DRUG WATCH WORLD NEWS

THE OFFICIAL NEWSLETTER OF

DrugWatch International™

March 2005

Vol. X, No. 1

HARM REDUCTION. A FIRST STEP TOWARDS A LAWLESS SOCIETY.

By Heitor De Paola, M.D.

For the past two years, Brazil has been the only country in Latin America with an official harm reduction drug policy. Drug policies based on interdiction and law enforcement, referred to in Brazil as "Repressive," are being replaced by policies that focus on health issues associated with drug use, i.e., distribution of syringes, safe crack kits, crack pipes, and injecting rooms where users can go to do drugs "safely." Government programs are being instituted to stimulate "the safe use" of dangerous, psychoactive drugs. The expressed reason is to protect drug users from AIDS and C-Type Hepatitis.

Advocates of "harm reduction" drug policies believe that drug prohibition is ineffective in significantly reducing drug abuse and its social consequences. They believe that prohibitive drug policies either view drug users as criminals and subject them to severe legal penalties, or view them as mentally ill and subject them to enforced drug treatment. So-called "harm reduction" portrays drug users as citizens with a right to use drugs -- citizens who may or may not commit crimes and/or have a kind of "mental disturbance." However, harm reductionists don't portray "harm reduction" policies as legalizing drugs.

But what do harm reduction policies lead to? In effect, "harm reduction" drug policies propose that governments act contrary to the law by allowing the Executive branch of government to ignore laws that have been passed by the Legislative branch and are meant to be enforced by the Judiciary branch. In my opinion, the intention of harm reduction is to create a fait accompli, creating the de facto legalization of dangerous, psychoactive drugs.

Would anyone familiar with history disagree that civilization has lived with drugs since its inception? Or that a world completely without drugs will ever exist? Before the days of Mohammed, hashish was used by a radical sect of Arab fanatics known as hashshashin – eaters of hashish – the genesis of the word "assassin." Almost every known culture has used psychoactive drugs in performing religious rituals, a practice still engaged in by some primitive tribes. However, these historical arguments are non-sequiturs to the legalization of drugs! Based on such silly "non" logic, we could say that murder should not be considered a crime, because mankind has lived with murder since the biblical story of Cain and Abel. We could use this same nonsensical logic to justify robbery, smuggling, slavery, pedophilia, or almost anything that civilized society now condemns. However, the function of laws has always been to limit the destructive impulses that afflict the human psyche. ***Being civilized is the opposite of accepting wrongdoing as good!***

A review of the literature on the subject clearly demonstrates that the arguments of harm reductionists are based on intermingling truths with half-truths. Although clear-cut lies are usually easy to recognize, half-lies are far more difficult, because the deceitfulness is concealed by the half-truths.

An example of a half-truth used by harm reductionists is that, in the past, opium was legal and was quite fashionable in the United States and Europe; Fumaderos [opium dens] were very chic meeting places. But harm reductionists do not discuss why opium became illegal—that the decision was based on trying to contain the serious harm caused to users and society alike. Actually, the history of opium use strongly refutes the notion that permissive drug policies work and restrictive policies do not.

Another half-truth is that modern day stress leads to drug use as a means of self-medicating.

Yet another half-truth is the old argument of "powerful economic interests." The assumption is that pharmaceutical companies are interested in drug prohibition to avoid competition. However, researchers, legitimate companies, and regulatory agencies control the potential risks. Curiously the same argument of powerful economic interests is never discussed in reverse, that the champions of legalization might benefit from billions of dollars from powerful foundations and other NGOs.

The award for the most flagrant lie goes to the argument that "prohibition is the cause of abuse or illegal actions!" Those who use this argument pretend that it is not the drugs that cause harm to users and society, but that the harm arises from their prohibition and illegality! The intent of the harm reductionists is to avoid debate by proclaiming the dogma that "prohibition" causes the harm to users and society. The strategy is to abolish all law, Constitutions, tradition, religion – anything that may stand as an obstacle to complete liberalization of drug use. Contrary to traditional knowledge – namely, that law was established by

(Continued on page 2)

(Continued from page 1)
mankind to inhibit and punish crimes and abuses – harm reductionists have adopted the opposite position and insist that the laws themselves cause crime. Are we then to assume that a lawless culture would be a paradise on Earth?

From these arguments, it should follow that use of the legal drugs, alcohol and tobacco, would be harmless. However, harm reductionists characterize these drugs as evil. Astonishing! This is an example of how far thought control may go within scientific and intellectual environments: Say anything, but say it with deep conviction, and no one will contest you! Ambiguity becomes the accepted mode of debate.

For example, fraudulent interpretations of statistical data are frequently published to prove that tobacco is the cause of more illnesses and deaths than illegal drugs. This is true in absolute figures, but it is a lie when we check relative ones. The number of cigarette smokers exceeds in millions those of hard drug users! Thus, it is obvious that a greater number of tobacco users acquire a number of illnesses not always related to smoking, whereas illegal drug users' illnesses are usually directly connected to their use of drugs.

Legalization obviously increases the number of users! Restrictive measures reduce users. In 1980, after liberal drug policies, there were 25 million users of hard drugs in the United States. After eight years of a combination of restrictive drug policies and drug prevention education, this number was reduced to a half, 12.5 million! Today, following a ten-year effort to liberalize drug policy, these figures have risen to approximately 15 million. But harm reductionists loathe such information, and it is never mentioned. Statistics that refute claims of drug legalizers are systematically concealed. The truth is, restrictive drug policies inhibit potential users.

Is civilization to allow its own destruction under the guise of reducing harm, when, in fact, harm actually increases under liberal drug policies? Aiding and abetting destructive behavior is not a feasible solution to the drug problem.

The author is a psychoanalyst in Rio de Janeiro, Brazil

FROM THE DESK OF THE HONORABLE RONALD G. GODBEY, ESQ.

President, Drug Watch International, Inc.

Ashcroft *v.* Raich, *et. al.*: U.S. Supreme Court Decision Eagerly Awaited.

The U.S. Supreme Court is expected to hand down its ruling in the *Raich* case this summer. It is an opinion anxiously awaited by *Drug Watch International, Inc.*, and other organizations and individuals that promote drug-free cultures in the United States and abroad.

The case arrived at the Supreme Court in the usual way. Angel Raich and other marijuana users under California's "medical" marijuana statute sought an injunction against the federal government to prevent its agents from seizing their marijuana. To do so, they sued Attorney General John Ashcroft and DEA Administrator Asa Hutchinson in federal court in the Northern District of California. They alleged the Controlled Substances Act was unconstitutional and also sought a declaration that the "medical necessity" defense precluded enforcement of that act against them.

In March 2003, the district court denied plaintiffs motion for a preliminary injunction because plaintiff's had not established a sufficient likelihood of success on the merits of the case.

Plaintiffs appealed to the 9th Circuit Court of Appeals in San Francisco. Incredibly, the 9th Circuit, (with Judge Beam dissenting), reversed and remanded the case back to the district court, holding that, "We find that appellants, (Raich, *et. al.*) have demonstrated a strong likelihood of success on the claim that as applied to them, the Controlled Substances Act is an unconstitutional exercise of Congress' Commerce Clause authority."

The Justice Department appealed to the U.S. Supreme Court. The case was argued on November 29, 2004. Several members of *Drug Watch* were present during oral arguments.

Interestingly enough, the issue in *Raich* has nothing to do with "medical necessity" as an exception to the Controlled Substances Act as the 9th Circuit had earlier found in U.S. v Oakland Cannabis' Buyers Cooperative. The U.S. Supreme Court overturned that 9th Circuit decision in 2001. In *Oakland*, the Supreme Court held there is no "medical exception" to the Controlled Substances Act, a decision *Drug Watch* and many other illicit drug use prevention organization applauded.

So, if the issue in *Raich* is not marijuana, what is it? The issue in *Raich* is whether the Controlled Substances Act, (21 U.S.C. 801, *et seq.*), exceeds congress's power under the Commerce Clause of the Constitution, as applied to the intrastate cultivation and possession of marijuana for purported personal "medical" use or to the distribution of such marijuana without charge. **The issue is, since the marijuana used by Raich was grown locally, used locally, and there was no fee or charge involved, does congress have the right to attempt its regulation under the Commerce Clause?**

Many are watching *Raich* because of its "states rights" implication. For example, Alabama filed an *amicus* brief supporting *Raich.* In it, Alabama argued "The question presented here is not whether vigorous enforcement of the nation's drug laws is good criminal policy, it most assuredly is...The question rather, is whether the Constitution permits the federal government, under the guise of regulating interstate commerce, to criminalize the purely local possession of marijuana for personal medical use." Many believe the narrow issue is marijuana...the broader issue is federal power over states rights.

