NARCONON®
Drug Prevention & Education Inc.

Ms. Kim Coates
School Health Programs Department
San Francisco Unified School District
1515 Quintara Street
San Francisco, CA 94116

24 May, 2004

Dear Ms. Coates,

This is in response to yours of February 20, 2004.

My apologies on not getting back to you earlier. You have dealt with us fairly up to this point, and that is appreciated. I will answer all of your questions thoroughly and completely, in the order presented. You asked a number of very technical questions, so some of the answers are technical (and will be either footnoted or have tabbed responses attached.)

First, let me explain the document you quote from. I prepared the "Presentation Outline" to assist in answering your first questions. It is an outline, not a script. Consequently, some of the items you requested be added, such as the complete definition of drugs or the short term effects of alcohol, which were not in the outline *do* form a regular part of my lectures. I understand that you wish to know if certain drug prevention subjects are addressed, and specifically how. To facilitate this, I am preparing a *revised* Presentation Outline to parallel your needs. You will have this shortly.

You asked a question about "Target Audiences. The answer is at TAB A.

Before I respond to your other specific remarks, let me make a few general statements. It is true that much of our training material for drug educators has been written in intentionally simple, plain English to teach them how to discuss basic fundamentals. We suggest terms and vocabulary that have worked well to communicate important truths to children. Despite the simple language, there is sound science behind the basic truths we present to children, and I will quote a few references below. These same principles used in adult drug rehabilitation have helped us to graduate more than *13,000* hard core addicts from our comprehensive life-skills program, living crime-free, productive lives off drugs. In other words, this data has proven itself invaluable as core principles in salvaging those whose lives are literally being destroyed by drug addiction. Consequently, their value in drug education is clear.

In over three decades of delivering drug education in a dozen languages across the globe, reaching 400,000 or more yearly, we have surveyed tens of thousands of children and

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teachers on what they have learned from our presentations. The great majority have repeatedly told us that our message about alcohol and other drugs is valuable and practical, as given. I believe you were sent the Preliminary Analysis on the Narconon Drug Education Program, done by Shelley Beckmann, Ph.D., for FASE (Foundation for Advancements in Science and Education) in 1995. This summary of responses to a detailed questionnaire by 1,045 students from 37 classes of 15 Los Angeles schools reported positive changes in attitude from youth (produced by these same drug education lectures.) We have had the opportunity to review this preliminary evaluation with Center for Substance Abuse Prevention staff at SAMHSA in Washington D.C., who commented favorably. We are working in coordination with SAMHSA to update the survey and bring it into publishable form.

When it has been a prerequisite, Narconon drug education offices have applied for and received official approval to deliver these same presentations. To cite a few recent examples, inside the United States this has included Battle Creek, Michigan and Pinellas County, Florida. In Mexico, the police have been working hand in hand with Narconon drug education teams in several cities. In Europe, our Narconon Italy Regional Office received on 31 March, 2004 official accreditation to train drug educators with Narconon materials throughout the European Union and in a total of 35 countries. In Asia, the Anti Drug Force of Pakistan has helped support Narconon drug education teams to deliver to tens of thousands of youth throughout the country, as well as printing and distributing our "Ten Things" booklet under government issue. These are only some examples of recognition and acceptance of our drug prevention program worldwide.

I state the above so that you can see that despite the apparent simplicity of training and presentation materials, the thought and science behind our drug prevention program is very serious indeed.

We certainly do not have a problem stating many of the things which you feel are important parts of a professional drug education program. You will see this in the detailed revised Presentations Outline.

Regarding your particular comments and questions, first, you quoted from the letter:

> "...'Presentation 1: Drugs and the Body, and Presentation 2: Alcohol and the Media.' Pg 2 – Part II "Drug defined." "All drugs are basically poisons. The amount which you take is what determines the effect. A small amount acts as a stimulant (speeds you up). A larger amount acts as a sedative (puts you to sleep). An even larger amount acts as a poison and can kill you. This is true of any drug."

