.

Paige: So, you see the role of government right now as being just as deadly as if Uncle Sam were to take a gun to somebody's head.

Friedman: That's what he's doing, of course. Right now Uncle Sam is not only taking a gun to somebody's head, he's taking his property without due process of law. The drug enforcers are expropriating property, in many cases of innocent people on whom they don't have a real warrant. We're making citizens into spies and informers. We tell people to call up, you don't have to give your name, just give your suspicions. That's a terrible way to run what's supposed to be a free country.

Paige: Let us turn in the final few minutes then to specifically what your vision is then. Under your system, if you could make a wish and have it come true, what system would that be? How would you legalize drugs? How would you go about doing that?

Friedman: I would legalize drugs by subjecting them to exactly the same rules that alcohol and cigarettes are subjected to now. Alcohol and cigarettes cause more deaths than drugs do, by far, from use, but many fewer innocent victims. And the major innocent victims, in that case, are the people who are killed by drunk drivers. And we ought to enforce the law against drunk driving, just as we ought to enforce the law against driving under the influence of marijuana, or cocaine, or anything else.

But I would, as a first step at least, treat the drugs exactly the same way we now treat alcohol and tobacco, no different.

Paige: You know what Representative Charles Rangel (D-New York) would say.

Friedman: I have heard Charles Rangel. He's a demagogue, who has had no relationship between what he says and the interests of his own constituents. His own constituents, the people he serves, are among the people who would be benefited the most by legalization of drugs. Charles Rangel is pursuing his own self-interest.

Paige: Forgive me for throwing out a name, but I just wanted to mention a typical response to that would be if you treat it like alcohol, you're talking about full-page ads in magazines with cocaine. You're talking about TV advertisers. You're talking about buying cocaine...

Friedman: I beg your pardon. TV advertising is forbidden today for alcohol.

Paige: For hard liquor, that's all.

Friedman: For hard liquor. And I say treat this the same way as you would treat Alcohol. So, presumably such ads would be forbidden for this.

But, of course, in any event I'm not prohibiting anybody from reading Mr. Rangel, and his ideas are at least as dangerous as those full-page ads you're talking about.

Paige: What scares you the most about the notion of drugs being legal?

Friedman: Nothing scares me about the notion of drugs being legal.

Paige: Nothing.

Friedman: What scares me is the notion of continuing on the path we're on now, which will destroy our free society, making it an uncivilized place. There's only one way you can really enforce the drug laws currently. The only way to do that is to adopt the policies of Saudi Arabia, Singapore, which some other countries adopt, in which a drug addict is subject to capital punishment or, at the very least, having his hand chopped off. If we were willing to have penalties like that--but would that be a society you'd want to live in?

Paige: Do these notions seem obvious to you?

Friedman: Yes. I have thought about them for a long time. I have observed behavior in this country and in other countries for a long time. And I find it

almost incredible how people can support the present system of drug prohibition. It does so much more harm than good.

Paige: If it is obvious, why is it that you're in such a minority, particularly among...?

Friedman: Of course. Very good question. And the answer is because there are so many vested interests that have been built up behind the present drug war. Who are the people who are listened to about drugs? The people who have the obligation to enforce drug laws. They think they're doing the right thing. They're good human beings. Everybody thinks what he's doing is worth doing. Nobody is doing it for evil motives. But it's the same thing all over the government.

Paige: Wouldn't you agree that fear is one of the strongest supports for the existing drug laws? Fear that, without them, the bottom would fall out.

Friedman: Yes, but it's a fake fear and it's a fear that is promoted. Listen to what the former drug czar, Mr. Bennet, said. First of all, he stated that consumption of alcohol after Prohibition has gone up three or fourfold or something. He was wrong, just factually wrong. He's made all sorts of scare talk about how many new addicts there would be. He's never provided a single bit of evidence, never provided any examples of any other place or anything. But why? Because he's got a job to do.

Paige: Vested interests, you're saying.

Friedman: Vested interests, self-interest, the same self-interest that people object to in the market. But in the market, if you start a project and it goes wrong, you have to finance it out of your own pocket.