However, the Supreme Court has held in past decisions that non-commercial activities that significantly affect interstate markets can be regulated under federal statutes.

Therefore, it's my belief that the Supreme Court ruling in *Raich* will favor the government. Drug laws must be on a national level. And to have state legislatures and ballot initiatives dictate what is medicine and what is not is indeed a scary concept. I know, because not so long ago, I sat as a member of a state legislature faced with this issue.

SYNTHESIZED CANNABINOIDS AS MEDICINE? YES. SMOKED CANNABIS [MARIJUANA] AS MEDICINE? NO.

By John Coleman, Director
International Drug Strategy Institute, a Division of Drug Watch International

The US Drug Enforcement Administration's (DEA) concerns are not whether smoked marijuana has therapeutic effects. The DEA's concerns are related exclusively to abuse potential. Clearly, a drug that continues to be the #1 drug of abuse in the United States has little chance of passing muster with the DEA.

The US Federal Drug Administration's (FDA) concerns are different. Although the FDA cooperates with the DEA on enforcement investigations as appropriate, the FDA's requirements consider effectiveness and safety. If the FDA approves a drug for these characteristics (on the basis of clinical trials), and the drug has abuse potential, the FDA has the authority to approve the drug and require scheduling by the DEA under the Controlled Substance Act.

If approved as a medicine by the FDA, the DEA would likely re-schedule cannabis from a Schedule-I drug to a Schedule-II drug, meaning that it had medical potential. Virtually nothing would change as far as the growing, possessing, or trafficking of cannabis is concerned. The penalties for unlawful activities involving Schedule-II drugs are the same for Schedule-I. But, reclassification of cannabis is not likely to happen. ***Cannabis provides no therapeutic benefits that cannot be obtained via other drugs without the psychic side effects and without the toxic consequences of smoke.***

Most biologicals, from common aspirin to some of the most advanced anti-cancer drugs, have a vegetative beginning. It would not be surprising to find that cannabis contains compounds that might have some beneficial properties if properly synthesized and engineered to remove the psychoactive side-effects and, of course, the smoke. The 1999 Institute Of Medicine (IOM) study essentially came to this conclusion when it recommended further research to develop safer delivery systems for individual cannabinoids – not the cannabis plant.

The findings of any FDA-approved clinical trials of cannabis would have to be reviewed by the FDA. A reliable, double-blind, placebo controlled study of smoked marijuana would be almost impossible, thus rendering any clinical trial evidence suspect from the very beginning.

John J. Coleman, Assistant Administrator (ret.), U.S. Drug Enforcement Administration, is President of the Association of Former Federal Narcotics Agents and Chairman of the International Drug Strategy Institute, a division of Drug Watch International. He is a doctoral candidate at George Mason University's School of Public Policy.

HARM REDUCTION: IS THERE SUCH A THING AS SAFE DRUG ABUSE?

By Marc Wheat
Staff Director and Chief Counsel
Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Committee on Government Reform
U.S. House of Representatives

In his National Drug Control Strategy, President Bush has called on the nation to work for "Healing America's Drug Users." From the evidence gathered by the Subcommittee on Criminal Justice, Drug Policy, and Human Resources, it remains to be seen if "harm reduction" brings healing or just harm.

The Subcommittee for which I work drives most of the agenda on illegal drug policy in the House of Representatives. I believe this Subcommittee, chaired by Congressman Mark Souder of Indiana, was the first to hold a hearing on measuring the effectiveness of drug treatment programs, and was the first to hold a hearing on the President's *Access To Recovery* initiative, which seeks to increase and enhance the availability of drug treatment in the United States. Many members of the Subcommittee are working together to pass the *Drug Addiction Treatment Expansion Act*, introduced by Chairman Souder.

But there is a broad level of disagreement in Congress on the merits of "harm reduction."

From the titles of presentations and workshops, the agenda of the "harm reduction" movement seems clear. But how well does that agenda serve Americans caught in the snare of drug abuse?

Congressman Souder, who chairs both the Subcommittee on Criminal Justice, Drug Policy, and Human Resources and Speaker Hastert's Task Force for a Drug-Free America, attempted to bring that matter into focus at the February 16, 2005, hearing. He asked, "When evaluating drug control policies, we must look beyond the intent

(Continued on page 4)

(Continued from page 3)
of a program and look to the results. We should always apply a common-sense test: Do the policies in question reduce illegal drug use? That is the ultimate 'performance measure' for any drug control policy, whether it is related to enforcement, treatment, or prevention."

Applying that same test, "harm reduction" would fail. It does not have the goal of abstention from drugs. Many members of the "harm reduction" movement assume certain individuals are incapable of making healthy decisions. Advocates of this position hold that dangerous behaviors, such as drug abuse, therefore, simply must be accepted by society, and those who choose such lifestyles -- or become trapped in them -- should be enabled to continue these behaviors in a manner less "harmful" to themselves or others. Often, however, these lifestyles are the result of addiction, mental illness, or other conditions that should and can be treated rather than accepted as normal, healthy behaviors.

Not all members of the "harm reduction" movement support the legalization of drugs, but the Subcommittee received testimony that legalization advocates had a great deal to do with launching the movement. According to the testimony of Robert Peterson, Vice President of PRIDE Youth Programs, the term "harm reduction" was "first selected and promoted in 1987 by a group of drug lawyers at a meeting in Great Britain sponsored by the drug legalization group, the Drug Policy Foundation. This group later merged into the George Soros-backed Drug Policy Alliance. The term 'harm reduction' ran a close second with the term 'harm minimization' to avoid the "L" word: 'legalization.'"

It is troubling how much support some members of the Subcommittee were willing to lend the "harm reduction" movement through their choice of witnesses for the February 16th. hearing.

One of the pro-harm reduction witnesses at the hearing, Dr Peter Beilenson, worked several years ago on a project to bring heroin distribution to Baltimore, Maryland. In June 1998, the Baltimore Sun reported that Johns Hopkins University drug abuse experts and Baltimore's health commissioner were "discussing the possibility of a research study in which heroin would be distributed to hard-core addicts in an effort to reduce crime, AIDS, and other fallout from drug addiction." At that time, "public health specialists from a half-dozen cities in the United States and Canada… met at the Lindesmith Center, a pro drug legalization policy institute supported by financier George Soros, to discuss the logistics and politics of a multi-city heroin maintenance study." "Such an endeavor would be 'politically difficult, but I think it's going to happen,' said Baltimore Health Commissioner Dr. Peter Beilenson."

Another pro-harm reduction witness, Dr. Robert Newman, served on the Board of Directors for the Drug Policy Foundation as early as 1997, and presently serves on the Board of Directors with another pro-harm reduction witness, Rev. Edwin Sanders, of the Drug Policy Alliance (the new name of the Drug Policy Foundation since its merger with the aforementioned Lindesmith Center). The Drug Policy Alliance describes itself as "the nation's leading organization working to end the war on drugs." Along with its major donor, George Soros, the Drug Policy Alliance helped produce a pro-marijuana legalization children's book, "*It's Just a Plant.*"

What are the prospects for the "harm reduction" movement in the United States? If we do not educate all our legislators about the dangers of "harm reduction," it seems likely to me that programs meeting the approval of groups like Drug Policy Alliance and the pro marijuana legalization Marijuana Policy Project (also a source for several of the witnesses) would increase.

But Chairman Souder is standing against such a policy. As he stated at the hearing, "Instead of addressing the symptoms of addiction -- such as giving them clean needles, telling them how to shoot up without blowing a vein, recommending that addicts use with someone else in case one of them stops breathing -- we should break the bonds of their addiction and make them free from needles and pushers and pimps once and for all."

ECSTASY LINKED WITH LONG-TERM MEMORY LOSS

By Kate Holton

LONDON (Reuters) - People who take the drug ecstasy are more likely to suffer from long-term memory loss, according to a British study.

The study, which surveyed users in Europe, the United States and Australia, found that those who regularly took the dance club drug were 23 percent more likely to report problems with their memory than non-users.

The study has been published in the current edition of the Journal of Psychopharmacology. Ecstasy users who also use cannabis were facing a "myriad of memory afflictions," the report said, which could represent "a time bomb" of cognitive problems for later life. The report, led by the University of Newcastle upon Tyne, said short-term memory was affected by cannabis.

Despite some high-profile deaths caused by ecstasy, there has been a widespread perception among young users that the drug is safe.

Users say it heightens awareness, intensifies their emotions and makes them feel good. But in extreme cases, ecstasy can cause spikes in body temperatures severe enough to be fatal. "Users may think that ecstasy is fun and that it feels fairly harmless at the time," said lead researcher Dr. Jacqui Rodgers of Newcastle University in Britain. "However, our results show slight but measurable impairments to memory as a result of use, which is worrying."