Your comment on the above was: *"In an attempt to simplify the message about drugs, the statement is inaccurate. We request you provide an accurate definition (e.g. Drug: A chemical substance that changes the structure or function of the body or mind) and information about classification of drugs (depressants, stimulants, etc.) and specific examples of substances that are known to cause lethal overdose."*

ANSWER: In fact in class we *do* define drugs, starting with a commonly accepted definition very similar to what you stated: "A drug is any substance, other than food, that

when entered into the body alters the functions of the body or mind." After making this definition understood, we continue to discuss the sequence and particular effects of drugs, based on the particular class discussion.

According to recognized and professional sources, our statement regarding "drugs being essentially poisons" IS accurate. A small section from Tabor's Cyclopedic Medical Dictionary definition of drug is appended, as an example. (TAB B). Corroborating this definition are the detailed description of "side" effects listed on virtually every drug label and even during television commercials promoting drugs. Side effects, of course, are unlooked-for, usually toxic effects caused in addition to desired pharmacological effects. Thus, combining this practical definition with the daily evidence they see on television of toxic side effects to pharmaceuticals, children can better realize that the street drugs they might be offered are also toxic.

The cellular response to drug dosage is quite complex, but there has been long and continuing study of the "pharmacological dose response curve." In other words, clinical or therapeutic dosages of drugs are within a tight, controlled range, but it has been known that either within or outside this range the first low-dose effect is stimulation followed by a high-dose inhibition. This also happens to be true of heavy metals and other poisons and of antibiotics. Additional data footnoted.[1]

On the issue of "simplifying the message," if we were to tell students (quoting from the same reference as above)...

"In accepted toxicological and pharmacological literature, the action known as 'hormesis,' which is basically alcohol or other drug induced bi-phasic dose-related response phenomena characterized by low-dose stimulation and high-dose inhibition has been frequently observed..."

I am sure you would agree that there would not be even *one* student whose attention was still on the subject or whose head was off his desk. In order to be effective in educating kids we must keep their attention focused by giving them important data in readily understandable terms.

We have found it very fruitful to bring youth *first* to look at drugs as a *general* category, and then to discuss individual drugs in more detail.

With regard to alcohol, the number one gateway drug for children worldwide, the above sequence of stimulation/inhibition/and toxic responses is demonstrably true. Anyone has seen this. Alcohol is first used for its stimulant (party-livening) effect, but more of it produces the inhibitive/sedative, stupifying effect. Even more alcohol produces a coma, and enough certainly does kill. Vis a vis opiate drugs, the first pain-suppressant effects are also associated to some degree with a mild or heavy euphoria, followed by sedation, and also with too much of a dose by death. Even aspirin taken in excess can kill.

Teaching children or adults to understand that drugs as a category fall into this chain of experience has proven very useful in bringing them to understand that the END of the chain of drug experimentation and use does have damaging consequences. We do *not* want

them buying into the falsehood that there are "soft" drugs that do no damage, but other "hard" drugs, which are the damaging ones. They need to understand that they must be responsible for *anything* they put into their bodies, even to the point of asking their doctors what are the side effects or longer term consequences of drugs being prescribed. When in classrooms we discuss different drugs as examples of the above, and in question and answer sessions, all the points you recommended are in fact covered.

To continue, next you quote from the letter:

> "Pg.2 – Part III "How drugs affect the body." "Drugs burn up vitamins and minerals in the body. Most drugs or their byproducts get stored in fat within the body and can stay there for years. Even occasional use has long-term effects. This is a problem because later, when the person is working or exercising or has stress, the fat burns up and a tiny amount of the drug seeps back into the blood. This triggers cravings so the person may still want drugs even years after he's stopped taking them."
>
> Your commentary on this was: *"The general statement about drug or their byproducts stored in fat and a tiny amount of the drug seeping back into the blood is misleading. We request you revise this piece to address short and long term effects of substance use with examples of specific substances (tobacco, alcohol, marijuana, etc.). Please clarify what the demonstration includes and the explanation that accompanies the demonstration."*