Paige: Last question. You have grandchildren.

Friedman: Absolutely.

You have a two-year-old granddaughter.

The “Physician’s” Case Opposing Legalization

Charles Mabry, MD, FACS

Dr. Benson Roe has proposed an interesting and controversial approach to the topic of illegal drugs and the “Drug War.” In his article, he espouses the following novel ideas:

- Legalization of currently illegal drugs (heroin, cocaine, crack, methamphetamines, and so on) would benefit everyone, except for criminals, lawyers, and the government bureaucracies.
- Legal and medical organizations “have been deceived...that cocaine, heroin, and marijuana are ...substances so dangerous that society must be rigidly protected from them.”
- Illicit drugs have never been identified with a serious or fatal disease process. Users of illegal drugs are at risk only because the substances are illegal and uncontrolled.
- There is little evidence that making drugs illegal decreases their use.

To summarize, Dr. Roe calls upon society to: legalize all illegal drugs, mainstream drug production to ensure a supply of quality drugs, fire the police officers and lawyers who are in collusion with the drug kingpins, and tax the drugs. If we take all these actions, he says, everybody will be happy down at the old ranch.

To these assertions I say, get a grip on reality, Dr. Roe. While he certainly is entitled to his opinion, the vast majority of scientists and physicians who have studied the problems of drug abuse and addiction would find exception to much of what he has opined. Let’s apply science to this complex and difficult subject, and review some objective evidence about what we do know.

Illegal drugs are dangerous.

First, illegal drugs are dangerous and cause a host of medical and societal problems. The use and abuse of drugs (including alcohol, as well as prescription and nonprescription medicines) has been ranked as “the nation’s number one health problem” by the respected Schneider Institute for Health Policy and by the Robert Wood Johnson Foundation.¹ More than 20 million Americans are addicted to alcohol and drugs. Those addictions cause about 130,000 deaths annually.

Additionally, a study by the Lewin Group for the National Institute on Drug Abuse estimated the total economic cost of alcohol and drug abuse to be \$244.7 billion for 1992. Of that cost, \$97.7 billion was due to drug abuse alone, including lost wages, health care costs, and crime associated with drug usage. The Lewin Group also found that employed drug abusers cost their employers twice as much in medical and worker compensation claims as their drug-free coworkers.²

Despite Dr. Roe’s assertions that these drugs have not been identified with fatal disease processes, the facts are that medical (and surgical) problems associated with drug abuse and addiction are well documented. Most Fellows who have taken trauma call in any major emergency room within the past 10 years don’t need a rendition of national statistics to fully appreciate the cause-and-effect relationship between drug abuse and traumatic injury. In 1994, 431,800 visits to emergency rooms were drug-related, nearly 143,000 due to cocaine abuse alone.³ Further, a 1993 National Highway Traffic Safety Administration study reported that 18 percent of 2,000 fatally injured drivers from seven states had drugs other than alcohol in their systems when they died.³ Finally, as only one example of how drug abuse is associated with active crime, the New York City Arrestee Drug Abuse Monitoring Program found that 74 percent

of male adults arrested for committing violent crime tested positive for drug use. Similar data were also reported out of Albuquerque, NM, and Ft. Lauderdale, FL.³

Legalization would increase use

Legalizing or decriminalizing drugs that are now illegal will only increase their usage and subsequently the numbers of patients addicted to those drugs. Most of the illegal drugs we are talking about have, at one time or another, been legal. They are now illegal for good reason. Society has repeatedly made the collective judgment that these drugs just shouldn't be freely available because their side effects are so horrible. An excellent objective review of the history and policy approaches to addictive drugs has been written recently by DuPont and Voth.⁴ The conclusions of this comprehensive article are clear: making addictive drugs legal and available will assuredly increase the numbers of citizens addicted.

