

ECSTASY

and Cheerleading:

A Basic Risk Comparison

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A January 8, 2006 *Boston Globe* article, “**The Most Dangerous Sport in School,**” reported on several instances of catastrophic, sometimes deadly, cheerleading accidents. Apparently, like taking prescription medications, living in a polluted city, and driving a car, recreational sports such as cheerleading are activities that our society views as having serious, but acceptable, risks.

How, then, does this compare historically to the risks society deems as unacceptable, such as those associated with the recreational use of Ecstasy? I did some research to find out.

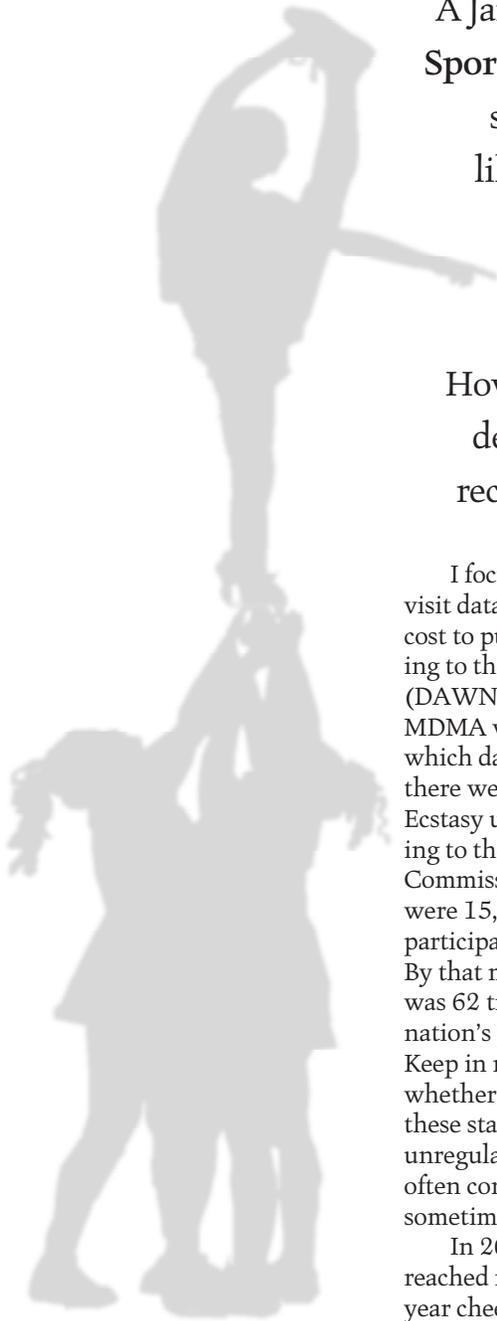
I focused on Emergency Room (ER) visit data, the most common indicator of cost to public health. For example, according to the Drug Abuse Warning Network (DAWN), in 1994—nine years after MDMA was criminalized, but the first for which data is available from SAMHSA—there were 253 ER visits as a result of Ecstasy use in the US. Meanwhile, according to the US Consumer Product Safety Commission (USCPSC), in 1994 there were 15,792 ER visits as a result of participation in organized cheerleading. By that measure, in 1994 cheerleading was 62 times more of a threat to our nation’s public health than Ecstasy use. Keep in mind that most users don’t know whether their Ecstasy is pure MDMA, so these statistics reflect the risks of using unregulated black-market Ecstasy, which often contains other substances and sometimes does not even contain MDMA.

