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TRANSCRIPT

# "METHAMPHETAMINE: FACT VS. FICTION AND LESSONS FROM THE CRACK HYSTERIA"

*A Conversation With Carl Hart, Bill Piper, Holly Catania and Howard Josepher*

*Moderator: Marykate O'Neil*

*Inroduction: Kasia Malinowska-Sempruch*

## ANNOUNCER:

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## KASIA MALINOWSKA-SEMPRUCH:

When-- Carl and I had a conversation about (UNINTEL PHRASE) for this report I think we were in a taxi in Bangkok. And-- one of the reasons we had this conversation is because it seemed that Thailand which has a serious stimulant program-- is experiencing what the U.S. was experiencing a number of years-- number of years ago which is sort of-- panic around which, in the U.S. was sort of a panic around (UNINTEL) they are now dealing with it-- in-- Thailand around stimulant use. So-- so it seems that if you look at-- if you look at the map of the world and sort of regardless of where you are moral panic is what seems to drive a large (INAUDIBLE) and so-- so we don't-- are looking at methamphetamines is one way to address this question sort of us-- us talking science and better use-- and utilized in order to make sensible policies.

And so I'm really pleased to, A, have the report, B, to have this fabulous panel here-- to move us to a discussion about-- about methamphetamines itself but also more importantly what are the lessons learned and how can we use science for good policy making. Also we'll be tweeting. And the hashtag is meth facts. So please if you are on Twitter or will be on Twitter late-- later this evening-- keep that--

## MALE AUDIENCE MEMBER:

What's-- what's the-- what's the hashtag?

## KASIA MALINOWSKA-SEMPRUCH:

Meth facts. So over to our fabulous panelists, I will-- let-- our (UNINTEL) into this other one.

## MARYKATE O'NEIL:

Hi, I'm Marykate O'Neil. And I'm moderating today. We have Holly Cantania. She is-- an expert in drug policy, law and health consultant. She has been working on harm reduction since the late '90s. On my far left we have Howard Josepher.

He's the founder and president of Exponents, a minority led, community based organization in New York City helping people who struggle with substance abuse. To my immediate left we have Bill Piper. (APPLAUSE) Bill Piper is-- hold your applause. (LAUGH) Bill Piper's the director of the Drug Policy Alliance Office of National Affairs in Washington D.C.

And then we have Carl Hart who is the professor of psychology and psychiatry at Columbia University. Carl was the first tenured African American professor of the sciences at Columbia University. He's also a research scientist in the division of substance abuse at the New York State Psychiatric Institute.

He's a member of the National Advisory Council on drug abuse, on the board of director of the college on problems of drug dependence and the Drug Policy Alliance. He was also featured in the award winning documentary *The House I Live In*. And his 2013 bestselling book *High Price* has been receiving national acclaim and is due out in paperback soon. (LAUGH) And-- I guess who is gonna start is Carl's gonna talk for a bit and then we'll-- each panelist will talk for about ten minutes. And then we can open things up.

## CARL HART:

Okay, thank you, Marykate. So thank you all for coming out tonight. I guess-- before starting I just wanna say a word about-- cautious comment about this report. She's right. We-- we-- we talked about, well this port-- report was-- the idea of the report was born in a taxi cab in Bangkok. She didn't say what had happened-- previously in-- the night before or something.

We were out all night or something, right, at some-- one of those bars in Bangkok. (LAUGH) She didn't say anything about that. But, no, that's not so important. I-- in doing this report-- I didn't think it was that important to do a report.

I thought it was more important to do the scientific paper. There was-- there was a scientific paper that accomp-- accomp-- accompanies this report and which-- it's a critical review of the scientific literature on methamphetamine particularly as it relates to brain imagining and cognitive functioning. And I didn't think this w-- the report was as important. But I-- I'm wrong. I was wrong. The report is important because it's translated into language that-- regular people care about. Scientific-- the scientific report-- there's only 20 people who r-- read it. Whereas this report, more people will read it.

So I thank you all for coming out and-- and we'll talk-- I'll talk briefly about-- my motivations, my primary motivations for writing the report and what I hope will follow as a result of the report. But before doing this I-- I have to acknowledge someone in the audience-- because I recently have gotten a lot of press surrounding drug related issues.

And people are-- talking about drug issues now more like adults than I have ever seen in this country. And I have been given a lot of credit-- for some of the things. But none of these ideas that I am talking about are new. They are actually-- you know, people have been saying this before me. And I just wanna acknowledge one of the people who I read as a graduate student and still do read to get some of these ideas. Stanton Peele is in the audience. And-- this is his latest book called *Recover*. Here Stanton. (APPLAUSE)

So I-- I just want people to understand that these ideas are not new. And I'm not the-- the person who-- invented them. People like Stanton Peele-- deserve more-- most of the credit. But back to the report. The report, the major motivation-- was kinda talking with caution about this but there had been something else that happened before our taxi ride and-- and something that happened in the United States.

I participated in-- in a panel, a roundtable discussion in 2005 with some writers-- writers put together by the Office of National Drug Control Policy. They did this sort of panel to help these writers better understand what the effects-- of methamphetamine were. And while participating at this panel, the panelists were-- a law enforcement official, a U.S. assistant attorney, somebody who was addicted to methamphetamine and myself.

There were a number of claims made about methamphetamine that just seemed incredible to me. And this was back in 2005. And it sounds like the hysteria surrounding crack cocaine. And so I tried to remind the panelist audience-- what had happened in the mid 1980s with crack cocaine and how we made those mistakes in terms of policy.

But no one was listening. And nobody really wanted the hear it because the stories that were being told about methamphetamine were just too sexy. They just made-- it was just too m-- TV was j-- it was just great television and great drama. I mean, the law-- the law enforcement official, he told a story about how a parent was so cognitively impaired she cut the head of her child off and threw it at him. You know, this is great TV. It's not reality. But it's great TV. And-- and so shows like *Breaking*

*Bad*, those kind of shows, they grow-- they grew out of this sort of hysteria.

It's great drama. But it's just simply not reality. And so what-- a way to try to help people understand what the reality is was to put together this report. And this is what we did in the report. The report basically goes through the scientific literature, the popular literature and evaluates what's real versus what's not real.

So-- just-- I'll give you one-- or two quick examples. And then we'll move on. But one example in the scientific literature, for example, is that-- you see these beautiful brain images. You see somebody who is-- addicted to methamphetamine and someone who's never used drugs. And you see what area light up in the brain of the non-users and then that same area doesn't light up in the-- in the-- in-- in the region for the methamphetamine user. But then-- when-- but when you critically look at this data and this information what you find is that there is considerable overlap in terms of the-- what you see on these images.

By the way, the images are not data. But when you actually look at the data you see this crit-- you see this tremendous overlap. So it would be as if I decided to just divide this room up in half and image this side of the room and image-- and also image this side of the room.

We will see brain differences more than likely. We will see brain differences. But what is the meaning of those differences? The meaning of those differences have been interpreted as being pathological. But when you look at the behaviors of these people, they all behave the same except one group takes methamphetamine and the other one doesn't. Other than that cognitive functioning, all of those sorts of things, they behave the same. But we have-- we have interpreted these differences as if the methamphetamine groups is-- is pathological. And it's just simply-- that's an inappropriate interpretation.

So you go down-- if you look at the scientific literature carefully like we did in the scientific paper, and some of that is in this report, you start to see that these effects were exaggerated. We have been hoodwinked. We've been bamboozled.

And this is part of our drug education in the country. And so the report tries to-- remedy that situation. So what I hope the report does is that it increases the intellectual tome surrounding discussions about methamphetamine. And then for the smart reader I hope they are able to apply this knowledge beyond methamphetamine and apply it to other drugs as well. And with that, I think I'll let somebody else speak.