Does making addictive drugs illegal work? Cocaine and potent narcotics were freely sold in America until the first two decades of the 20th century, and the number of patients addicted dropped sharply once availability was curtailed.^{4,5} Addiction rates have dropped for several other drugs once availability was decreased and penalties for trading them were established.^{3,4,5}

More recently, several European countries have experimented with various attempts to legalize or decriminalize some illegal drugs. These experiments have resulted in a rise in the number of drug-addicted patients and a corresponding increase in the crime rate.^{3,4,5} Of substantial note: these European experiments were such a failure that in 1994 a group of major European cities (including London, Berlin, Paris, Madrid, Stockholm, and others) banded together and signed the "European Cities Against Drugs" resolution, which called for a rejection of "demands for legalizing illicit drugs...."³

The National Center on Addiction and Substance Abuse has stated the situation concerning illicit

drugs in this country most eloquently: "Drugs are not a threat to American society because they are illegal; they are illegal because they are a threat to American society."^{6,7}

Two important aims

Proper medical management of addiction and use of the law of the land to contain and decrease the supply of addicting drugs are both important goals and are not mutually exclusive. Dr. Roe disingenuously implies that the National Coalition for Drug Policy Change stands for legalizing addicting drugs. As one of the original signatories of the group's 1993 resolution, Dr. Roe should know that document reads: "WHEREAS, the overall situation regarding the use of drugs in our society and the crime and misery that accompanies it has continued to deteriorate for several decades ... THEREFORE BE IT RESOLVED, that our society must recognize drug use and abuse as the medical and social problems that they are and that they must be treated with medical and social solutions...."⁸ The coalition's main thrust was to ask the President to appoint a special commission to study how Congress should change existing drug laws—not to legalize illicit drugs.

The Robert Wood Johnson Foundation has published an excellent monograph that covers the subject of substance abuse and current approaches for policy and treatment, for those interested in reading more about this subject.¹ Addiction is a disease and should be treated like all other chronic relapsing diseases. Modern research has shown that addiction is, in many instances, inherited. The tendency to become addicted when exposed to addicting drugs is therefore not under the control of a given person. Increasing the availability of extremely addicting narcotics increases the likelihood of susceptible people coming in contact with these drugs and, thus, becoming addicted. As history has shown us on several occasions, changing social mores (and laws) does not repeal inherited physiology or its consequences.^{1,4,5} The more addicting drugs become available, the more likely it is that people will become addicted, and the more that society will suffer. It is tragic but simple math.

There is another stark reality: In some cases, the only thing that forces someone who is addicted to drugs and spiraling out of control into therapy is the threat (or reality) of incarceration. Do away with laws prohibiting sale of these drugs, and you do away with the only hope of help for so many people who are addicted but just can't stop themselves.

Of course, simply incarcerating addicted patients does nothing to help them overcome their disease. Clearly, we need to expend much more effort on the treatment and prevention of this medical problem. We need to not just talk about but to ensure that proper treatment for this chronic, relapsing disease is available for all of our citizens, in and out of jail.^{7,8,9} In 1994, the RAND Corporation found that law enforcement costs 15 times more than drug treatment to achieve the same benefit for cocaine addiction. Similarly, a study published in the *Journal of Quantitative Criminology* showed that drug treatment saves about \$19,000 in crime-related costs in the year following treatment. Currently only about a third of those needing treatment for addiction receive it.⁷

Physician involvement

One of the best organizations trying to change policies for the treatment of drug addiction and to refocus the aim of the criminal justice system is the Physician Leadership on National Drug Policy (PLNDP).^{8,9} The basic premise of PLNDP is that "drug addiction is a chronic, relapsing disease, and...that emphasis on the criminal justice approach alone is not solving drug problems in this country." Of the 37 distinguished founding physicians, I am proud to note that three (Drs. Claude Organ, Seymour Schwartz, and Donald Trunkey) are distinguished Fellows of the College. The PLNDP believes that we need to treat drug addiction as any other disease and make sure that all physicians are educated to identify and treat this disease. Further, the PLNDP calls for increased research into drug addiction, improved insurance coverage, and for the establishment of community based health partnerships. The PLNDP does not advocate decriminalization of illicit drugs, but

instead calls for "reallocation of resources...and utilizing criminal justice procedures that are shown to be effective in reducing supply and demand...."