The survey team based their findings on responses from 763 participants but they also looked closely at a sub-group of 81 "typical" ecstasy users who had taken the drug at least 10 times.

The typical users showed their long-term memory to be 14 percent worse than the 480 people who had never taken ecstasy and 23 percent worse than the 242 who had never taken drugs at all. Additionally, the typical users made 29 percent more mistakes on the questionnaire form than the people who did not take drugs at all.

"The findings also suggest that ecstasy users who take cannabis are suffering from a 'double whammy' where both their long-term and short-term memory is being impaired," Rodgers said.

SOURCE: *Journal of Psychopharmacology*, December, 2003

DRUG USERS MUST BE HELD ACCOUNTABLE

By Robert DuPont, M.D.

Robert L. DuPont, M.D., is a clinical professor of psychiatry at Georgetown Medical School and president of the Rockville, MD-based Institute for Behavior and Health. Dr. DuPont served as Drug Policy Advisor to threeUS Presidents and was the founding director of the National Institute on Drug Abuse.

I began my career in Corrections. In 1969, I headed all of the Parole and Halfway House services for the District of Columbia Department of Corrections in our nation's Capital.

One of the most important policy disputes in drug abuse prevention today is the role of the criminal justice system. The harm reductionists/legalizers loudly call for "treatment not jail." They mean turning to a voluntary treatment system with minimal or no consequences for continued illegal drug use. They also mean to decriminalize not just possession but sale of illegal drugs. Few people, who are attracted by the "treatment not jail" slogan, realize what lies behind it (just the way many people do not understand what is behind the "medical marijuana" drive).

Blackmail is what so many drug-using kids do to their parents -- "If you don't let me do what I want to do, then I will ruin my life, and it will be your fault." American parents can rarely stand up to that threat. Neither can many drug abuse policy wonks. Feeling sorry for drug offenders is not helping them. It is not respecting them. Ultimately, a drug user – just like everyone else – is responsible for his life. He is responsible personally for the consequences of his actions.

In policy discussions, more attention needs to be paid to the stories of the people who were in prisons and in other ways caught up in the criminal justice system and who got well, who are in recovery. When one of my patients has gotten arrested, it has almost always been a strongly positive development. Many drug users and drug sellers get well and go straight as a direct result of the criminal justice system's tough love stance. Drug users usually get well only when confronted with painful consequences flowing from their drug use. These painful consequences come in many forms. For many of the most serious drug abusers, the consequences that make the most difference are those experienced in the criminal justice system.

Society's message needs to be crystal clear: because illegal drug use is dangerously wrong, it is prohibited by the full force of the law. The penalties for drug sale need to be equally clear. They need to be enforced if our society is not to be overrun by illegal drugs.

Much more can be done to use the stick of the criminal justice system to help drug users get well and stay well. The future of prevention will not be found in the false battle between "treatment ***or*** prison." The future of drug abuse prevention in the United States lies in finding better ways to use "treatment ***and*** prison" for the benefit of drug offenders, their families, and for our entire society.

Think what a drug user's life would be like if drug use and possession were decriminalized and, worse yet, if drug sales were decriminalized? It is hard for me to think that an addict's life would be improved by a softer more "tolerant" approach to illegal drugs. Having spent a lot of time with addicts who are in recovery, I have never met one who thought that his life would have been improved if the government had set up clinics to give him free drugs until he decided that he wanted to quit, if he ever would decide to quit.

A lot of attractive sounding "reform" ideas look mighty silly when they are applied to the personal stories of drug addicts. As the folks in Narcotics Anonymous say, "There is no problem so bad that drugs will not make it worse."

NEVADA TO BE A LAUGHING STOCK?

On March 10, 2005, a panel of the Nevada Assembly Judiciary Committee refused to take a position on whether the state should legalize and tax marijuana, meaning that the question will appear on the November 2006 ballot. Under the citizen initiative petition, **half of all the marijuana tax revenue would be earmarked for drug addiction treatment.**

Lobbying for passage of the petition was Rod Kampia, head of the Washington D.C.-based Marijuana Policy Project, an organization advocating the legalization of marijuana, primarily under the guise of "medicine."

According to an article in the Reno Gazette-Journal, law enforcement officers and prosecutors from across the state testified against the initiative. **Sheriff Bill Young said, "We would be the laughing stock of the country. This thing makes no sense. It has no logical basis in fact and is simply the wrong thing for our citizenry."**

Rob Kampia, head of the Marijuana Policy Project (MPP), and other pro-drug legalization lobbyists, are asking voters in Nevada to LEGALIZE pot. They are no longer hiding behind the facade of "medical marijuana." Soros, Lewis, and Sperling monies are hard at work.

Gerri Silverman, Drug Watch New Jersey Delegate

MARIJUANA HAS REACHED TOXIC STATUS. LEGALIZATION WOULD MAKE IT WORSE.

By Sandra Bennett, Director, Northwest Center For Health & Safety; Past President, Drug Watch International

Long before hybridization of today's extremely potent strains of cannabis (celebrated annually at Holland's "Cannabis Cup" competition), there were individuals who suffered severe psychotic episodes when smoking marijuana (feral cannabis hemp). In fact, "Reefer Madness," the 1930's zombie movie, depicted individuals who became crazed and demented from smoking cannabis. Today, those who lobby to legalize marijuana insist that it be given the same status as alcohol and tobacco. In that pursuit they continually refer to "Reefer Madness" and scientific data that points to marijuana's many harmful aspects, as "scare tactics." This allegation is used repeatedly by pro-drug partisans and the media to disparage drug prevention and law enforcement efforts.

The average potency of marijuana today is 10 to 15 times greater than that smoked in the 60's and 70's. (Think of taking 30 aspirin at a time instead of two.) In fact, marijuana is now so toxic that it has become a leading cause of drug related medical and psychiatric emergency room episodes, severely impacting already limited medical resources. Several recent scientific studies have found that marijuana can both cause psychosis and worsen existing psychiatric disorders. It also contributes to absenteeism and health problems in the workplace. Legalization would increase availability and accessibility of marijuana and exacerbate all these problems.

And marijuana use breeds crime. The actual number of persons jailed for marijuana possession, many of whom have plea-bargained down from more serious drug charges, is around 35,720. There are approximately 3,365 local jails in the United States, for an average of 10 to 11 per jail. This figure does not include those incarcerated in federal prisons on marijuana charges, where the average possession is measured in tonnage, not grams.

The unemployment rate of addicted drug users exceeds 40%. It is society that pays for their housing, food, utilities, medical expenses, clothing, transportation, and other needs/ wants. Easy access would increase the rate of use and addiction, just as easy access to tobacco has always been a factor to attracting new users.

Marijuana plays a key role in auto accidents, and it plays an even larger role in trucking related fatalities than does alcohol. One scientific study on airplane pilots found that even 24 hours after smoking one low-potency marijuana cigarette, the pilots could not land a plane on a flight simulator on which they had been trained. Of equal concern should be marijuana's impact on American education. Tobacco has insidious long-term medical consequences but it does not interfere with short-term memory and the ability to learn. Yet, tobacco is portrayed as the greater menace. Does anyone believe that dumbing down American students, many of whom can now claim they smoke pot for "medical" reasons, will make them competitive in the job market? Special education teachers are already overburdened with children who come to school impaired by pre-natal effects of drug-using parents and by second-hand smoke inhaled from the psychoactive drugs used by their parents.

California, with its lax marijuana laws, now mandates treatment instead of incarceration for its drug users. This policy is bankrupting the system, and most arrestees don't complete treatment or bother to participate. California's three-strikes law worked so well that crime fell significantly. Now, the state wants to repeal it! Sweden and Japan both tried drug legalization, but the dire consequences of that folly forced reversals. Unfortunately, society has a short memory and is often doomed to repeat its most egregious mistakes. Legalization would be one of those terrible mistakes that would take generations to undo.

MARIJUANA AND STROKES

SOURCE: March, 2005, Journal of Neurology, Neurosurgery and Psychiatry.

"Marijuana seems to be a risk factor for stroke," said Dr. Juan Carlos Garcia-Monco of the Hospital de Galdacano in Vizcaya, Spain. And the risk may be higher when it is used along with alcohol or other drugs.

Marijuana is known to have a number of short-term effects on the cardiovascular system, including speeding the heart rate, raising or lowering blood pressure, and even elevating the risk of heart attack in the hour after use. Some past research has found that marijuana users may develop changes in blood flow to the brain that makes it harder for blood to diffuse through the small vessels in the brain.