## MARYKATE O'NEIL:

Okay-- next we're talk-- gonna-- Bill-- I was wondering if you could tell us something about the penalties associated with meth?

# BILL PIPER:

Yeah, so (CLEARS THROAT)-- you know, methamphetamine is one of the most-- demonized drugs-- in the country. And it's also one of the drugs-- that congress and state legislatures have legislated on-- the most. It's been the subject of-- at least a dozen federal laws over last several decades and then dozens-- more bills that have been introduced-- that didn't go anywhere.

So really congress has probably done more in methamphetamine than any other drug. And the penalties are extremely harsh-- comparable-- to crack cocaine in their harshness. And it's interesting-- when you consider kind of the history of methamphetamine and amphetamine and how we got here. One of the things I like about-- the report, methamphetamine dangers exaggerated is that it gets a little bit into the history. Meth isn't new. Amphetamine was discovered in late 1800s. Methamphetamine was synthesized in-- in-- I think-- 1919, back in the early 1940s. It was widely available both amphetamine and methamphetamine for all sorts of medical uses to treat alcoholism, to treat obesity, to treat narcolepsy.

Soldiers in World War II were given methamphetamine and amphetamine-- to help improve-- their stamina and their endurance. Probably an entire generation of Americans were introduced-- to these drugs-- as part of their military service.

And then after World War II-- amphetamine and methamphetamine were widely marketed. Amphetamine was-- marketed for-- obesity and for athletic performance and to help truckers stay awake-- so they could their cross country halls. Methamphetamine in particular was especially marketed-- to women to treat-- depression and obesity. And this is gonna be a little hard to see probably for most people. But here's an ad-- from the '50s-- geared towards women telling them that methamphetamine-- will keep their reducer happy.

And it goes onto say-- that-- methamphetamine helps-- reduce abnormal cravings for food. I'm not even sure what an abnormal craving for food-- (LAUGH) is. But the bottom line is-- and, you know-- is that these drugs were legal and readily available in the '40s and '50s.

They certainly were-- folks were talking about the health implications and suggesting maybe people were doing too much stimulants. But you didn't have the problems that we have-- today. You didn't have people stealing to support their habit.

You didn't have illegal meth labs. You didn't have drive by shootings over meth. You didn't have meth related violence. You didn't have, you know, so called tooth decay and meth mouth and all of these myths-- that Doctor Harding's colleagues-- dismiss in their-- report.

And this is at a time when we see drugs are readily available. It wasn't until the early 1960s that we even began to see-- illegal meth labs and congress-- trying to curtail that-- with-- various restrictions. And that was after the government had convinced-- makers of an injectable form of methamphetamine to take it off of the market-- 'cause people were misusing it.

The demand for injectable methamphetamine remained. So the illicit market began fulfilling that demand. Then the '70s come along. Congress takes amphetamine, methamphetamine, makes them both schedule two drugs-- making it very, very hard to get. That's the most restricted category. So p-- for people who were used to using stimulants to help them keep awake-- to work two jobs-- or just to generally feel good suddenly could no longer get those stimulants. So the illicit market expanded.

And then we saw in the '70s, '80s and '90s a series of-- of somewhat-- somewhat of a long answer to your question but-- a series of bills, some designed to-- enact penalties for people producing and selling and using meth and then kind of an escalation of harsher and harsher penalties.

Then you had a series of precursor restrictions all designed to stop people from illegally making-- meth. And then every step of the way-- drug traffickers exploited loopholes in the laws. They switched ingredients. They found new ways of making meth. They-- began making-- meth in smaller batches.

So instead of having a couple large, illegal methamphetamine laboratories to deal with polimay-- policy makers soon had dozens then hundreds and thousands-- to deal with with all the associated problems associated with that. More recently-- congress and a number of states-- you might be aware have restricted access to cold medicine and allergy-- every state you have to show ID and sign-- a government registry to buy-- medicine with pseudoephedrine in it.

Some states have made those medications-- prescription only-- which is really hurting people who have colds and-- and-- and allergies. And that's had some sort of-- it's reduced probably the number of domestic labs especially the small type of labs. But the evidence shows that most methamphetamine comes-- either from outside of the U.S. made in Mexico and smuggled in or it's made in the U.S. but it's made with precursor restrictions-- that are smuggled into the U.S. And so all these penalties and all these precursor restrictions have done nothing to reduce the supply. Anyone in this room who wants to get meth-- can get it. I think that's probably the most important part. And-- Dr. Harding's colleagues talk about that-- that-- just the supply is still there despite these harsh-- penalties.

And-- so the supply side doesn't work. There is good news that your treatment does work. There's dozens of studies that show methamphetamine is as treatable as any-- other-- drug. The-- the court kind of gets into some of the science. But 15 percent of people who take-- methamphetamine end up with some sort of dependency problem.

It's a relatively low addiction rate. It's actually pretty on-- on par with alcohol. So methamphetamine-- is treatable. But one caveat and-- and I'll end with this is that with some drugs, say, heroin and nicotine I think they're in some ways easier to deal with. Nicotine you have nicotine patches, nicotine gum. Heroin, you have buprenorphine and methadone. On some countries pharmaceutical heroin-- is available for addicts. And you really don't have that-- you don't have the methadone-- for-- methamphetamine and other stimulants.

I know there's been some research. They talk about that in the report with

dextroamphetamine with some studies in the U.S. and around the world that have shown-- that if you give-- pill form dextroamphetamine or-- pill form other stimulants to-- illegal meth users that that improves their health.

It changes how they use drugs. So they're using it in pill form instead of injecting it, reduces criminality. It has, you know, some-- interesting improvements. But, you know, those studies are limited. And more needs to be done. And if-- if people take one thing away from that I think it-- from what I'm saying is I think there needs to be a lot more research and our goal should be to find a treatment for methamphetamine-- misuse-- that is equivalent to what methadone or buprenorphine is-- for heroin. And finally-- you know, considering that we have the harsh, harsh penalties for meth which hasn't stopped people from using meth-- and all these precursor restrictions which hasn't stopped its supply and the history that all of this shows that at every step of the way the government has made legal axe-- access to legal stimulants harder and harder to get which has created an illicit market for drugs that are even worse than what they were on the legal market.

This suggests that policy makers at the very least need to stop making it hard for people to get-- low to medium dose stimulants-- from their doctors-- 'cause when you do that that drives people to the illicit market. It forces people-- to not only use very highly potent-- stimulants. But you know, where they once were using it in pill form, they're not snorting it or injecting it. This creates a whole class of-- of risk. And so all-- all-- all-- in-- I'll end on that that for decades-- we didn't really have a lot of the problems that we have now. And people were on-- a stimulant.

And people still are on stimulants. The court talks about the number, you know, of-- of-- of people including young kids that are on pred-- pretty high doses of stimulants-- that they're taking daily. And they don't have meth mouth. And they don't have cognitive deficiencies.

And-- after decades of use I'm pretty sure it would show up. And so I don't think our country has a meth problem. It has a meth policy-- problem. And a lot of the problems that we have are not a result of methamphetamine, the substance itself. It's a result of the policies that policy makers have chosen to enact. And with that I'll let someone else talk.

## MARYKATE O'NEIL:

Bill, maybe you could pick up-- I'm sorry, Howard, you can pick up on where Bill left off talking about-- different forms of treatment.

## HOWARD JOSEPHER:

Okay-- good, I bet-- that treatment and medication that you just spoke about, Bill-- is in the second level of clinical trials right now. And it's called ibudilast, ibudilast. I'm trying to find out (LAUGH) if ibudilast is-- has any connection to ibogaine. But it

doesn't. It's-- it's-- it's what you said, it's-- kind of-- a meth.