What can we as physicians do? We can start by educating ourselves and encouraging increased emphasis on understanding and treating drug addiction in medical school and residency training. About one of every five medical students receives no education about substance abuse, and a little over half of medical students receive only a small amount.⁷ Drug addiction affects our patients every day, and surgeons need to be able to identify its effects and know about treatment. Addiction also affects our families and ourselves. Knowing how to spot the symptoms of drug abuse can lead to early intervention and treatment. The College has produced an excellent videotape, *Out of Control* (see p. 21), which deals with the topic of substance abuse by professionals. There are also several good Web sites and organizations that gladly provide information and help on the topic of substance abuse and addiction.^{10,11,12}

Drug addiction is a disease that affects each and every one of us daily. We have the responsibility as physicians to help the fight for better treatment of that disease by our society. That fight, or "war," is best pursued not just with improved medical therapies, but by also using the laws of our land to protect our citizens from the very real threat of illicit drugs.

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Author’s note: I first became involved with this topic when my son became addicted to alcohol and drugs. He is now in recovery and is working as a drug rehabilitation counselor here in Arkansas. Our family is grateful for his progress but realizes that his is a lifelong medical problem; relapse is just one symptom of the disease. In our case, it was only with the assistance of the courts and the legal system that we were able to first get him into therapy. Without a beneficial legal and criminal justice system in this country, many people would not be exposed to this essential treatment, especially when they are out of control and addicted. I know that our case is not unusual and, in fact, is quite typical. My hope is that we as physicians can influence the system and encourage more widespread and accessible treatment for all patients afflicted with this disease. If you, your family, or your friends need help, please contact one of the agencies listed in the references that follow or your local chapter of Alcoholics or Narcotics Anonymous. Just remember—you are not alone, and there is a lot of help out there. Just ask.

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A "Religious" Case Opposing Decriminalizing Drugs

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A Nine Inch Nails album *The Downward Spiral* features a song "My Self Destruct" with the lyrics: "I am the needle in your vein and I control you, I am the high you can't sustain and I control you." Another song, "Hurt," explores drugs as a means of escape with lyrics like, "The needle tears a hole, the old familiar sting, try to kill it all away."

Five Dodge City, Kansas teenagers, high on marijuana, killed a stranger for no obvious reason. Three West Palm Beach, Florida teenagers mixed beer, rum, marijuana and cocaine. They then kidnapped and set ablaze a tourist from Brooklyn.

Nearly everywhere we look, the consequences of drug abuse can be seen. Violent street gangs, family violence, train crashes, the spread of AIDS, and babies born with cocaine dependency all testify to the pervasive influence of drugs in our world.

The statistics are staggering. The average age of first alcohol use is 12 and the average age of first drug use is 13. According to the National Institute

on Drug Abuse, 93 percent of all teenagers have some experience with alcohol by the end of their senior year of high school and 6 percent drink daily. Almost two-thirds of all American young people try illicit drugs before they finish high school. One out of sixteen seniors smokes marijuana daily and 20 percent have done so for at least a month sometime in their lives. A recent poll found that adolescents listed drugs as the most important problem facing people their age, followed by crime and violence in school and social pressures.

Drugs have changed the social landscape of America. Street gangs spring up nearly overnight looking for the enormous profits drugs can bring. Organized crime is also involved in setting up franchises that would make McDonald's envious. But these are not hamburgers. In the world of drugs, homicidally vicious gangs compete for market share with murderous results. Many gang members outgun the police with their weapons of choice: semi-automatic pistols, AK-47s, and Uzis. Drug dealers have also gone high tech using cellular phones and computers to keep track of deals, while their teenage runners wear phone beepers in school.

The Parents' Resource Institute for Drug Education (PRIDE) reports that children who abuse illicit drugs are significantly more likely to carry a gun to school, take part in gang activities, think of suicide, threaten harm to others, and get in trouble with the police than children who abstain.

One survey released by the University of Colorado shows that the problem of drug use is not just outside the church. The study involved nearly 14,000 junior high and high school youth and compared church young people with unchurched young people and found very little difference. For example, 88 percent of the unchurched young people reported drinking beer as compared to 80

percent of churched young people. When asked how many had tried marijuana, 47 percent of the unchurched young people had done so compared to 38 percent of the churched youth. For amphetamines and barbiturates, 28 percent of the unchurched had tried them while 22 percent of the church young people had tried them. And for cocaine use, the percentage was 14 percent for unchurched youths and 11 percent for churched youths.