ANSWERS (one at a time): (1) There is a large amount of scientific literature validating that drugs and/or their metabolites store in fatty and other tissue. Marijuana, cocaine, opiates, amphetamines, benzodiazepines (or tranquilizers, such as Valium), barbiturates, PCP, alcohol and nicotine have been detected in sweat[2], as well as heavy metals and other toxins that can store in fat, such as PCBs and other carcinogenic compounds. Thus sweat is a plausible route of excretion when something causes an increase in the metabolization of fat stores. Adipose tissue has been found to contain drugs of abuse at concentrations lower than, approximately equal to, or even greater than the concentrations found in the blood, which may reflect a consequence of long-term chronic exposure, or acute intoxication, or some combination of both. (A few other source references on this issue can be found at Tab C.)

(2) The short and long term effects of each of the drugs that you mentioned, as well as others, *are* discussed regularly in our lectures, with language appropriate to the age level of the group, and also dependent on the particular lecture being given. (The revised Presentation Outline details this.) In addition, students regularly ask questions on particular drugs of immediate concern to them (date rape drugs, steroids, etc.) and they are given additional data in response.

(3) The "demonstration" you mention is a simple graphic drawing of a blood vessel, showing that it has some degree of fat around it, and showing how some of the contents of blood pass through the walls of the blood vessel, particles that have an affinity for fat may be absorbed into fat tissue or stores. And that these fat stores, when later metabolized, can mobilize and release whatever toxins are stored in them (many more than just drug

metabolites) which then may circulate around the body, creating effects of trace toxins and metabolites.

> You further comment about "Pg. 2 – Part IV" that "*Definition of addiction is not provided. Reasons given for why people take drugs is incomplete.*"

ANSWER: As I stated above, the letter was only an introduction to our content, not a detailed accounting. Of course, we define addiction and discuss its psychological as well as physical aspects (as the revised Outline will show). We also discuss thoroughly the many reasons why people can start or experiment with drugs, involving students' own contributions as much as possible.

> You quote from the letter "Pg. 3 – Part III – 'Like any other drug it [alcohol] is poisonous to your body. ...Alcohol is made of dead rotted food.'" Your comment was "*Both statements are misleading. We request these statements be removed from the presentation. Please provide short and long term effects of alcohol use.*"

The chemical component in alcohol which produces intoxication, pure ethyl alcohol, *is* toxic to the body. The effects that alcohol-based drinks create come directly from the quantity of ethyl (or other) alcohol that they contain. The fact that human body organs can detoxify a limited amount of alcohol in a short period of time does not belie that the liver and kidneys ARE trying to get the alcohol OUT of the body. Alcoholic drinks *are* produced through fermentation of grains and fruits. Fermentation is the action of yeasts, molds, and bacteria on sugars of grain and fruit, once picked and crushed. Alcohol, as you know, is falsely advertised and promoted to youth as associated only with desirable outcomes. It is positioned as sexy, full of youth, creating vigor and vitality. The truth that it is essentially a toxic substance based on "fermented dead stuff" certainly starts up conversations on the subject. You should see kids pick up on this. One can then get into its short-term (party time) and long term (tissue damaging) effects. This is exactly what we do, including discussing the dangers of drinking liquids that contain non-food and much more poisonous alcohols. I am sure you would agree that this is a thorough and responsible handling of this gateway drug.

> There was a question about data omitted from an incomplete sentence. (TAB D).