And they're-- they're finding that it dampens cravings. And it improves-- some-- cognitive functioning. And so the-- you know, those studies should go on. Some of the other treatments that-- that have been used in terms of addressing methamphetamine addiction, there are some of the-- cognitive behavioral therapies-- some contingency management-- interventions. Certainly it's being addressed in narcotics anonymous and especially in crystal meth anonymous. There are specialized meetings now going on. My-- my organization and the treatment programs that we primarily with inner city what you would call poor people of color, mostly.

What we're seeing in terms of who's coming in for treatment are primarily young, black, gay men. To understand the kind of treatment that we offer which is a harm reduction drug treatment, you understand that harm reduction itself is, you know, to minimize-- harmful effects and negative consequences of-- drug and alcohol-- that some ways of getting high are safer than other ways of getting high.

Harm reduction services do not require that people quit using drugs. Services are presented in a nonjudgmental manner-- non-coersive manner. Harm reduction services seek to empower the-- the drug users. And often the people who are actually providing the service are reflective of the people that are receiving the services. We call that peer-- peer to peer services. The difference between harm reduction and harm reduction drug treatment is harm reduction drug treatment does everything harm reduction does.

But our job in treatment is to reduce or minimize pain. And that it is pain that drives the self-medicating behavior of people who become abusive, self-destructive and addicted to drugs. So treatment reduces pain. What's important about the treatment in harm reduction is-- is that you wanna make it easy for people to access the services.

And so what we do is we lower the threshold. As opposed to traditional treatments, if you wanna get into a traditional treatment program, you gotta stop using drugs. You gotta actually kick your habit before you even get into the program. Harm reduction treatment does not require people to get off drugs before they can access the services. We develop that basically because of the AIDs epidemic when tens of thousands of drugs addicts were coming-- becoming infected and dying from HI we-- V related illnesses.

And how could you if you have a program that you're trying to help people, how could you tell somebody, "You gotta get off drugs before I'm gonna help you in the middle of a damn ep-- epidemic?" And so we lowered the threshold. You-- in harm reduction drug treatment you don't require front end abstinence.

You also don't require immediate lifestyle changes or as they do in many drug treatment programs, you gotta avoid certain places, people and things, these things that are known as triggers. And in harm reduction drug treatment, you accept goals other than abstinence and that the goal setting is set in a collaborative way. Let's call

that person who participates in a program-- let's call him a client. It's not my favorite way of referring to people. But just for making it easy that it's both-- the-- the goals are set by the client and by the clinician or-- or the-- the treatment person.

And that-- and that-- you know, when I say that a lot of treatment programs, they-- they-- they set the goals for you. So it's the treatment programs values that the client is supposed to accept where in harm reduction treatment it's the goals and the values of the clients.

Like if you get into-- some treatment programs they say, "You gotta admit your powerlessness. You gotta accept that you are in the need of a higher power." I mean, these are all good things. But they're also the same kind of conditions that turn people off from entering those programs. So-- so some of the goals can be-- you know-- they change.

Of course goals change. They-- so they could be-- they could range from reduction of problematic drug use to maybe responsible drug use or even sobriety. All goals are accepted as long as they're both client centered and-- and the-- the-- the program-- you know, are doing this collaboratively.

There are small steps at first in treatment. Don't forget treatment, in order to mitigate the pain, you gotta change or-- or help the person start to change some of the behavior. And so like a small step might be, listen, you're welcome into this treatment program.

You don't have to kick your habit. But how about you come to your treatment sessions, your counseling or group session, you just don't get high before that session, a small goal. You can go get high afterwards. But just-- or-- or-- another-- another-- goal that you might wanna-- talk about with somebody is-- listen, let's do an evaluation on you as part of your treatment process that time to time we're gonna evaluate to see whether you need to go into a detox, you know, because-- you know, the-- that might be helpful.

And it might also be very helpful in terms of you progressing in treatment that there be periods of time where you're abstinent. So-- so these-- these are some of the goals, some of the things that you establish with somebody as they-- as they-- start in a program.

All right, let's just talk about methamphetamine and-- and how it's used. You smoke it. You shoot it, injection. You snort it or you swallow it. In our way of addressing-- the pain and mitigating the pain is that what you clearly see in an addictive personality is self-destructive behavior. And if you're self-destructive what you see is that people sabotage themselves, that they may progress. They may get better. They may be moving forward in life but they somehow yank the rug out from end-- under themselves. So self-destructive behavior if we look at it closely means you're not gonna let yourself win or succeed, that you are in a lousy relationship with yourself.

And so that's where you gotta bring the focus. The individual's relationship with themselves, if you don't like yourself, you're not gonna win. You're not gonna succeed. If you don't like yourself, you're gonna be in pain. And if you're in pain,

you're gonna need to medicate that pain.

So it's healing the relationship with self that becomes the way to reduce the pain and the way that you're gonna minimize or reduce the drug use. So how do we do that? You bring in the ten-- person's attention to their-- to their relationship with themselves. And that-- the way we go about it is you're not here on this planet to be improved by other people. You're not here to be loved not even accepted by anybody but yourself. And whatever it takes for you to love and respect yourself, whatever it takes for you to heal that relationship with yourself is that's what you gotta do.

Our society got this whole thing screwed up. You know, we think you're supposed to be successful and famous and people love you. And you follow the precepts of your church, of your synagogue or your mosque or your government and that then they'll accept you. And you're supposed to be cool and okay at that point. But if you ain't okay with yourself, you're not okay. So how do you become okay with yourself?

## MALE AUDIENCE MEMBER:

Take drugs. (LAUGH)

## HOWARD JOSEPHER:

You know, that's not a bad idea because if you're okay with yourself with-- and you take drugs, you're just elevating your good mood, right. That's why most people take drugs. You know, your life is up, it lifts you up. But if you're taking drugs because you're hurting, because you're suffering, well, then something else is going on there.

And so the way we try to help people to see to make that a better relationship is is you gotta stop reacting. We're given free will whether you believe in a higher power or not. We are given free will. We have a choice. So if you stop reacting, don't make choice-- stop, now you got a choice, how are you gonna deal with this situation where whether you win or lose, whether you get what you want or you don't get what you want but you're gonna come away from it saying I like the way I handled that.

You're okay with yourself. I don't give a damn if the rest of the world don't like what you do. But if you like what you do, you're okay with it, that's what counts. So I can't teach people a value system. They have to find their own value system. They have to find-- how do they behave that they're gonna be okay with themselves. So I'll tell you a little story and finish. I had a young lady in class.

And she said, "You know-- I was in prison. And that every time this guard came up to me in prison, he got right in my face and he yelled at me. And when he's yelling at me he's spitting on me." And she's saying, "I wanted to hit him." Well, you know what happens if you're gonna hit a prison guard. You're in-- you're in-- you're in solitary.

I said, "So what did you do?" She said, "I hit him." (LAUGH) "What happened?"

"They put me in solitary." I said, "Well, how was that for you?" she goes, "Well, I had a room to myself." (LAUGH) In other words she made a choice. And she was okay with it. And that's the way you heal that relationship with yourself.

You-- you do the best you can. And if you can do the best you can and you can say that to yourself, then you're gonna be okay with yourself. And you're not gonna need to-- you're not gonna be in so much pain. And you're not gonna need to medicate that much. You may even start to enjoy drugs for different reasons.

## MARYKATE O'NEIL:

Okay, last up we have Holly who has some visuals for us.

## HOLLY CANTANIA:

So I need to give you a little background about how I got into this methamphetamine discussion. Those of you who know me know that I've been working on the meth since 1997. That's methadone. And-- but the-- issue has always been a stigma-- and beyond.

But I actually was doing some research on a case that while I was working at the international center for advancement of (UNINTEL) and treatment with Bob Newman, we used to get a lot of cries for help from-- advocates and-- and pay-- patients who were in the methadone treatment system. And we got a call from someone in Taswell, Virginia, I think I'm saying that right and asking for help.