Fighting drugs often seems futile. When drug dealers are arrested, they are often released prematurely because court dockets are overloaded. Plea bargaining and paroles are standard fare as the revolving doors of justice spin faster. As the casualties mount in this war against drugs, some commentators have begun to suggest that the best solution is to legalize drugs. But you don't win a war by surrendering. If drugs were legalized, addiction would increase, health costs would increase, and government would once again capitulate to societal pressures and shirk its responsibility to establish moral law.

But if legalization is not the answer, then something must be done about the abuse of drugs like alcohol, cocaine, marijuana, heroin, and PCP. Just the medical cost of drug abuse was estimated by the National Center for Health Statistics to be nearly \$60 billion, and the medical bill for alcohol was nearly \$100 billion.

How to Fight the Drug Battle

Society must fight America's drug epidemic on five major fronts. The first battlefront is at the border. Federal agents must patrol the 8426 miles of deeply indented Florida coastline and a 2067 mile border with Mexico. This is a formidable task, but vast distances are not the only problem.

The smugglers they are up against have almost unlimited funds and some of the best equipment available. Fortunately, the federal interdiction forces (namely Customs, DEA, and INS) are improving their capability. Customs forces have been given an increase in officers and all are getting more sophisticated equipment.

The second battlefront is law enforcement at home. Police must crack down with more arrests, more convictions, longer sentences, and more seizures of drug dealers' assets. Unfortunately, law enforcement successes pale when compared to the volume of drug traffic. Even the most effective crackdowns seem to do little more than move drugs from one location to another.

An effective weapon on this battlefront is a 1984 law that makes it easier to seize the assets of drug dealers before conviction. In some cities, police have even confiscated the cars of suburbanites who drive into the city to buy crack.

But attempts to deter drug dealing have been limited by flaws in the criminal justice system. A lack of jail cells prevents significant prosecution of drug dealers. And even if this problem were alleviated, the shortage of judges would still result in the quick release of drug pushers.

A third battlefront is drug testing. Many government and business organizations are implementing testing on a routine basis in order to reduce the demand for drugs.

The theory is simple. Drug testing is a greater deterrent to drug use than the remote possibility of going to jail. People who know they will have to pass a urine test in order to get a job are going to be much less likely to dabble in drugs. In 1980, 27 percent of some 20,000 military personnel admitted to using drugs in the previous 30 days. Five years later when drug testing was implemented, the proportion dropped to 9 percent.

But drug testing is not without its opponents. Civil libertarians feel this deterrent is not worth the loss of personal privacy. Some unions believe that random testing in the workplace would violate the Fourth Amendment's prohibition against unreasonable searches. A fourth battleground is drug treatment. Those who are addicted to drugs need help. But the major question is, Who should provide the treatment and who should foot the bill? Private hospital programs are now a \$4 billion-a-year

business with a daily cost of as much as \$500 per bed per day. This is clearly out of the reach of many addicts who do not have employers or insurance companies who can pick up the costs.

A fifth battleground is education. Teaching children the dangers of drugs can be an important step in helping them to learn to say no to drugs. The National Institute on Drug Abuse estimates that 72 percent of the nation's elementary and secondary-school children are being given some kind of drug education.

Should We Legalize Drugs?

Those weary of the war on drugs have suggested that we should decriminalize drugs. Former Surgeon General Joycelyn Elders suggested we study the impact of legalizing drugs. For years, an alliance of liberals and libertarians have promoted the idea that legalizing drugs would reduce drug costs and drug crimes in this country. But would it? Let's look at some of the arguments for drug legalization.

1. Legalization will take the profit out of the drug business?

As surprising as it may sound, relatively few drug dealers actually earn huge sums of money. Most in the crack business are low-level runners who make very little money. Many crack dealers smoke more crack than they sell. Drug cartels are the ones making the big profits.