Finally, you commented on an article from our newsletter, part of a continuing series called The Life Cycle & Mechanics of Addiction, which, you stated "*includes information about effective detoxification methods. This information is not substantiated by any reputable authority (e.g. NIDA or NIH) and is not appropriate to share with school staff. School Health Programs cannot authorize or recommend that Narconon distribute the newsletter to SFUSD school staff.*"

The Narconon program for the healthful reduction or elimination of drug or other toxic residuals from the body has been studied and favorably reported on in international conferences and peer literature for more than two decades. Peer-review studies continue to be done on various applications of this protocol. As early as 1982 the journal Medical Hypotheses presented a peer-reviewed study of the procedure to reduce toxic environmental *and* drug residuals from the body.[3] Shortly thereafter, the Royal Swedish Academy of Science (which contributes to selections for Nobel Prize winners) published a study in its

international journal AMBIO, A Journal of the Human Environment of the procedure being used specifically to reduce carcinogenic PCBs and PBBs, etc. from body tissues.[4]

The program was discussed favorably in the 1998 Proceedings of the "International Radiological Post-Emergency Response Issues Conference" in Washington D.C.[5] A pertinent quote from the paper's Conclusion is attached (TAB E).

These are merely a few of the available papers. Numerous studies exist on other aspects of the program, such as the efficacy of the dosages of the vitamins used and the success of the social model generally.

Therefore, I believe it is perfectly appropriate to present this methodology as being part of the Narconon program to *any* public in the world, including educated teachers, who would appreciate being apprised at least of the existence of this protocol.

Ms. Coates, we have met personally. It was very clear to me at that time that you really do care for kids and that the "Healthy Kids" initiative is part of an expanding effort to help youth. We had a constructive conversation and discussed the fact that someone had launched a hostile and ill-informed attack on Narconon methodology. We talked about the realities of having to get on with the job in such a climate. Let's be frank. Do you seriously think we will do better if we just parrot what others are saying, and do not offer a fresh point of view? I would expect you to be glad to have our efforts joined with yours in the vitally important campaign to reduce youthful drug experimentation and alcohol use. Narconon staff *have* labored in this endeavor for decades and received many awards, recognitions, and commendations. Above quoted are true data and sources. You may have had pressure brought to bear on your office from some with their own biased, vested interest. We trust you will balance science and fact against mere rumormongering.

Meanwhile, let me end off with a fact that challenges us to find more ways to cooperate in educating youth: The University of Michigan "Monitoring the Future Study" reports that across the US one out of three 12th graders admit being drunk on alcohol (five or more drinks in a row) *in the last 30 days*, and one out of five smoking pot. And these are only the gateway drugs.

We have work to do. I look forward to working together with you. I would appreciate having a meeting with you to review this matter and to make sure all your questions and concerns have been answered. Please let me know when this might be possible.

Sincerely,

Tony Bylsma
Director
Narconon Drug Prevention & Education, California

Attached: Tabs A – E.
~~Revised "Presentation Outline."~~ (coming shortly)

[1] As early as 1888 this was called the Arndt-Schultz Law. A paper published in Science (Vol 302, 17, October 2003) states "The [cellular] receptor for a specific compound tends to come in two flavors: stimulatory or inhibitory. When the concentration of the drug is low, the stimulatory type of receptor is more likely to be activated; at higher levels, inhibition takes over. Opiates work this way, for example."

[2] Kidwell DA, Holland JC, Athanaselis S. Testing for drugs of abuse in saliva and sweat. *J Chromatogr B Biomed Sci Appl* 1998 Aug;713(1):111-35.

[3] DW Schnare, G Denk, M Shields, S Brunton, *Medical Hypotheses* 9: 265-282, 1982

[4] DW Schnare, M Ben, M Shields. "Body Burden Reductions of PCBs, PBBs and Chlorinated Pesticides in Human Subjects," *Ambio*, Vol. 13, No. 5-6, 1984.

[5] Sponsored by the US Environmental Protection Agency and co-sponsored by 9 other agencies including Health and Human Services Center for Disease Control, the Department of Defense, and the International Atomic Energy Agency), this conference presented a paper by 3 Russian, a Ukrainian, and a US scientist on the use of this same detoxification protocol addressed to the problem of persistent radioactive residue.