So it was a young woman who was-- arrested on some minor charges. And the police looked in her purse. And they found some drugs. And she was sentenced to-- she was going to be sentenced to prison. She was in treatment. And the judge ordered her to get out of methadone treatment or he would sentence her to double her length of time.

And she tried to get-- taper her dose and finish the treatment just to be able not to go to jail for that length of time. And she couldn't do it. And she's-- they raised her dose back up as she was trying to taper down because she was getting sick.

And she was very scared. And her doctor and everyone treating her tried to weigh in, went to the court. But the judge was adamant about his-- his warning. And he ended up sending-- sentencing her instead of six months to four and a half years in prison for defying the court's order.

So-- what you're seeing on the screen is some of the news stories that came out of that case. And they were surprisingly favorable. I mean-- people were interpreting this in a way that I think we were, that the judge was making medical decisions by forcing her off her medication.

I was doing further research about methadone in Taswell County. And by accident I happened upon this. And-- there happens to be a Taswell, Illinois. And it really

captured my attention. This was a campaign by-- a prosecutor in this town who got the idea and got federal funding to do a prevention, methamphetamine prevention program because they were having-- they said a lot of problems with methamphetamine especially with young people. So there was also a sheriff about the same time in-- Washington state-- Oregon, excuse me, who was interested in the same thing.

I think this-- I think this D.A. beat him to it. Anyway he did get a federal grant to do this program. This woman got arrested. And she was facing a prison sentence. And the D.A. said to her-- "You can get probation if you agree to let me show your pictures, before meth and after meth pictures." They are just I think three-- three years apart, these two photos. They're mug shots.

And-- he said when I go to campaign-- go to talk to schools, I have-- I go out to schools and teach kids not to-- not to methamphetamine, not to use it. So faced with that, she's-- she actually had-- she has children and young grandchildren. And she didn't want to be in prison. So she agreed. However what happened was they took-- he took his campaign. He put it onto billboards. This flyer poster was sent to every school including the schools where her grandchildren were.

And someone wrote a story about it. This is how I came-- I started really digging to find out what is going on here. And the woman was telling the reporter this story that she regrets the day she did this. If she had just gone to jail, she would've been out and gone on with her life.

She-- she's like my whole family is suffering because of this. And that's the last I saw of this. And this was about 2006 of her-- her case. But I'll come back. Oh by the way I looked at the ad. And I thought, okay, it's all about reporting crime. But there was a get help for a meth user. So I called the number. And I said, "I have a brother who's getting involved with methamphetamine. How can you help him?" She said, "Well, what insurance does he have?" And I said, "He doesn't have insurance. He's young. He's in school." She s-- I said, "Do you take Medicaid?" And no it was self-pay for certain insurances.

And I said, "Okay, that wasn't terribly helpful." And then in the New York Tie-- oh, and then there was a story that I found that this idea has crossed the ocean. And police in Scotland Yard in the U.K. decided that's a great idea, too. So they posted pictures similar-- another person-- this is supposed to be the progression-- supposed to be the progression of someone on methamphetamine.

And they're all arrest photos. However they never identified the person. There's no confirmation of what her-- what was going on in her life. But they decided when that campaign started, they actually tr-- started it with people in the country and quickly withdrew it because it offended their privacy laws. And then they thought, well, we don't have that issue if we use American photos. So they went to Florida and asked for some-- a progression of-- a drug at any-- actually they called this crack.

So it doesn't seem-- m-- matter which drug it is. And then I see this. Some of you may know the artist Damien Hirst. He's a British artist, has a reputation of being a

bad boy. And I'm like, oh my gosh, that's-- that's the lineup, the meth-- the face of methamphetamine lineup from Florida.

And he put some green wash over it. And he is displaying it in the Gagosian Gallery. And I thought, wait, well, that's not even-- that's derivative. Like, that's not even his work. So I-- I called the gallery. Nobody really cared what I had to say. I wrote-- I wrote an email. I got his email address.

And I thought he likes controversy. That's why he does stuff like this. He didn't answer, didn't want to talk. But again there's this woman. Nobody bothers to know who sh-- like, what her name is. Is she still alive? What's going on in her life?

You know, what illnesses does she have that she looks that way? It's just like random drug use. So then I really started-- I don't know very much about methamphetamine. I wanted to look at the policies 'cause that's what I was doing. And at the time-- this is like 2006 they were starting-- the police were taking other measures to-- this is more prevention.

Apparently I couldn't find any other prevention programs except that were based in law enforcement as Bill-- talked about. So there were these internet registries that-- and several states included people's names and their home addresses much like the sex offender registries. These people had been-- some of them arrests, some convictions. So the people who had been arrested were, you know, supposedly presumed innocent. But their names on the internet to live forever and their home addresses.

And as you can see the governor of Minnesota was one of the first states to-- to be the early adopter, said, "Well, the purpose of this was to protect the community. I mean, you know, there's danger in these homes where meth labs were made," like making some link between people where they lived and where they were cooking meth is-- you know, without any connection.

And then also I thought, well, if this is to protect the community what about their property values. If the real-- I mean, if their neighbor is identified as a meth-- possible meth lab and who goes into thinking that through, how is that gonna affect the rest of it?

So how could say this is really, you know, about-- protecting people's property and interests? But I thought Graham Boyd who was the former drug policy director of the ACLU had it exactly right. He said, "Really, this-- one group for whom this registry is going to be incredibly good resources is people looking to buy methamphetamine."

They have a whole list there with the addresses. (LAUGH) So that probably wasn't the best move for the police. But they still exist these registries. And in fact that's-- that's kind of why I wanna start bringing us up to date. Unfortunately I don't know if anybody's ever seen these things.

But there are so many of them on the web. And there-- these websites rehabs.com, they have 50 before and after pictures. There are several others that-- have these headlines that say, "New faces of methamphetamine." And like, oh, click on and see

who-- who else we have. Only this one I thought it was-- I only found the first two pictures at first, this woman, two different arrest photos again-- three years apart. But I thought what-- that second photo they're-- they're saying that that's-- her face looks that way as a result of methamphetamine use?

There's no explanation, nothing. I-- but her whole name was there. So I dug around. And I found out that she w-- as you probably can imagine was burned in a fire, allegedly. It was a meth lab that had blown up. And this one is really getting-- it's all over the web because-- and as you can imagine the comments are very-- not very nice about her because she keeps-- she's got new-- more arrests and apparently is still using methamphetamine.

And these-- someone posted this as the progress of her plastic surgery. And there was this whole discussion about, well, who paid for that? And part of the points why I'm bringing this up is can-- I mean, this is all because it's about drug use and drug users. And this complete lack of regard for people's dignity, privacy, their family's l-- their family lives, you know, this is supposed to be about recovery.

But the-- all-- all of these prevention programs are completely aimed at shaming people, outing them and trying to scare teenagers because they don't want to look-- and on the surface a lot of people say, "Well, you know, scaring people away from using methamphetamine, that's not-- that makes sense to me until you see what they-- how they're doing it."

And there's no confirmation about what's behind it, what's going on in their lives. But some of the other legal things beside these-- these terrible, social shaming campaigns-- have been-- you know, I mentioned the registry use and the-- results-- I think-- and we're-- this is all, again, from around 2006 and before that, like, reading stories now of the same things. You mentioned the-- the methamphetamine babies now are being completely linked with the crack-- it's just like we're doing the same thing over again.

I-- I won't go through everything 'cause I think we're a little short on time here, or I am. But-- one other thing with those registries that I found, there were from-- this period where there's-- where there's a lot of media attention to the issue of methamphetamine and it quieted down and then now it's flared back up again.