Studies show that marijuana is not as innocuous as many think. "In that recreational cannabis use appears not to be as harmless as was thought," writes Dr. Dominique Deplanque of the University of Lille in France, "there is a need to improve public information." Garcia-Monco suggested that doctors screen for the presence of marijuana and other drugs whenever a young person inexplicably suffers a stroke.

INTERNATIONAL NEWS BRIEFS

- On March 29, 2005, the Ontario, Canada, government announced a $50-million fund for tobacco farmers, with $35 million going to farmers wishing to switch crops. The Agriculture Minister, Steve Peters, said that "industrial" hemp (cannabis sativa) could be a viable option for tobacco farmers. Peter Kormos, Marijuana Policy Project (MPP), said that tobacco farmers should be allowed to grow "medical" marijuana and, if legalized, pot for the recreational user. *(Toronto Sun: March 30, 2005)*

> "Vancouver, British Columbia, has one of the highest rates of drug abuse and [HIV] infection in the world, according to scientific studies published about the city. That is why Vancouver's latest plan to maintain heroin users on their drugs of choice – cornering more addicts into a life of despair and sickness – is worrying me and scores of public health officials worldwide."
>
> *Kevin Sabet, Vancouver, BC, Sun, March 19, 2005*

- Swiss researchers reported in the April 2005 issue of the BMC Psychiatry that, even in clinical situations where cannabis is administered orally at low doses, psychotic reactions could occur. Dr. Bernard Favrat and colleagues at Institut Universitaire de Medicine Legale in Lausanne suggested, "Consuming oral cannabis may produce more potent, yet unknown psychotomimetic metabolites of THC." Favrat's group cautions that doctors and users should be aware of the increasing availability of oral cannabis in 'special' drinks or food as well as in medications under development, which can result in "significant psychotic reactions." *(Reuters Health: April 1, 2005)*
- The American Medical Association rejected including the compassionate use of "medical" marijuana into its recommendations. The committee on public health didn't find that there was enough evidence to support "medical" marijuana. "There is just no scientific evidence to establish the effectiveness of marijuana," said Dr. Herman Abromowitz, a family physician in Dayton, Ohio, and a member of AMA's Board of Trustees. *(NewsMax.com Wires: June 20, 2001)*
- New Mexico, United States, rejected a Bill to legalize the use of marijuana as a medicine. Reena Szczepanski, director for the Drug Policy Alliance of New Mexico in Santa Fe, had been lobbying for the bill during the legislative session. *(Carlsbad, NM, Current-Argus: March 19, 2005) [The Drug Policy Alliance is a national pro legalization organization funded by George Soros.]*
- According to data from the Washington, D.C. Pretrial Services Agency, 49 percent of juvenile arrestees tested positive for marijuana in 2004, down from the peak of 64 percent in 1999. Cocaine positives have also declined slightly. Data from the U.S. national Monitoring the Future school survey have shown similar declines in marijuana and cocaine use in recent years. *(CESAR Fax: March 28, 2005)*
- The British Government is to review its decision to downgrade cannabis after mounting scientific evidence that the drug could be more harmful than thought. The Advisory Council on the Misuse of Drugs will review the issue. The Home Secretary noted that two recent studies had linked cannabis with increased mental health problems. . . 1. Professor Jim van Os, of Maastricht University, 2004, "Cannabis use moderately increases the risk of psychotic symptoms in young people, but has a much stronger effect in those with a predisposition for psychosis.". . . 2. A study of 2,437 people aged between 14 and 24 found that half of those who were psychologically vulnerable and smoked cannabis developed psychotic symptoms over a four-year period – twice the rate of those who did not use cannabis. *(London Times Online: March 19, 2005)*

> Most babies with AIDS are born to mothers or fathers who have shot drugs. *(NIDA, 1988 poster)* Basic research begun in the 1970s demonstrated that prenatal exposure to heroin, cocaine, and marijuana can impair the physiological and behavioral development of animals. New NIDA studies suggest that prenatal exposure to MDMA can lead to cognitive and behavioral impairments among juvenile offspring, particularly males. *(NIDA Notes, April 2004)*

- The U.S. Surgeon General, the American Medical Association, the National PTA, and the American Academy of Pediatrics are among those joining the White House Drug Czar, Public Health, Prevention, and Parent leaders urging parents to talk to their kids about the risks of marijuana. "Young marijuana users face serious risks. Marijuana can harm the brain, lungs, and mental health. Research also shows that marijuana is addictive," said Surgeon General Richard Carmona, M.D. "More teens enter drug treatment each year for marijuana than for all other illicit drugs combined. Marijuana use is also

(Continued on page 8)

INTERNATIONAL NEWS BRIEFS

(Continued from page 7)

three times more likely to lead to dependence among adolescents than among adults." *ONDCP Press Release: August 29, 2002)*

- The admission rate for those who seek treatment for marijuana use nearly tripled between 1992 and 2002, according to the latest data compiled by the federal government. The study, conducted by the US Substance Abuse and Mental Health Services Administration (SAMHSA), estimated that 41 states experienced an increase in the number of people who sought treatment for marijuana use during the decade studied. "Marijuana is not a harmless substance, and these treatment trends emphasize that point," said Charlie Cook, the administrator for SAMHSA. *(The Associated Press: March 4, 2005)*
- San Francisco, California, [US] Mayor Gavin Newsom learned that a "medical" marijuana clinic planned to open on the ground floor of a city-funded welfare hotel that is home to a number of recovering drug addicts. On March 21, 2005, Newsom called for a moratorium on so-called "medical" marijuana clubs in the city. *(San Francisco Chronicle; March 21, 2005)*
- George Soros, retired billionaire hedge fund manager, became known in 1992 as the man who broke the Bank of England, when his funds were said to have made a billion dollars betting that the British government would be forced to devalue its currency. On March 24, 2005, a French appeals court upheld Soros' 2002 insider trading conviction on charges stemming from investment in a French bank in 1988. Soros was ordered to pay 2.2 million euros, or $2.9 million. *(New York Times; March 25, 2005)*
- According to the US Substance Abuse and Mental Health Services Administration (SAMSHA), a study by the US Drug Enforcement Agency (DEA) indicates that 30 percent of the national drug problem relates to prescription drugs. In the United States, emergency room visits involving hydrocodone combinations more than doubled between 1992 and 2002. The US Department of Health and Human Services reports Emergency Room visits that involved oxycodone more that quadrupled from 1994 to 2002. For information about medical treatment for addiction to prescription painkillers, visit www.buprenorphine.samhsa.gov. *(Herald-Dispatch, West Virginia, March 19, 2005)*

> "For far too long, the message to our nation's young people has been that marijuana is harmless, when research has clearly proven that is not the case. Marijuana is mind-altering, it can be addictive, and it can lead to destructive behavior."
>
> *Richard F. Corlin, M.D. Past President, American Medical Association.*

- Chicago, Illinois [US] area emergency room admissions related to methamphetamine almost tripled from three per 100,000 in 1995 to eight per 100,000 in 2002, the latest available figures. Experts think that number has continued to rise. *(Chicago Sun-Times; February 18, 2005)*
- Methamphetamine use has gradually spread eastward, but the majority of meth use and production remains west of the Mississippi River. It appears to be concentrated and growing in rural communities. According to the US National Clandestine Laboratory Database, one methamphetamine lab was found in Maryland in 2004, compared to 474 in California, and 1,049 in Missouri. *(CESAR Fax; March 7, 2005)*
- US college students who use stimulants non-medically are substantially more likely to use other drugs. For example, 69.4% of past year non-medical stimulant users reported using marijuana in the past month, compared to 14.6% of college students who had not used prescription stimulants non-medically. *(CESAR Fax, February 21, 2005)*
- American Indian and Alaska Native youth had the highest rate of past month illicit drug use (20.2%) in 2002 and 2003, nearly twice the average rate of all youth (11.4%). American Indian and Alaska Native youths are also more likely than other races to perceive minimal risk of harm from substance use. *(SAMHSA National Findings, 2004; CESAR Fax: April 4, 2005)*
- US parents are talking less to their kids about drugs, according to a study by the Partnership for a Drug-Free America. This may reflect the relaxed attitudes of a generation that came of age in the late 1970s, when US teen drug use peaked. However, today's marijuana can contain 12 percent or more of the mind-altering ingredient THC, compared to 1 to 3 percent in the 1970's. "Children of today's generation are more likely to get in trouble with drugs if parents don't do something," said Dr. Herbert Kleber, director of Columbia University's Division on Substance Abuse. *(Reuters Health; February 23, 2005)*
- People under the age of 21 consume the majority of illegal drugs. *("Speaking out against drug legalization", US Drug Enforcement Administration; 2002, as seen in The Best of IDEA: Winter 2005)*
- According to information gathered by the US Bureau of Justice Statistics and the National Center for Education Statistics, in 2003, students in grades 9-12 were asked about using drugs on school property. In the 30 days prior to the survey, 5 percent of students reported having at least one drink of alcohol on school property and 6 percent reported using marijuana. *(The Best of IDEA; Winter 2005)*