Would legalizing drugs really affect large drug dealers or drug cartels in any appreciable way? Drug cartels would still control price and supply even if drugs were legalized in this country. If government set the price for legalized drugs, criminals could undercut the price and supply whatever the government did not supply.

Addicts would not be significantly affected by legalization. Does anyone seriously believe that their behavior would change just because they are now using legal drugs instead of illegal drugs? They would still use theft and prostitution to support their habits.

Proponents also argue that legalizing drugs would reduce the cost of drugs and thus reduce the supply of drugs flowing to this country. Recent history suggests that just the opposite will take place. When cocaine first hit the United States, it was expensive and difficult to obtain. But when more was dumped into this country and readily available in less expensive vials of crack, drug addiction rose and drug-related crimes rose.

2. Drug legalization will reduce drug use?

Proponents argue that legalizing drugs will make them less appealing they will no longer be "forbidden fruit." However, logic and social statistics suggest that decriminalizing drugs will actually increase drug use.

Those arguing for the legalization of drugs often point to Prohibition as a failed social experiment. But was it? When Prohibition was in effect, alcohol consumption declined by 30 to 50 percent and death from cirrhosis of the liver fell dramatically. One study found that suicides and drug-related arrests also declined by 50 percent. After the repeal of the 18th amendment in 1933, alcoholism rose. So did alcohol-related crimes and accidents. If anything, Prohibition proves the point. Decriminalization increases drug use.

Comparing alcohol and drugs actually strengthens the argument against legalization since many drugs are even more addictive than alcohol. Consider, for example, the difference between alcohol and cocaine. Alcohol has an addiction rate of approximately 10 percent, while cocaine has an addiction rate as high as 75 percent.

Many drugs are actually "gateway drugs" to other drugs. A 1992 article in *The Journal of Primary Prevention* found that marijuana is essentially a "necessary" condition for the occurrence of cocaine use. Other research shows that involvement with illicit drugs is a developmental phenomenon, age correlates with use, and cigarette and alcohol use precedes marijuana use.

Dr. Robert DuPont, former head of the National Institute on Drug Abuse, argues that the potential market for legal drugs can be compared to the number of Americans who now use alcohol (140 million persons). If his analysis is correct, then approximately 50 million Americans would eventually use cocaine if it were a legal drug.

But the real question is not, Which is worse: alcohol or drugs? The question is whether we can accept both legalized alcohol and legalized drugs. Legalized alcohol currently leads to 100,000 deaths/year and costs us \$99 billion/year. We don't need to legalize drugs too.

3. Legalizing drugs will reduce social costs?

"We are losing the war on drugs," say drug legalization proponents, "so let's cut the costs of drug enforcement by decriminalizing drugs."

Currently the U.S. spends \$11 billion/year to combat drug-related crime. If drugs were made legal, some crime-fighting costs might drop but many social costs would certainly increase: other forms of crime (to support habits), drug-related accidents, and welfare costs.

Statistics from states that have decriminalized marijuana demonstrate this concern. In California, within the first six months of decriminalization, arrests for driving under the influence of drugs rose 46 percent for adults and 71.4 percent for juveniles. The use of marijuana doubled in Alaska and Oregon when it was decriminalized in those states.

Crime would certainly increase. Justice Department figures show that approximately one-third of inmates used drugs prior to committing their crimes.

And juvenile crime would no doubt increase as well. A 1990 study published in the *Journal of Drug Issues* found a strong association between the severity of the crime and the type of substance used: the more intoxicating the substance, the more serious the incident.

Meanwhile, worker productivity would decrease and student productivity would decrease.

The Drug Enforcement Administration estimates that drug decriminalization will cost society more than alcohol and tobacco combined, perhaps \$140-210 billion a year in lost productivity and job-related accidents.

Government services would no doubt have to be expanded to pay for additional drug education and treatment for those addicted to legal drugs. And child protective services would no doubt have to expand to deal with child abuse. Patrick Murphy, a court-appointed lawyer for 31,000 abused and neglected children in Chicago, says that more than 80 percent of the cases of physical and sexual abuse of children now involve drugs. Legalizing drugs will not reduce these crimes; it would make the problem worse.