And I'm-- was wondering, like, why is that happening? It's not because the problem went away. In fact the states where the problem was-- found to be the greatest at least in the low-- southern-- the Midwest and southern con-- states, they were getting a lot of federal law enforcement money pumped into them. So there were these registries.

There was a lot of-- arrests and supply reduction-- efforts. And part of those efforts-- what was tied to that was also clean-- clean ups of the meth labs after they had-- arrested the people who were cooking in them. I read a report from Tennessee which I think probably has the highest-- if you guys know, but I think that's the place where-- that reports the most methamphetamine arrests.

They had an interstate registry agreement with the states surrounding it. And there

was-- I didn't put it up here. You know, I can send it to people if they're interested. One of the clerks was complaining that the cooperation from the other states seems to have disappeared because they're not getting reports anymore.

And Kentucky used to report ten arrests every week. They got one in the last month. And I thought did the clerk die? Like, what happened? You know, how-- why did this stop? And apparently why it stopped was because the-- the law enforcement money dried up. So there were-- the police were not making the same arrests. But more importantly even if they were arresting people, they weren't-- they left the labs contaminated places, burn-- half burned or burned places still standing in neighborhoods and communities and-- and really creating-- something that looks worse than any photo of someone's face could ever-- I mean, I-- the photos I saw of some communities-- so some of these policies where they think they're preventing people from using drugs are really more than recreating what happened with crack.

It's actually seeming-- they're making it much, much worse. And some states opened private meth prisons just for methamphetamine arrestees and convicted-- people convicted of those crimes. And-- I'll just run through it. A female meth prison-- I can't go over this now.

But there was a whole conversation, I mean, in detail, I'll just touch on it, about how the response to methamphetamine has been much nicer than the response to crack because methamphetamine users are white and-- and crack users are black.

And so there was this public kind of discussion about how unfair that was which I think from the same point of view that the law enforcement-- it's just the-- it's the wrong way to look at how to solve the problem. Like, so the answer was coming up, well, we should do the same thing to people that we did to people in the crack days. It's well intentioned.

But it's still the same approach to people who use drugs. And they're repeating. And the money is still going to law enforcement. But if you look at the-- the budget for-- drug policy for the-- country-- the treatment dollars went up. But if you look closely at the breakdown, that is a big-- in large part due to the drug courts being in-- under the budget line of treatment. And while they're growing and spreading-- but they're not treating very many methamphetamine users.

## MALE AUDIENCE MEMBER:

'Cause they don't need treatment.

## HOLLY CANTANIA:

Well, didn't Mari-- people who used marijuana, 36 percent of New York and Manhattan drug courts are treating people for marijuana. So--

## MALE AUDIENCE MEMBER:

Well, there are-- the number of the people who use marijuana are so much more than the numbers of people who use-- methamphetamine. So you expect to see that. That's not-- that's not a surprise.

## HOLLY CANTANIA:

We can have another panel on that (LAUGH) or talk later. But the point is if the-- if people think that these are the people with the most need, they're not even addressing them in the way they address other drugs. So instead our drug courts are-- are taking in people charged with marijuana offenses and giving them marijuana treatment. So I think I should probably stop there. There's so much more to go into in that-- last slide. I feel bad that we couldn't really talk about that 'cause there were a lot of issues there. And I'm happy to answer questions after this or beyond. Thank you. (APPLAUSE)

## MARYKATE O'NEIL:

People with questions?

## MALE AUDIENCE MEMBER:

Stanton?

## MALE AUDIENCE MEMBER:

Carl-- Carl spoken some of the least so I just wanted to give you a chance to say some more things. But before that I-- Howard, I-- I just-- this-- the treatment program I lay out is almost exactly what you described except for one thing. This book is called *Recover*, stop thinking like an addict and claim your life to the perfect program. Except for one thing you described your treatment as empowering which I would describe mine as. But then you describe people going into programs where they t-- were told that they were powerless. And they needed to seek a higher power. So I'd like you to comment on the seeming inconsistency of that. But before that I just wanna say I had this kind of bet going with Carl, it's kind of a discussion where he comes and he demystifies amphetamines and drugs.

And I say-- always say to Carl, "You know, the group that you're talking to I bet that they're subject to all the mist-- that you're demystifying. Everything that was talked about here is predicated, all the things that Holly described, all the lows are predicated on the idea how horrible these drugs are, how out of control they are.

So I wanna give a quiz-- I'm gonna tell you four things that Carl believes, I mean, he--

and I wanna see how many people believe them. Are you ready? (LAUGH) Carl says that 80 to 90 percent of people who use meth and crack aren't addicted and that those who do become addicted in no way resemble the standard addicts that you see all the time on shows like *Breaking Bad*. How many people believe that? It's a minority would you say?

(OFF-MIC CONVERSATION)

## MALE AUDIENCE MEMBER:

80 to 90 percent are not addicted. And those who are addicted don't appear like the kind of standard addicts. So I would say a minority of people believe that in this room. Or--

## CARL HART:

That's what's showing up in our programs. It's not-- what's showing up in our programs are people who use methamphetamine. But it's part of a lifestyle of-- of sexual activity and clubbing.

## MALE AUDIENCE MEMBER:

So isn't it depressing that in this room of advanced people, a majority of people don't believe that. Okay, you ready? Carl believes the same thing about heroin users. How many people believe that?

## CARL HART:

That they're not addicted?

## MALE AUDIENCE MEMBER:

80 to 90 percent of users are not addicted.

## HOWARD JOSEPHER:

I'll put my arms down.

(OFF-MIC CONVERSATION)

## MALE AUDIENCE MEMBER:

75 percent are not addicted and-- 25 percent are addicted or-- or do not behave like the kind of person you see. How many people believe that?

(OFF-MIC CONVERSATION)

## CARL HART:

Absolutely, but-- but clearly they haven't read *High Price* because they-- they-- their hands would be up. (LAUGH)

## MALE AUDIENCE MEMBER:

Okay, I'm really gonna challenge you now. These weren't even challenging questions. Carl does not believe-- and not-- by the way, I'm so honored that Carl should give me credit 'cause I don't believe these things either. So I'm not putting Carl down. The major-- the large majority of people who die from what is called heroin overdoses in fact have not taken especially intense concentration or too great an amount of heroin. How many people believe that? Another minority.

Okay, one last question, Holly showed all of those pictures of that woman being deteriorated. And her concern was, you know, the righteous concern who-- who gave her permission to show this woman? But those pictures are fake. Carl does not believe that amphetamine-- and I'm-- I'm not-- I agree with Carl, they don't meet the-- the concept of the rotting mouth.

That whole deterioration thing is not due in fact to amphetamines. How many people believe that? So when you're watching that picture if you're agreeing, well, it's horrible they're showing that but you believe, still a minority, are onboard.

## CARL HART:

Right on, right, great-- great point, great illustration. So-- (LAUGH) so I guess-- when-- when we have this kind of situation actually I am-- Stanton and I have this ongoing thing. And-- I didn't believe what he just said would happen. I-- I'm-- I would've lost this bet. In fact I did l-- lost-- I did lose this bet. So I owe you some heroin, my bad. Okay. (LAUGH)

(OFF-MIC CONVERSATION)

## CARL HART:

I know. So since we have this situation I think it would be really useful if-- people ask questions in order to get at these issues to figure out-- I-- I wanna know why is it so

difficult because my belief, by the way, is based on empirical information, the evidence. And so I wanna know why your beliefs are different. So please ask questions that are related to that.

## MALE AUDIENCE MEMBER:

Yeah, my question is why do we always in this country rationalize someone's drug use or drug behavior? We had a (UNINTEL PHRASE) Long Island there. He was a sociopath who used drugs as an excuse to go ahead and murder innocent people. He was a failed (UNINTEL PHRASE) he had a miserable life.