(Continued on page 9)

INTERNATIONAL NEWS BRIEFS

(Continued from page 8)

- A report by the European Union drugs agency (EMCDDA) stated that drug overdose is one of the major causes of death among young people in Europe. According to the report, there were almost 100,000 reported overdose deaths between 1990 and 2002 in Western Europe, with 8,000 to 9,000 deaths per year since 1996. But this figure probably underestimates the full extent of the tragedy, as under-reporting is likely to occur in many countries. *(ECAD Newsletter; February 2005)*

The United Nations (UN) estimates that 60 percent of Afghanistan's economy is tied to the illegal drug trade, and drug lords have become so powerful that they could strangle the entire economy. The Paris-based Senlis Council says it is time for international officials to consider the possibility of allowing Afghan farmers to be among the small group of licensed opium producers that provide legal opium for legitimate interests and essential medicines. A team of 15 to 20 international specialists and researchers in pharmacology, economics, international law, criminal justice, and academics from leading Western universities are considering conducting a feasibility study. *(RFE/RL, Prague, March 10, 2005)*

- On January 31, 2005, the city of Oslo, Norway, opened the first municipal drug injection room in Scandinavia, an obvious breach of the 1988 UN Conventions on drugs. The United Nations' drug control organ, the International Narcotics Control Board (INCB) has time after time called attention to the fact that introduction of injection rooms for drug addicts plays into the hands of the international drug traffickers. By opening drug injection rooms a government can be held responsible for breaking an international agreement by facilitating the crimes of possession and consumption of drugs as well as of drug trafficking. *(ECAD Newsletter; February 2005)*
- PARENTS BEWARE . . . The US National Research Group website advertises "Smoke Pot-Get Paid Studies!" The site informs young people age 18 or over how to make money through private "research" studies by smoking marijuana, having weekly sex, drinking alcohol, and "other adult paid programs." This is a commercial site that first seeks money from interested "volunteers."
- "Some people with MS have claimed that smoking marijuana (cannabis) has reduced MS spasticity. Studies done so far, however, have not provided convincing evidence that marijuana benefits people with MS." . . . "It is the opinion of the National Multiple Sclerosis Society's Medical Advisory Board that marijuana is not recommended as a treatment for MS. Long-term use of marijuana may be associated with significant serious side effects. In addition, other well-tested, FDA-approved drug are available, such as baclofen and tizanidine, to reduce spasticity in MS." *(The MS Information Source book; produced by the National MS Society.)*
- Cognitive-behavioral therapy (CBT) is an effective treatment for cocaine addiction, but dropout rates range from 33 to 64 percent. Researchers have found that patients with impaired attention, learning, memory, reaction time, and cognitive flexibility – all documented consequences of chronic cocaine abuse – were much more likely to drop out of the 12-week CBT program than those not cognitively impaired. *(Drug and Alcohol Dependence 71(2):207-211)*
- A new instrument will allow researchers to simultaneously monitor dopamine-producing cells as they release the neurotransmitter and the electrical changes in dopamine-receiving cells as they respond to it deep within the brain. It would be like watching learning as it happens. The fast scan cyclic voltammentry (FSCV), with a microscopic probe roughly 10 millionths of a meter in diamerer, will allow researchers to explore the role of dopamine during drug-seeking behavior. *(NIDA Notes, April 2004)*
- On January 27, 2005, two trains collided in Los Angeles, California, killing at lease 11 people and injuring more than 180 in the worst US train wreck in nearly six years. The crash was caused by an aborted suicide attempt by a man who parked his SUV on the tracks, changed his mind at the last minute, and left the SUV on the tracks. Carmelita Alvarez alleged that her husband abused drugs and threatened the family. Police said that Alvarez has a criminal record that involved drugs. *(St. Louis Post Dispatch, 1/27/2005; AP 2005-01-27 01:58:58)*
- A St. Louis, Missouri, police officer helped a drug ring by checking secret law enforcement databases to see whether customers were undercover informers, according to a federal indictment announced February 4, 2005. *(St. Louis Post Dispatch, 1/5/2005)*
- According to the Miami Herald, Washington, DC, has been frustrated with the Dominican judicial system, which a U.S. official here called "weak." A full 80 percent of the cases against drug traffickers are dismissed on technicalities, a U.S. Official said. *(Miami [Florida] Herald, Feb. 5, 2005, by Pablo Bachelet and Nancy San Martin)*

References available on request. Send self-addressed, stamped envelope to:

Drug Watch World News
P.O. Box 318
Carlinville, Illinois
62626

CANNABIS, DEPRESSION, AND SCHIZOPHRENIA

New Scientist (UK) Author: Emma Young Published: November 21, 2002

The link between regular cannabis use and later depression and schizophrenia has been significantly strengthened by three new studies. The studies provide "little support" for an alternative explanation – that people with mental illnesses self-medicate with marijuana - according to Joseph Rey and Christopher Tennant of the University of Sydney, who have written an editorial on the papers in the British Medical Journal.

One of the key conclusions of the research is that people who start smoking cannabis as adolescents are at the greatest risk of later developing mental health problems. Another team calculates that eliminating cannabis use in the UK population could reduce cases of schizophrenia by 13 per cent. Until now, say Rey and Tennant, there was "a dearth of reliable evidence" to support the idea that cannabis use could cause schizophrenia or depression. That lack of good evidence "has handicapped the development of rational public health policies," according to one of the research groups, led by George Patton at the Murdoch Children's Research Institute in Melbourne, Australia.

The works also highlight potential risks associated with using cannabis as a medicine to ease the symptoms of muscular sclerosis, for example -- Patton's team followed over 1600 Australian school pupils aged 14 to 15 for seven years. Daily cannabis use was associated with a five-fold increased risk of depression at the age of 20. Weekly use was linked to a two-fold increase. The regular users were no more likely to have suffered from depression or anxiety at the start of the study.

The reason for the link is unclear. Social consequences of frequent cannabis use include educational failure and unemployment, which could increase the risk of depression. "However, because the risk seems confined largely to daily users, the question about a direct pharmacological effect remains," says Patton.

In separate research, a team led by Stanley Zammit at the University of Cardiff, UK, evaluated data on over 50,000 men who had been Swedish military conscripts in 1969 and1970. This group represents 97 per cent of men aged 18 to 20 in the population at that time.

The new analysis revealed a dose-dependant relationship between the frequency of cannabis use and schizophrenia. This held true in men with no psychotic symptoms before they started using cannabis, suggesting they were not self-medicating.

Genetic factors

Finally, researchers led by Terrie Moffitt at King's College London, UK, analysed comprehensive data on over 1000 people born in Dunedin, New Zealand, in 1972 and 1973.

They found that people who used cannabis by age 15 were four times as likely to have a diagnosis of schizophreniform disorder (a milder version of schizophrenia) at age 26 than non-users.

But when the number of psychotic symptoms at age 11 was controlled for, this increased risk dropped to become non-significant. This suggests that people already at greater risk of later developing mental health problems are also more likely to smoke cannabis.

The total number of high quality studies on cannabis use and mental health disorders remains small, stress Rey and Tennant. And it is still not clear whether cannabis can cause these conditions in people not predisposed by genetic factors, for example, to develop them.

"The overall weight of evidence is that occasional use of cannabis has few harmful effects overall," Zammit's team writes. "Nevertheless, our results indicate a potentially serious risk to the mental health of people who use cannabis. Such risks need to be considered in the current move to liberalise and possibly legalise the use of cannabis in the UK and other countries." *British Medical Journal (vol 325, p1195, p1199, p1212, p1183)*

ORAL CANNABIS INDUCES PSYCHOSIS AT LOW LEVELS.

Reuters Health, 2005-04-01; SOURCE: BMC Psychiatry, April 1,2005.

Even in clinical situations where cannabis is administered orally at low doses, psychotic reactions can occur, Swiss researchers report the current issue of BMC Psychiatry.

Recreational cannabis use has been associated with psychotic reactions, but this is the first such report in closely monitored subjects participating in a clinical trial, note Dr. Bernard Favrat and colleagues at Institut Universitaire de Medicine Legale in Lausanne.

Favrat's group was conducting a study to examine the effects of ingestion of THC (delta-9-tetrahydrocannabinol) on psychomotor function and driving performance in eight occasional cannabis users.

The first case of psychosis was in a 22-year-old man given 20 milligrams of dronabinol, a synthetic THC. Ninety minutes after dronabinol administration he experienced severe anxiety and symptoms of psychosis, and was unable to perform the two psychometric tests.