TABBED NOTES from Narconon California Drug Ed Letter 24 May 04

TAB A: You quote from our letter: "Target Audience: 1. Pg. 1 'Narconon presentations are suitable for 3rd grade and up.'" Then you made the comment: *"The list of participating schools you provided lists Alice Fong Yu and Sanchez ES – grade levels 1, 2, and Kindergarten. Our understanding is that Narconon did not provide presentations for K, 1, and 2 students. Please clarify."*

ANSWER: These were very special cases in which the speaker was asked specifically by the schools to participate in after-school programs. The Narconon drug education program begins in third grade and continues through high school sometimes in colleges. The only times that younger children are included is the occasional Health Fair or other functions such as these and only when specifically requested by the schools concerned. There they are given a simple, fun presentation about the dangers of smoking.

TAB B: In its essay defining the word *drug*, Tabor's Cyclopedic Medical Dictionary compares "toxic and allergic reactions" of all drugs, stating that the toxic reaction time may "occur with the first dose, or may be due to cumulative effects." In describing the "general or systemic action" of drugs, there are 13 sections (only one of which is listed as the "therapeutic" effect, but one of which is "toxicological: a toxic or undesired effect, generally from result of an overdose or long-term usage.")

TAB C: The presence of these illicit drugs in adipose tissue has raised significant drug-testing questions, especially the use of sweat patches to monitor recent cocaine or heroin use in chronic drug users, as such drugs can redistribute from adipose into sweat.[1] Here are just a *few* other footnoted references on drugs being found in fat and storing for long periods of time: LSD[2], PCP[3], cocaine[4], marijuana[5] and diazepam (Valium)[6]. The Narconon program itself has participated in a case study of Valium and Cocaine metabolites precipitating out in sweat and urine with use of the sauna/nutrition protocol.[7]

TAB D: "Pg. 3 – Part V: Answer to second question is incomplete and reads 'Making alcohol illegal was tried once but it failed to keep people ___.'" Your comment is *"Please provide the rest of the answer."*

I am sorry that the type or copy was cut off. The sentence should have read, "Making alcohol illegal was tried once but it failed to keep people from using illegal

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[1] Levisky JA, Bowerman DL, Jenkins WW, Karch SB. Drug deposition in adipose tissue and skin: evidence for an alternative source of positive sweat patch tests. *Forensic Sci Int* 2000 May; 110 (1): 35-46.
[2] Axelrod J, Brady RO, Witkop B and Evarts EV (1957) The distribution and metabolism of lysergic acid diethylamide. Ann NY Acad Sci 66: 435-444. Additional reference: Stoman A (1974) The absorption, distribution, and excretion of drugs and poisons and their metabolites. Progress in Chem Tox. Vol 5, *Academic Press* pp 1 –99.
[3] James SH and Schnoll SH (1976) Phencyclidined: tissue distribution in the rat. *Clin Tox* 9: 573-582.
[4] Nayak PK, Misra AL and Mule SJ (1976) Physiological disposition and biotransformation of [3H] cocaine in acutely and chronically treated rats. *J Pharmacol & Exper Ther* 196: 556 – 569.
[5] Dackis CA, Pottash ALC, Annitto W and Gold MS (1982) Persistence of urinary marijuana levels after supervised abstinence. *Am J Psychiatry* 139: 1196-1198.
[6] Friedman H, Ochs HR, Greenblatt DJ and Shader RI (1985) Tissue distribution of diazepam and its metabolite desmethyldiazepam: A human autopsy study. *J Clin Pharmacol* 25: 613-615.
[7] M Shields MD, S Beckmann PhD, F Tennant MD, RM Wisner, Reduction of drug residues: Applications in drug rehabilitation, Presentation at 123rd Annual Meeting of the American Public Health Association, San Diego, 1995.

sources to purchase it and, in fact, created a whole illegal industry to transport and supply it. Alcohol use is best reduced through educating people on its effects."

TAB E: Quoting from the *Conclusion* of the paper "Rehabilitation of a Chernobyl Affected Population Using a Detoxification Method" (August 1998, EPA 402-S-98-001): "There is evidence suggesting that the program revitalizes the immune system and improves the general physical condition of the participant...In addition, the detoxification program devised by Hubbard possesses a powerful psychotherapeutic potential that has been associated with significant improvement in the general health of the participant."