Why do we rationalize people's drug addictions, drug use whether it's methamphetamine, heroin, crack? That's what this problem is. People who are sociopathic or-- (UNINTEL PHRASE) but it's my belief that we are sociopathic by nature, just that some of us take it overboard and we use drugs as an excuse to carry out heinous and ridiculous and criminal--

## CARL HART:

Well--

## BILL PIPER:

I could-- say something, give you a moment. I mean, I think your question is why do we-- why do we put behavior like that on drug taking. Is that what you're saying?

## MALE AUDIENCE MEMBER:

The gentleman who spoke-- let's saying let's look-- I've been around 50, 60 years. You don't see all of us addicted, running around with our pants hanging down. LSD was always a problem back in the-- in the '60s. I mean, it-- it's just--

## BILL PIPER:

Well, I-- I think that it's because the issue of drugs and drug taking is so stigmatized that it gets a reaction. And-- and it's-- and it's-- it's sort of like there's a gut reaction in most people and people who write newspapers and do TV, they know this.

You say drugs, it's like-- people react. And so-- so they-- they get-- they get the response they want. This is-- this is-- comes about from years of-- of-- you know, politicians manipulating the use of drugs, you know, frightening people, scaring people for their own benefit, for the politician's benefit not because it has anything to do with the truth. And that's what Carl was trying to present is that-- is that the

whole issue was so stigmatized that we don't have clear thinking and a clear way of dealing with this issue.

## CARL HART:

They believe it because you all answered the question wrong. And if-- as long as the public remains ignorant about drugs, you can see these incredible things about drugs. And you the public will believe them. So we cannot say these incredible things about tobacco or alcohol because we have extensive histories in the country.

And we know of a number of people who use those drugs. But really cocaine, methamphetamine, heroin, all of these sorts of things people behave rationally. People behave just like folks on alcohol. But you need the education first to know how to do these things in a way that people can be safe and have a good time. And we haven't shared that with the public. That's why you all believe these incredible stories about drugs.

## FEMALE AUDIENCE MEMBER:

Carl, you said one of your goals was you were hoping to increase the intellectual tone. But you know, those pictures-- I mean, I've seen those on *Frontline* not Bill O'Reilly. So I just think there's-- there's a big challenge ahead of us when I'm watching this on PBS versus FOX. And I don't know if anyone had any thoughts about that or how we overcome that issue.

## CARL HART:

That's why I wrote *High Price* in order to interact with the public. I had been for the past 27 years only talking to scientists. I wrote this book in order to translate what we know in science to you all. So the in-- so-- I think that the in-- so the information is getting out in the public. It's certainly-- people are inviting me to mainstream television shows. FOX loves me. You know, those sorts of things (LAUGH)-- I-- I think-- I think that's a part of this public education campaign.

## MALE AUDIENCE MEMBER:

So-- so I just moved here from Arizona. And-- in Arizona there's a drug trafficking, like, storyline because used-- it's highly politicized as a means of immigration, you know, regulated immigration. It's-- it-- it's pitched as-- undocumented immigrants are coming across the border and bringing drugs.

And so therefore it serves-- as that purpose in Arizona. But then the punitive nature really stigmatizes the actual drug addicts. I worked with a lot of drug addicts in a

nonprofit-- organization in-- in Phoenix where they would get treatment to have a better quality of life. But then you would have these felony convictions. They were never-- they were never able to recover from those.

And so it poses barriers. So I'm just trying to figure out how to-- I mean, I-- I just-- I know that we have a policy problem. And these policies served as political-- you know, political leverage to-- for other-- you know, other purposes.

But-- how do we-- I mean, what steps do we take to kind of balance the scales as far as treating the person who-- or helping the person who they recognize that they have substance problems. But then also-- I guess I'm getting lost in my words. So-- I'm being-- addressing all these issues-- they're actually, you know, this unbalanced scale.

## HOWARD JOSEPHER:

Well, I could say-- we don't just have-- policy problems. We have-- we have a drug treatment problem. According to federal government SAMPSA, substance abuse and mental health services administration, there are 23 million people in this country who need treatment.

And only ten percent of those people ever access the treatment. See, I think that what's happened because-- people like Carl, because of this organization, drug policy alliance, that we're making progress when it comes to policy and laws. You see things changing. We're not changing in treatment. And that said why aren't 90 percent of people who need treatment coming into treatment? They just don't want what we have to offer. And we're not changing that.

## BILL PIPER:

I do think it's important to emphasize that the vast majority of drug users don't need treatment. And that's the case whether it's alcohol or heroin or methamphetamine or cocaine or-- or-- or marijuana. And-- and even within those who may have issues-- they might not necessarily need-- treatment at least in the-- in the conventional form.

Like, their problems may be life issues which is one of the things I know that you work on. I would say just in terms of-- of how to deal with the issue of drug use, I think we-- we as a society really need to commit to the idea that drug use is a health issue not a criminal justice issue.

(OFF-MIC CONVERSATION)

## BILL PIPER:

Well, drug use is a personal issue. For some people it's a health issue. It's certainly not a criminal justice issue, you're right. Thank you for correcting me. But the-- the

idea that we would take other health issues-- people who were slowly gaining weight over time and-- and do an ad campaign randomly picking out people and demon-- to demonize-- (LAUGH) is absurd.

So the level of stigmatization-- is-- flows from the criminalization. So no matter what the drug, meth, cocaine, PCP, marijuana, I don't really care, no one should be criminalized for it. I think if we can start there, then we can really-- begin to deal with the issue.

## CARL HART:

Let's some people get in here with questions.

## MALE AUDIENCE MEMBER:

Dr. (UNINTEL PHRASE) NYU Medical Center and the health staff. I loved the cover of this-- it's a *Breaking Bad* rift actually. I don't know if you caught that we were doing that. But-- I have a ques-- well, first I wanna make a comment about the 23 million figure that SAMPSA quotes. I have an article in *Huffington Post* where I kinda critique what percentages they use to derive those big numbers.

And a lot of times it's based on somebody who has, like, legal problems that you-- that they picked up on a survey of-- and they say, "Oh, that person's got a drug abuse problem." So then you factor how many people you sample in terms-- what that represents in the population, that's how you get the 22 million figure. Some of those numbers-- I'm not saying that the-- there's not a need but I don't-- I dispute, yeah, that actual number especially when you look at the nine percent figure for marijuana that's quoted which is-- pulling a lot of hair, so. What I wanted to ask-- Professor Hart about is-- Nora Volkow and her drug-- brain imaging studies.

I learned from a book called farm-- *The Cult of Pharmacology* by Richard DeGrandpre which is an amazing book that her-- her research showed that coke-- cocaine and methylphenidate are pharmacologically equivalent that you-- you could do brain scans to two people who are blinded.

Or you give them an IV of the-- these drugs. They don't know which one's which. And one's an angel drug and one's a demon drug. Ritalin, you know, everyone's on it. Methyl-- cocaine is the demon. So he calls this term pharmocologicalism, moral ordering of drugs and all that, angels-- so do you-- d-- has she also-- and she's the director of NIDA. If anybody doesn't know that name-- I mean, the-- this is the director and chief of sort of drug abusology, the science of it and all that. So what-- what is her-- has she done work on methamphetamine, too, showing that it's, you know-- the same as other-- other stimulants that are used routinely. You know, is-- and is there something-- is there-- a message that we can get from that given that she's-- through-- through scientist are-- thanks.

## CARL HART:

Thank you, so-- that's a politically charged question. (LAUGH) I am on her committee. (LAUGH) So-- but that's a great question. I mean, this is really what we're talking about. When we think about treatment, we think about all of those things 'cause to answer your question in short-- she's done a tremendous amount of work in methamphetamine.