Levels of THC and its active metabolite 11-OH-THC in the blood at the time of the strong adverse effects were 1.8 and 5.2 nanograms per milliliter, respectively.

The second case was also a 22-year-old man who developed severe anxiety one hour after taking 16.5 milligrams of a THC compound, when his THC blood level was 6.2 nanograms per milligram and 11-OH-THC was 3.9 nanograms per milligram. For several hours he was unable to perform psychometric tests

The authors note that smoking a 3.5-percent marijuana cigarette leads to blood concentrations of THC in the range of 50 to 100 nanograms per milliliter. They believe that oral administration produces higher levels of 11-OH-THC, with slower elimination.

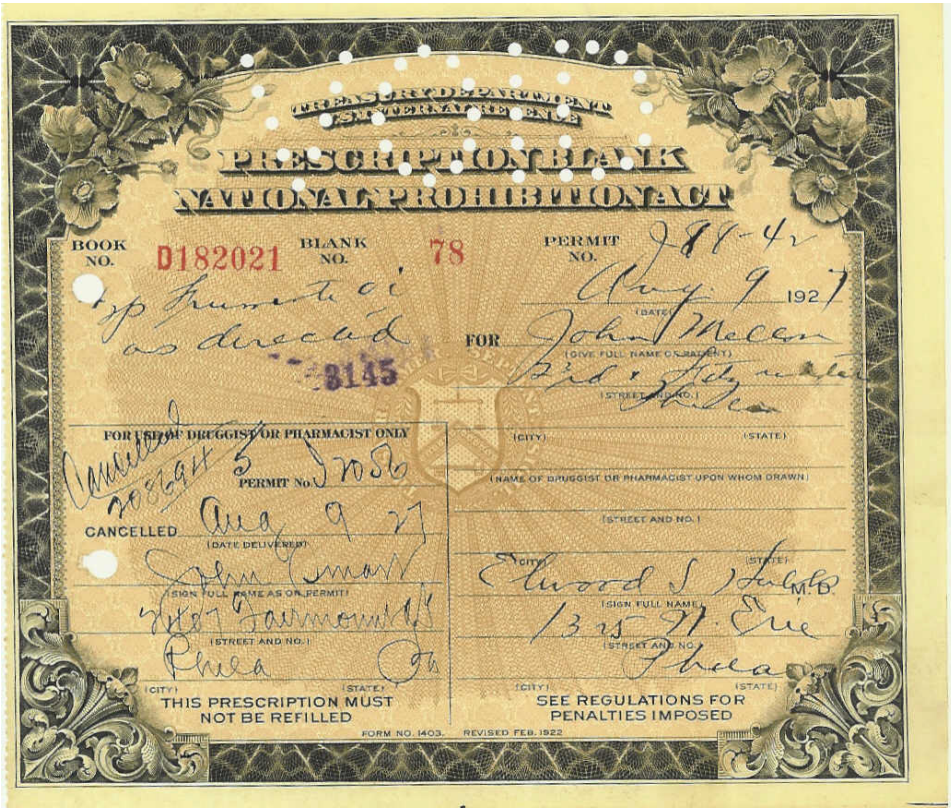
Alternatively, they suggest that "consuming oral cannabis may produce more potent, yet unknown psychotomimetic metabolites of THC."

"Doctors and users should be aware of the increasing availability of oral cannabis in 'special' drinks or food as well as in medications under development," which can result in "significant psychotic reactions," Favrat's group cautions.

"TAX AND FIX" STRATEGY FOR POT WON'T WORK!

By John J. Coleman
Director, International Drug Strategy Institute, a division of Drug Watch International
Former Asst. Administrator, US Drug Enforcement Administration

I know of no earmarked tax scheme that has ever worked. The Prohibition of alcohol ended around Christmastime in 1933 with the ratification of the 21st Amendment on December 5. The "new" federal taxes on booze were supposed to help pay for the social and health consequences of permitting this drug to be available again for "recreational" use. Even during Prohibition, whiskey was available, but only by prescription and if authorized by a physician. It was stocked at pharmacies. The federal government (Internal Revenue Service) issued serialized prescription forms and collected copies of all issued and filled alcohol prescriptions. Prescriptions were not refillable but had to be re-issued each time.



It's interesting how today's push for prescription monitoring programs for controlled substances is sometimes looked upon by some as innovative and unprecedented.

The same might be said for the taxes gained from sales of tobacco. They hardly begin to pay for the actual health consequences attributed to tobacco, and they have no way of assuaging the social consequences of early and debilitating illness and death. Given this experience with two "recreational" drugs, alcohol and tobacco, is there even the slightest rationale for why we would experiment with letting yet another evil genie out of this bottle?

Lastly, anyone who seriously subscribes to the "tax and fix" strategy for pot should spend a few moments studying the history of the First and Second Opium Wars in China during the 19th century. The 1842 Treaty of Nanking ended the first of these wars between the British and Chinese but, like the World War I Treaty of Versailles, it set the stage for future hostilities. Besides ceding Hong Kong and Amoy to the British, the treaty called for the Chinese to impose tariffs on all imports, including opium. This was a way to force China to "legalize" a drug that was literally destroying its culture and people. Needless to say, this created even more problems. An 1888 London Times article claimed that 70 million Chinese were addicted to smoking opium. Only the strict policies of Chairman Mao Zedong and the communist takeover in the 1950s would eventually rid China of this problem. While there were many reasons for the outbreak of violence in the Second Opium War in 1856, we cannot overlook the influence of the failed taxing scheme imposed by the Treaty of Nanking.

The imposition of tax on all imports, including opium, stimulated indigenous production and distribution of untaxed and, therefore, cheaper supplies. The Indian opium initially forced on China by the British traders had a higher morphine content than the species grown in China and, therefore, was sought initially as a superior product. Over time, however, Chinese farmers were able to produce opium equal, or superior, to the imports. In a sense, the free-market system worked and created an entirely new domestic industry. This, in turn, corrupted Chinese society and destroyed any semblance of social order throughout China. Even the Imperial Palace was not spared its addiction to opium. While this is a disturbing and inexcusable period in Western history, we surely can and should benefit from the experiences gained. One such experience is the unintended consequence of the Chinese Imperial taxing scheme in 1842 that stimulated domestic production, distribution, and use of untaxed opium. If the same theoretical taxing scheme were to become part of proposed marijuana legislation in this country, for example, aside from the fiscal uselessness of such policies – as demonstrated by the examples given above for tobacco and alcohol – it would likely stimulate production of more indigenous supplies to be marketed as cheaper and untaxed commodities. The potential consequences of this are obvious and don't need to be repeated.

DRIVING UNDER THE INFLUENCE AMONG YOUNG PERSONS

SAMHSA National Survey on Drug Use and Health Report, December 31, 2004.

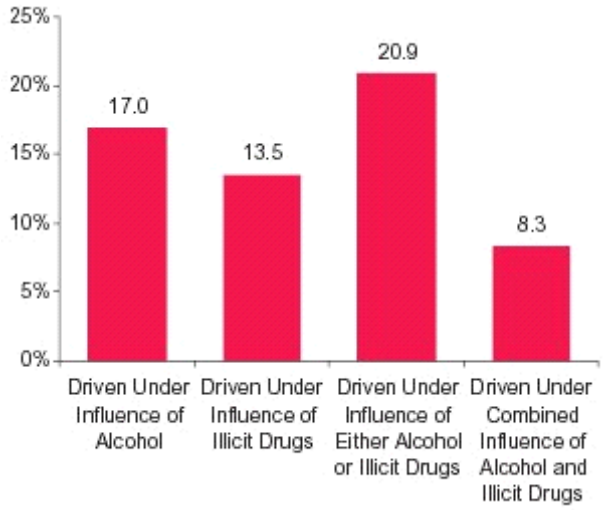


FIGURE 1. Percentages of Persons Aged 16 to 20 Who Reported Driving a Vehicle under the influence of alcohol or illicit drugs in the past year: 2002 and 2003.

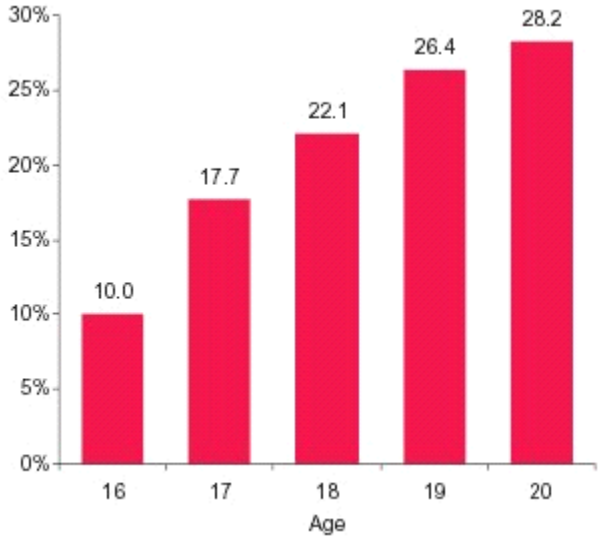


FIGURE 2. Percentages of persons aged 16 to 20 who reported driving a vehicle under the influence of alcohol or illicit drugs in the past year by age: 2002 and 2003.