And is it accurate to say we are losing the war on drugs? Drug use in this country was on the decline in the 1980s due to a strong anti-drug campaign. Casual cocaine use, for example, dropped from 12 million in 1985 to 6 million in 1991. You don't win a war by surrender. Legalizing drugs in this country would constitute surrender in the drug war at a time when we have substantial evidence we can win this battle on a number of fronts.

4. Government should not dictate moral policy?

Libertarians who promote drug legalization value personal freedom. They believe that government should not dictate morals and fear that our civil liberties may be threatened by a tougher policy against drugs.

The true threat to our freedoms comes from the drug cartels in foreign countries, drug lords in this country, and drug dealers in our streets. Legalizing drugs would send the wrong message to society. Those involved in drug use eventually see that drugs ultimately lead to prison or death, so they begin to seek help.

Obviously some people are going to use drugs whether they are legal or illegal. Keeping drugs illegal maintains criminal sanctions that persuade most people their life is best lived without drugs. Legalization, on the other hand, removes the incentive to stay away from drugs and increases drug use.

William Bennett has said, "I didn't have to become drug czar to be opposed to legalized marijuana. As Secretary of Education I realized that, given the state of American education, the last thing we needed was a policy that made widely available a substance that impairs memory, concentration, and attention span. Why in God's name foster the use of a drug that makes you stupid?"

Biblical Perspective

Some people may believe that the Bible has little to say about drugs, but this is not so. First, the Bible has a great deal to say about the most common and most abused drug: alcohol. Ephesians 5:18 admonishes Christians not to be drunk with wine. In many places in Scripture drunkenness is called a sin (Deut. 21:20-21, Amos 6:1, 1 Cor.6:9-10, Gal. 5:19-20).

The Bible also warns of the dangers of drinking alcohol in Proverbs 20:1, Isaiah 5:11, Habakkuk 2:15-16. If the Bible warns of the danger of alcohol, then by implication it is also warning of the dangers of taking other kinds of drugs.

Second, drugs were an integral part of many ancient near East societies. For example, the pagan cultures surrounding the nation of Israel used drugs as part of their religious ceremonies. Both the Old Testament and New Testament condemn sorcery and witchcraft. The word translated "sorcery" comes from the Greek word from which we get the English words "pharmacy" and "pharmaceutical." In ancient time, drugs were prepared by a witch or shaman.

Drugs were used to enter into the spiritual world by inducing an altered state of consciousness that allowed demons to take over the mind of the user.

In that day, drug use was tied to sorcery. In our day, many use drugs merely for so-called "recreational" purposes, but we cannot discount the occult connection.

Galatians 5:19-21 says: "The acts of the sinful nature are obvious: sexual immorality, impurity and debauchery, idolatry and witchcraft [which includes the use of drugs]; hatred, discord, jealousy, fits of rage, selfish ambition, dissensions, factions, and envy; drunkenness, orgies, and the like. I warn you, as I did before, that those who live like this will not inherit the kingdom of God." The word witchcraft here is also translated "sorcery" and refers to the use of drugs. The Apostle Paul calls witchcraft that was associated with drug use a sin. The non-medical use of drugs is considered one of the acts of a sinful nature. Using drugs, whether to "get a high" or to tap into the occult, is one of the acts of a sinful nature where users demonstrate their depraved and carnal nature.

The psychic effects of drugs should not be discounted. A questionnaire designed by Charles Tate and sent to users of marijuana documented some disturbing findings. In his article in *Psychology Today* he noted that one fourth of the marijuana users who responded to his questionnaire reported that they were taken over and controlled by an evil person or power during their drug induced experience. And over half of those questioned said they have experienced religious or "spiritual" sensations in which they meet spiritual beings.

Many proponents of the drug culture have linked drug use to spiritual values. During the 1960s, Timothy Leary and Alan Watts referred to the "religious" and "mystical" experience gained through the use of LSD (along with other drugs) as a prime reason for taking drugs.

No doubt drugs are dangerous, not only to our body but to our spirit. As Christians, we must warn our children and our society of the dangers of drugs.

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