If you look at the report, you look at my-- my-- my scientific paper that critically reviews-- or evaluate this literature on brain imaging and methamphetamine, her research, there must be about ten papers of hers that I go through with a fine tooth comb. And as a result-- let's just say-- I'm persona non grata in some circles. But it is-- it is a lesson in critical thinking. If you-- you get this-- this-- this paper, this critical review, you will see-- the-- the problems with that literature.

And-- and-- and-- and a lot of this deals with not so much the data. The data are what they are. It's the interpretations of the data. They wildly exaggerate some of the claims. And I point this out. And that's part of the problem is we're thinking about treatment as well here.

On the one hand I think about if I had a relative, a child who needed drug treatment, who would I send them to? I-- I'm-- I'm in trouble because I think most of the people who are working with these folks know little about drugs themselves.

And so I am in trouble. That's why I'm trying to make sure we all get education about drugs. These things are not magical. They are not magical. And we know how to keep people safe with it. We just haven't shared that with the public.

## MALE AUDIENCE MEMBER:

You mentioned self-esteem. You mentioned to feel okay about yourself as a major condition to avoid destructive behavior. No one country in the world makes so strong effort to increase self-esteem of children. Everybody consider himself king of universe. Everybody proud of themselves.

Every parents proud of themselves. To be shy, to be modest since-- incredible, impossible the child and adult cannot be like this. So how else we can make people by educate, by (UNINTEL) them to feel good about themselves? And another thing about education, (UNINTEL PHRASE) you just give education and it's about youth, drugs in Russia, no way, ridiculous, forgive me language because it's too serious to deliver all about this. Every child from school, from kindergarten knows how dangerous it is. It does not work.

## CARL HART:

Okay, thank you. So-- wow, I don't know how to answer that. That's just so much ignorance in that comment-- particularly when we think about education. When we

think about things that are potentially dangerous in this society, driving an automobile, that is potentially dangerous.

One of the things we do is we educate the public. We don't ban automobiles. We don't put people in jail because of them driving reckless. Instead what we do is we keep them safe. The same thing can happen with drugs rather than arresting certain members of the society in selective sort of numbers. So if you come from a community, for example, or cared about justice, you would understand that the approach that we are taking has-- has had considerable disproportionate injustice impact on certain communities. So I-- I don't even know how to deal with questions like that. If we go and have a discussion about these sorts of things, I'm happy to have discussion with you because it will require quite an amount of time to really-- do some education. But I'm up to the task.

## HOWARD JOSEPHER:

Oh, at the same time, yeah, I-- I-- I agree with you Carl. It's the right way to go. Let's talk truthfully about drugs. Let's teach people about drugs. let's really be honest about it. But you're still gonna get people who are gonna get fucked up on drugs. Okay, so what are we gonna do?

## CARL HART:

You cannot prevent every accident anywhere. That-- any society that thinks that they can prevent anything from-- bad happening they're delusional.

## HOWARD JOSEPHER:

Right, there's always gonna be some fall out, right. And there's always gonna be some-- some people who just--

## CARL HART:

There are-- there-- there-- there--

## HOWARD JOSEPHER:

--can't-- can't-- can't make it, can't manage it.

## CARL HART:

There are people dying tonight in automobile accidents. That's just how it is.

## HOWARD JOSEPHER:

But, you know, they don't care that they die in their automobile accident as much as do they take somebody else out with them. That's-- that's where the issue with drugs is is you're gonna do drugs, you know, do yourself in. But then you do crime, you-- you transmit-- you transmit infectious disease, you're taking other people out with you. So we gotta-- we gotta-- we gotta deal with it.

And-- and I don't think we found, really, you know, a great-- great way yet. I mean, I-- I like what I'm doing. You know, I-- I think it's another form of education where you're all-- you know, you're just helping to open people's eyes, just raise awareness. Hey moderator.

(OFF-MIC CONVERSATION)

## MALE AUDIENCE MEMBER:

Thank you guys, thanks. Thank everyone for their great presentations. My question really is, you know, I've heard it a couple ti-- times mentioned tonight. And I've heard Dr. Hart say this before, the similarities between drugs like Ritalin-- and methamphetamine. So they're-- you know, we're prescribing a whole generation of students the-- these-- these drugs that are very similar to, you know, methamphetamine.

And you know, we're not seeing the same kind of prohibition related problems of all these kids who are taking it every single day in a controlled setting under supervision. So my-- my question is, you know, why is it that over 95 percent of the general public doesn't know that there are, you know, legal versions of this-- of these other drugs. And can we use that as an opportunity?

I mean, can we speak at a level that is not scientific to the general public and make them aware that methamphetamine is the, you know, quote/unquote poor man's Ritalin or someone who doesn't have insurance and is using a drug like that. You know, what-- how can we inform the public that these drugs are so similar? And can we use that as a way to show that the problems are mostly prohibition related and not drug related?

## CARL HART:

So if-- if the question-- the question relates to how-- how can we better inform the public so they understand that a drug like Adderall is the same drug as methamphetamine, they're the same drug, by the way. And-- and so how can we help the public understand so the public will not vilify methamphetamine on the one hand, not vilify Adderall. What you have to understand that the public, you all, the public, we need drugs to vilify other people.

And that's what we do. Drugs are great tools in order for us not to deal with certain

social problems, certain problems that a society has. Politicians can use this as a way to show their constituent that they're doing something. You the public said, "Yeah-- I don't understand that behavior. So therefore it must be crack cocaine or methamphetamine."

I'm satisfied. It's emotionally satisfying. I know what's going on even though you don't. But it's a great tool to help vilify or-- not deal with what rish-- real issues are. You don't have to think. You can remain ignorant. And you can stay-- make ignorant comments because you can just blame drugs. That's the real-- that's the real thing that's-- that's really underpinning this problem. And-- and this has happened-- this has happened since the early 1900s. We figured out this formula. And we continue this formula because the p--

## MALE AUDIENCE MEMBER:

Well, I guess my question-- how do we tell people that they're the same because even like-- if I tell people, like, I learned from a St. Louis that Adderall's the same thing as methamphetamine, over 95 percent of the folks don't believe what they hear. So how-- like, we're not getting-- like, I can say--

## MARYKATE O'NEIL:

So the question how to better communicate science into policy and law, did you wanna take that?

## MALE AUDIENCE MEMBER:

It needs to be-- how do we s--

(OFF-MIC CONVERSATION)

## BILL PIPER:

We could give people a copy of *High Price*. (LAUGH) I-- I-- I do say that-- as-- as the biggest chal-- as one of our biggest challenge is-- is undoing the myths, decades-- more than a century worth of myths around certain substances-- and certain people who use those-- substances because the same substance in one setting used by certain groups of people is perfectly fine.

And then it shifts to a different group of people. And all of a sudden-- there's a desire to-- to criminalize it. And I don't really have a short-- I don't really have an answer because it-- you have forms, I guess, like this. But I do see that as the most important thing-- that with can be doing is letting people know, one, the majority of people who use any substance, legal or illegal never have a problem with it.

It's never a problem for themselves or others. And that's across all-- drug groups. And, you know, as-- the methamphetamine danger is exaggerated, points out and just to plug DPH port-- (UNINTEL PHRASE) approach to methamphetamine-- in addition to having-- all sorts of adults and young people on these substances, methamphetamine available in pill form to treat attention deficit disorder, people who are on it for very long periods of-- of times in their lives and don't seem to develop problems.

These things were also widely available for recreational use for decades. And we didn't have these problems. And I-- I don't know how to get to that. But it's partially educating people into science. But it's also partially what Dr. Hart was talking about-- about getting at the reasons that the criminalization exists which has to do with race and class and the other in America. (APPLAUSE)

(OFF-MIC CONVERSATION)

## HOLLY CANTANIA:

I'm agreeing with all of this. But I-- I-- part of why I wanted to offer what I did was to say you're competing with, you know, the bulk of funds from our federal government are still responding in the law enforcement way. I'm glad people here have better answers than I do.