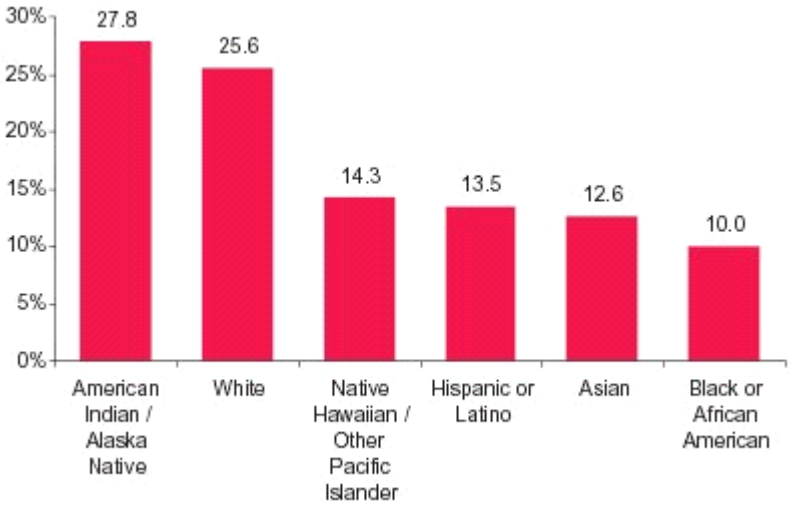


FIGURE 3. Percentage of Persons aged 16 to 20 who reported driving a vehicle under the influence of alcohol or illicit drugs in the past year, by Race/Ethnicity: 2002 and 2003.

- In 2002 and 2003, 21 percent of persons aged 16 to 20 reported that they had driven in the past year while under the influence of alcohol or illicit drugs.
- Among persons aged 16 to 21, whites and American Indians/ Alaskan Natives were more likely to report Driving Under the Influence (DUI) than other racial/ethnic groups.
- In 2002 and 2003, approximately 4 percent of persons who reported DUI in the past year had been arrested and booked for DUI in the past year.

International Task Force on Strategic Drug Policy
Contact: Calvina Fay – (1)(727) 828-0211 – cfay@dfaf.org

STATEMENT ON SO-CALLED `HARM REDUCTION´ POLICIES

Representing drug prevention, treatment, and policy organisations from around the world, the International Task Force on Strategic Drug Policy met in Brussels, Belgium on Feb. 27-28, 2005, to discuss effective drug policy strategies and compose this statement on so-called "harm reduction."

We support the United Nations position that the goal of national and global drug policies and strategies must be to prevent or stop drug use. We agree with the United Nations that drug demand reduction is a fundamental pillar to sound drug policy. We support abstinence from drug use as a reasonable and achievable goal for public health policy. We support a policy of no use of illegal drugs or destructive use of legal drugs.

Rational drug policies which recognise that the temporary use of measures to reduce harm with the goal of ultimate abstinence are fundamentally different from so-called `harm reduction´ drug policies which accept the inevitability of drug use.

The phrase `harm reduction´ and its obvious meaning has been hijacked and cynically employed by those whose goal is to legalise drugs. They use the obvious, universal desire to reduce harm to promote the legalisation of drugs. Drug legalisers use the phrase to gain the sympathy of well-meaning people and government officials.

We oppose so-called `harm reduction´ strategies as endpoints that promote the false notion that there are safe or responsible ways to use drugs. That is, strategies in which the primary goal is to enable drug users to maintain addictive, destructive, and compulsive behaviour by misleading users about some drug risks while ignoring others. These strategies give the message that society has given up on the addict, condones their drug use, and condemns them to a life of drug dependence. So-called `harm reduction´ as a drug strategy undermines drug prevention efforts and messages by taking advantage of drug addiction and deadly diseases like HIV to advance the political agenda of drug legalisation lobbyists and billionaire advocates.

We support the International Narcotics Control Board (INCB) position on so-called `harm reduction´ that does not support stand alone needle exchange programs and taxpayer-funded shooting galleries (so-called safe injection rooms) because such policies encourage drug use and violate UN Conventions. Article 4 of the 1961 Convention, which:

...obliges State parties to ensure that the production, manufacture import, export, distribution of, trade in, use and possession of, drugs is limited exclusively to medical and scientific purposes. Therefore, from a legal point of view such facilities violate international drug control conventions.

We oppose usurping multi-national treaties and agreements and replacing the goal of preventing and reducing drug use with a strategy by whatever name (e.g. so-called `harm reduction´) that seeks to normalise various forms of drug use.

We support comprehensive prevention, treatment, and enforcement strategies to prevent and eliminate illegal drug use, and thereby their undeniable harm. We support harm prevention and harm elimination through expanding treatment, outreach, and social services for drug users, addicts, and those with infectious diseases. We support research into effective outreach and treatment techniques for addict populations.

It is insufficient, illogical, and inhumane to proclaim that drug dependence should be maintained in the name of so-called `harm reduction.´ History, science, and reason tell us that drug use *can* be prevented, and drug dependence *can* be overcome and its attendant consequences reduced, if not eliminated.

UK RE-THINKS DOWNGRADE OF CANNABIS

Peter Stoker, Director NDPA, UK Delegate to Drug Watch International

In January 2004, within a surprisingly short time of taking office, David Blunkett, UK Home Secretary, downgraded cannabis from a Class B to a Class C drug, which meant that possession was no longer an arrestable offence. On March 18, 2005, Charles Clarke, the current Home Secretary, asked for a review of that position, signaling that the British government was having second thoughts.

A major concern, however, is that the re-think is being conducted by the Advisory Council on the Misuse of Drugs, the same group that endorsed the original downgrading.

David Davis, the Shadow Home Secretary, said, "We welcome the government's recognition that they got this wrong. The downgrading of cannabis was a dreadful decision which sends out mixed messages about the dangers of drugs." He added that the latest psychological evidence shows that cannabis is a serious threat to the health of young people and a gateway to harder drugs.

According to David Raynes, former senior UK Customs Officer and a member of National Drug Prevention Alliance (NDPA), the rise in mental illness associated with cannabis and the situation in respect to all drug problems in the UK have worsened at an accelerating rate since the UK Customs stopped interdicting cannabis in any substantial way.

GUIDELINES FOR DRUG INFORMATION INTERNET SEARCHES AND A CASE STUDY

William R. Walluks
C.E.D.A.R.S.
***C**enter for **E**ffective **D**rug **A**buse **R**esearch & **S**tatistics*
Madison, Wisconsin, U.S.A.
"Bringing Facts to Bear on Drug Problems"
608/256-5427—billwall@sbcglobal.net

Uncritical use of the Internet to research and refer anti-drug information can lead to considerable problems with inappropriate or factually bad material due to the large number of pro-drug sites. The following guidelines are suggested.

Recognize that certain professional groups promote particular points of view, such as nurses favoring "medical" marijuana and public health practitioners promoting harm reduction approaches. If unsure about the site, consult any available information on its philosophy, funding, and principals, with an independent Internet search of the group sponsoring the site.

Look for key "code" words and phrases in the domain name and in material on the site. This will often provide perspectives into the true philosophies and motives of the sponsor. Be wary of sites and material emphasizing "drug policy reform," fighting (against) the "Drug War," complaining about drug offender "prison" and "incarceration" sentences, or with a goal of "reducing the harm drug abuse causes."

Personally review all web sites before using them in your own work and referrals. When forwarding a site, be very specific on the complete site name (explicit spelling with suffix, such as "com" or "org"). Be especially cautious with similar-sounding names (for example, "ONDCP.com" is actually a pro-drug site).

Even supposedly objective sites need to be very carefully reviewed. "MedicalMarijuanaProCon.org" (previou sly called "MarijuanaInfo.") constitutes a good case study of the types of potential problems that may not be readily apparent to more casual users. This site bills itself as presenting information on the issue in an unbiased format. A glance reveals a great deal of information, supposedly from both sides of the issue, with approximately 180 questions divided into 37 categories.

Certain facts should be noted at the outset for "MedicalMarijuanaProCon.org." The site prominently displays a scientifically-irrelevant 4,700-year "History of Medical Marijuana." The Editor of the site has been a Director of the American Civil Liberties Union Foundation of Southern California since 1979.