I wasn't promoting (UNINTEL) by the way. But I'm thinking that's what you're facing. And you know, we've made a lot of strides. We started out saying the conversation's really shifted about-- certainly about marijuana. But behind that there-- like, the majority of people going into drug court and still going through all of these regimens of-- of people who are trying-- or would-- and labeled addicted to marijuana. So it's not like-- it-- and it's the same people you're concerned about. This is--

## HOWARD JOSEPHER:

Of course, I know.

## HOLLY CANTANIA:

So I-- that was the point I was making. I think you have to be aware that-- whenever you're competing with that force, doing what you're doing, appearing on the popular (UNINTEL) one of the-- there was 44 slides on CBS.com not that I think so much of them. But (LAUGH) they're very popular.

And it's considered mainstream. So how do you compete with those messages going on doing what you're doing. And more of that push-- but how long is-- I-- I worked at Linda Smith Center in 1997. I've only-- it's only been the last two years that the

marijuana conversation has changed. So we should keep at it. I don't have the magic answer either. But know what you're against and how maybe to counter that.

## MARYKATE O'NEIL:

And one more question?

(OFF-MIC CONVERSATION)

## FEMALE AUDIENCE MEMBER:

I have a question for the panel. Do you consider addiction to be a brain disease? (LAUGH)

## HOWARD JOSEPHER:

That's a good answer, Carl. (LAUGH)

## CARL HART:

So it all-- when we say a brain disease-- when I think of a brain disease or particularly a psychiatric illness or something related to psychiatry or psychiatric illnesses, I think of things like Alzheimer's disease, Parkinson's disease as brain disease.

So-- when you look at brain images of people who are afflicted with those horrible conditions, you can see differences and you can pretty much make some pretty nice predictions about-- the-- the state of that individual. You look at a brain of somebody who is quote/unquote a drug addict based on the DSM criteria or the criterias that we use, you can't tell by looking at their brain whether or not they are-- addicted to anything. So there is no evidence in people. Although that doesn't mean that researchers shouldn't continue to look. They certainly should. But one of the reasons that we have this sort of belief or this-- this-- this-- this-- these comments about brain disease is that it's kind of easy to sell to congress in terms of funding this type of research.

If you tell someone that, oh, we can see it in the brain, we have these pretty pictures and people think they got it and then they understand that they really should fund this. So I think a strategy to increase funding has now-- it's-- well, public enemy had the great line, like, don't believe the hype. That's hype. But now scientist are starting to believe their own hype. You know, so it's-- we don't have any evidence to say that it's a brain disease. But people are believing the hype.

## FEMALE AUDIENCE MEMBER:

So why is it some people-- I'm sorry.

## HOWARD JOSEPHER:

It's also-- it's also-- fits very well with the AA concept of powerlessness which they-- they-- they try to get people to accept because it will help them to find their way out of addiction. But that you have a disease-- means in a sense you're powerless.

Most of the people who believe that in terms of people who have been addicted choose not to get high. Well, if you have a disease and yet you-- you m-- you're choosing not to use drugs or alcohol, then it doesn't look like a disease. I mean, you give into something when you become addicted. You surrender to some-- I remember the day I decided to use heroin every day. I didn't wanna come down. I decided to do that. You know, and then there came a day where I decided not to do that. So I don't think it's a disease.

## MARYKATE O'NEIL:

Let's have one more, Tim for one more and we're done.

## MALE AUDIENCE MEMBER:

I'm-- I'm 20 years clean through-- through an NA program. And-- and I have-- I have accepted some powerlessness. But as a 64--

(OFF-MIC CONVERSATION)

## MALE AUDIENCE MEMBER:

I'm trying to grab onto the disease concept versus the appropriate-- I-- I come from-- from Vietnam addicted to opiate, '67, '68. But I have a 13 year old son who may be experimenting with marijuana. I don't know how I can not-- because of my whole past-- see that heroin addiction in my life didn't just drag me through hell, it dragged my wife and my whole family through hell.

And I don't know-- I'm-- today I don't-- I don't think I can as-- as a former drug user like I was, an addict, Coors light would take me out. So I-- I don't choose to drink. But I know when I do drink that it leads me into some things that take me all the way back to the first time I-- I-- I-- I did drugs.

And I've never done crack. But I've seen a lot of people on-- been with a lot of people who have done crack. So I don't know the appropriateness on how you can-- how I can explain that to my son who may be experimenting with-- with marijuana, that it's

cool, that it's not-- you know, that it's not-- it's not a thing not to do-- because it's-- it's not gonna take you to where it took me.

Or it's not-- things like that-- I can't even wrap that around-- I know that my addiction took me through-- the Rockefeller drug lords, locked up, had to sign myself-- become a certified addict to make some laws work for me so I don't get so much time, those kinda things.

The-- the kind of hard that I went through-- through fighting my addiction and the recovery and all the processes from the Phoenix House, detox and then I-- I-- I was a staff member. And then at the staff meetings drinking Cutty Sark and still counseling people about the-- the abuse of drugs. Those things I went through. But I'm thinking now personally and hearing what the panel had to say, how do I address a son who likes to play basketball who may be addicted to texting, I can see that. (LAUGH) He might be addicted texting but to say that it's not too crazy to get-- get a joint or to buy a tray bag or to hang out with the guys that are doing it, to me, that's not rational. I don't-- I don't-- I don-- I don't understand it.

## CARL HART:

He's 13?

## MALE AUDIENCE MEMBER:

He's 13.

## CARL HART:

Well, come on. If you have a 13 year old kid doing a psychoactive drug that's illegal, that's not cool. That-- that's not the drug.

## MALE AUDIENCE MEMBER:

Okay, so the-- if he's 16, if he's 18.

## CARL HART:

If he's-- if he's 16, he's-- if he's 18, if he's meeting all the responsibility like he's getting A's in school, he's doing all those kinds of things, you have to think about the whole person. So when we think about, like, a 13 year old kid you-- you still have to parent. You still have to do all the things that you do. And so, like, the 13 year old kid doing illegal or-- or a psychoactive drug period, I-- I-- I wouldn't advise it. I mean, I would just-- it would be really clear in my household, that's not cool.

## HOWARD JOSEPHER:

I'd-- I'd like also to say-- we traveled very similar paths also-- not just the heroin but the Phoenix House. We did-- we did all that. And I don't-- I never-- I haven't really used heroin. But I've-- I've been-- you know, I've tried Percocet and I've been-- had surgery, I've used opiates, you know, to overcome my surgery.

I'll drink. I'll smoke a joint. And I've never, ever gone back into opiate addiction. The truth also is that when we started Phoenix House, abstinence was not the end goal. It was returning to society as a responsible member. So I got a different message than you got. And I think those messages are very powerful.

People can recover, overcome addiction. It's my message. And use substance responsibly. I'm not gonna throw my life down the tubes for anything. But why someone might do that is going to the root of the cause. And that might be that I might've-- I did use drugs because I was self-medicating my depression.

And that's the issue. That-- that you might have been depressed. And depression is transmitted genetically or it comes from trauma in early childhood. And then if you're in pain every day, every day, then you're gonna one day maybe self-medicate with an illegal drug. You have a millions of Americans taking legal drugs to medicate their pain. Then you have others taking illegal drugs. So I don't think there's an answer. It's working for you. Mine works for me. And it don't prevent me from helping other people, too, because I was one of those counselors with that-- would go out and have a drink afterwards. What do I gotta be perfect to have value for you? I don't gotta be perfect, man.

(OFF-MIC CONVERSATION)

## MARYKATE O'NEIL:

Thanks everyone for coming tonight. Thank you to our panelists. And-- and thank you. (APPLAUSE)

* * *END OF TRANSCRIPT* * *