Until recently, a physician well-known for his opposition to marijuana as a medicine and for his strong drug prevention views was incorrectly identified by ProCon as supporting marijuana as medicine.

Some of the material on the site constitutes egregious examples of taking things out of context, using incomplete material and omitting significant broad or follow-up clarifying information, and thereby distorting the overarching conclusion of a report or action. This leads readers to inaccurate conclusions regarding support for "medical" marijuana.

Within the "Pro and Con Statements" in the "Site Summaries" section, prominent notice is given to the 1999 Institute of Medicine Report Recommendation #6 for short-term (under 6 months) use of smoked marijuana for debilitating symptoms under documented failures of other medicines, reasonable expectations for relief, under medical supervision, assessment of effectiveness, and an oversight strategy. This is touted as a "Pro" statement for use of marijuana as medicine.

These requisites are most likely absent under the extremely loose regimens for marijuana use in "medical" settings in permitting states. And this particular Recommendation was the sixth and final one provided, suggesting it is the least significant.

There is no corresponding side-by-side prominence given to the overriding conclusion of the IOM Report that, "Smoked marijuana should not generally be recommended for long-term medical use." Moreover, the very first Recommendation in the IOM Report was that, "Research should continue into the physiological effects of synthetic and plant-derived cannabinoids…." (emphasis added).

The second Recommendation was for clinical trials with the goal of developing rapid-onset, reliable, and safe delivery systems (emphasis added). Even these clinical trials were recommended to be conducted under only short-term (under six months) use, where there is reasonable expectation of efficacy, with review controls, and efficacy data collection.

Another substantial omission of important information occurs in the same section. The American Medical Association's Council on Scientific Affairs 2001 report calling for "compassionate use" of marijuana receives prominent display as an "endorsement" of marijuana as medicine. In true "pro-con" fashion, then the very lengthy actual policy statement passed at that time by the full AMA is presented. A careful reading of this final statement shows the absence of any call for "compassionate use;" which in itself might be overlooked in a rapid review. Readers—if cognizant—must go to another section of the site for the "rest of the story." Compassionate use was immediately rejected by the AMA's committee on public health and the full AMA House of Delegates then without debate also rejected the compassionate use concept (emphasis added). This latter section concludes with a quote at the time by an AMA Trustee saying, "There just is no scientific evidence to establish the effectiveness of marijuana."

The "MedicalMarijuanaProCon" site evidently has solicited or otherwise gathered views of various individuals and organizations endorsing or opposing the so-called "medical" use of marijuana.

(Continued on page 15)

(Continued from page 14)

Strangely--or perhaps not--the number of proponents always outweighs the number of those in opposition, and usually very dramatically. Here are the numbers: doctors (31 "Pro," 8 "Con"); "experts" (11 for, 5 against; 7 of the 11 are commonly known as drug advocates); VIPs (7 for, and here 6 against; this curiously lists the ONDCP Director as a "VIP," discounting his wide knowledge and policy-making authority); and health/medical organizations (27 "Pro" vs. 8 "Con").

To add perspective to the 31-doctors-for-vs.-only-8-against "vote" tally, which suggests approval by a wide margin, reports have shown that only 10 doctors in Oregon, and only 10 in California, account for two-thirds, and for over 80%, of the marijuana "medical" use recommendations in those respective states.

One additional facet of this site should be noted. Due to a substantially flawed "rating system" for individuals and organizations, it automatically provides any physician, regardless of actual expertise in marijuana "medical" effectiveness and risk issues, with a very high "four star credibility" rating. On the other hand, the Drug Enforcement Administration, the Office of National Drug Control Policy, the ONDCP Director, and the Partnership for a Drug-Free America—all charged with and devoted to fighting drug abuse in America--and even the American Medical Association, receive only a puny one star each as a measure of their "standing" in the site's eyes.

Bill Walluks is the retired Chief of Strategic Intelligence, Division of Narcotics Enforcement, Wisconsin Department of Justice, and now operates the Center for Effective Drug Abuse Research and Statistics/C.E.D.A.R.S., a voluntary research and information resource for the drug prevention community.

GUIDELINES FOR INTERNET DESIGN

William R. Walluks
C.E.D.A.R.S.
***C**enter for **E**ffective **D**rug **A**buse **R**esearch & **S**tatistics*
Madison, Wisconsin, U.S.A.
"Bringing Facts to Bear on Drug Problems"
608/256-5427—billwall@sbcglobal.net

The drug prevention community should make extensive use of the Internet and World Wide Web to fight drug use and proliferation. Many employ this technology to present their views and drug prevention information through their own web sites.

There are several technology-related issues in web site design to consider to protect interests and prevent problems from developing.

1. Be aware of the domain names system and how to register names. The following site is associated with the U.S. Department of Commerce and non-technically explains name and registration matters. http://www.internic.net/

Consider the potential negative impact on your operations of similar-sounding or abbreviated name variations that may in the future be registered by others for their use--in particular by pro-drug groups. For example, a recent Internet search showed that the authentic White House Office of National White House Drug Policy (ONDCP) site, "whitehousedrugpolicy.com" is currently "under construction." However, "ONDCP.com" is a pro-drug web site.

You may wish to take suitable precautions to prevent problems for your website by paying the small registration fees required for related domain names.

Include domain name suffixes such as ".net," ".org," ".com," ".info," ".name," etc.

Carefully consider all that may apply in your review and name registrations.

If potentially conflicting domain names are already registered, visit these sites to identify any operated by groups favorable to drugs.

2. Be careful when linking to web sites over which you have no control. A site may not keep postings up-to-date or may post material with which you disagree. Pay particular attention to sites containing news articles, as these may contain pro-drug articles that may in turn link to pro-drug sites. Advertising space may be sold to pro-drug groups. News article sites may shift or rotate their links, and your occasional spot-check review may not detect offensive materials.

3. Be smart in your other operational practices. Exercise caution in accepting free computer equipment and in hiring computer technicians. Asking the question, "What do you think of the drug problem?" may generate useful information to identify conflicts of interest and assess philosophical qualifications. Questions to further elicit attitudes can be found in the C.E.D.A.R.S. document, "Illegal Drugs Problem: Questions & References for Self-Awareness and Objectivity." Contact C.E.D.A.R.S. for a copy.

DrugWatch International™

PRINCIPLES

- Support clear messages and standards of no illegal use of alcohol, tobacco and other drugs, (including "no use" under legal age) and no abuse of legal drugs for adults or youth.
- Support comprehensive and coordinated approaches that include prevention, education, law enforcement, and treatment in addressing the issues regarding alcohol, tobacco, and other drugs.
- Support strong laws and meaningful legal penalties that hold users and dealers accountable for their actions.
- Support the requirement that any medical use of psychoactive or addictive drugs meets the current criteria required of all other therapeutic drugs.
- Support adherence to the scientific research standards and ethics that are prescribed by the world scientific community and professional associations, in conducting studies and reviews on alcohol, tobacco, and other drugs (without exception to illicit drugs).
- Support efforts to prevent availability and use of drugs, and oppose policies and programs that accept drug use based on reduction or minimization of harm.
- Support International Treaties and Agreements, including international sanctions and penalties against drug trafficking, and oppose attempts to weaken international drug policies and laws.
- Support efforts to halt legalization or decriminalization of drugs.
- Support the freedom and rights of individuals without jeopardizing the stability, health, and general welfare of society.

MISSION STATEMENT: Drug Watch International shall provide accurate information on psychoactive and addictive substances; promote sound drug policies based on scientific research; and shall oppose efforts to legalize or decriminalize drugs.

Drug Watch International networks with organizations that have goals consistent with our mission statement; however, as a matter of policy, Drug Watch International does not officially endorse other organizations and/or individuals. Drug Watch International is not responsible for the contents of any website other than its own (www.drugwatch.org), nor does it endorse any product or service provided by any other organization.

This newsletter is for educational purposes, and nothing in it should be construed as an attempt to aid or hinder the passage of any legislation.

Drug Watch International, Inc., together with the International Drug Strategy Institute, a division of Drug Watch International, is a 501 (c) 3 volunteer non-profit drug information network and advocacy organization. Founded in September 1991, our membership includes physicians, psychiatrists, educators, psychologists, attorneys, judges, law enforcement, research organizations, legislators, and grassroots drug prevention experts. Our Delegates are in over 30 countries.

In order to maintain its independence, Drug Watch International does not accept funding from any level of government. Drug Watch programs and projects are entirely dependent upon the generosity of committed individuals. Please send your tax-deductible donation to:

Drug Watch International
P.O. Box 45128
Omaha, NE 68145
USA
Telephone 1-402-384-9212