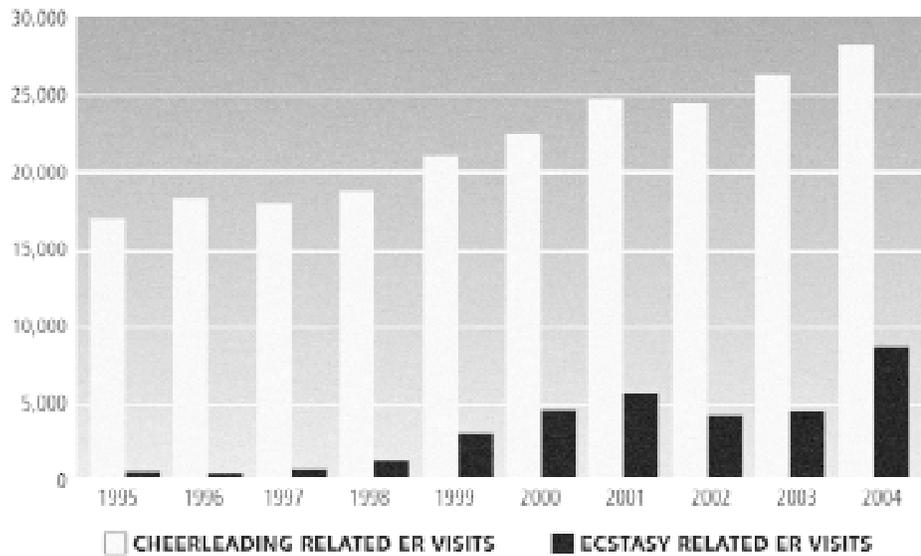
In 2001, when past-year Ecstasy use reached its peak, the total number of past-year cheerleaders (3.8 million) and Ecstasy users (3.25 million) were relatively similar¹. Still, past-year participa-

tion in organized cheerleading was four and a half times more likely than past-year use of Ecstasy to have caused a medical crisis necessitating a visit to ER.

To look at those numbers another way, in 2001, one out of every 152 organized cheerleading participants sought ER treatment, while only one of out of every 585 past-year Ecstasy users sought ER treatment. Note that this data does not account for the differences between users; a cheerleader who practices daily and an Ecstasy user who takes the drug once a month are both counted here simply as participants. It is also worth noting that a study of ER admissions in the Netherlands found that most patients (89%) with an Ecstasy-related complaint did not require treatment beyond the initial visit with a doctor².

In 2003, DAWN implemented a new methodology for calculating drug-related ER visits, and my estimate of 4,442 for that year is based on the only data available, an interim estimate from July–December 2003 of 2,221. In 2004, once the “new” DAWN had been implemented,





their estimate for Ecstasy-related ER visits nearly doubled to 8,621, much higher than the previous high of 5,542 in 2001, but still a far cry from the whopping 28,414 cheerleading-related ER visits that year. DAWN recommends not comparing the “old” DAWN to the “new” DAWN³, but, taking this into consideration, the “old” DAWN is still valuable data, in fact the only data, available for 1994-2003.

Just Say No to Cheerleading?

Do these statistics mean that cheerleading should join Ecstasy in the shadowy underground of prohibited activities? Most would argue that cheerleading offers benefits that balance its risks, and that with careful preparation and education, these benefits make the risk of injury an acceptable one, even for young people. Unfortunately, the public debate on Ecstasy is limited by both an exaggeration of risks and a silence on benefits. Without a clear look at the actual impact of its use on individuals and on society, the costly decision to prohibit Ecstasy is difficult to justify.

As mentioned earlier, most of the risks associated with Ecstasy are a direct consequence of prohibitionist public policy. These risks include poor access to realistic harm-reduction educational materials, health risks related to ingesting unregulated material, and delay in medical treatment due to fear of criminal prosecu-

tion, imprisonment, stigma, and employment discrimination. Even in rare situations when Ecstasy does cause acute health-related problems and/or dependence, abuse, or addiction, prohibition accentuates these problems.

The economic cost of prohibition of certain drugs is also risky public policy, as billions of dollars are spent every year on propaganda, law enforcement, mandatory treatment, and prisons, forgoing billions of dollars from regulation and taxation that could be spent on honest education, voluntary treatment, and other pressing societal needs. Instead, these billions of dollars fuel underground criminal networks while squandering precious government credibility.

Most relevant to MAPS' mission is the risk that MDMA's potential therapeutic benefits will be lost on our society. While young people can still access street Ecstasy almost as easily as taking cheerleading lessons, prohibition has delayed for decades our ability to investigate MDMA's potential as a medicine and a tool for healing. •

1. “Past-year” refers to someone who has participated in organized cheerleading or consumed Ecstasy at least once in the past year.

2. Spruit, I.P. “Ecstasy use and policy responses in the Netherlands.” *Journal of Drug Issues*, 1999; 29(3): 653-678.

3. “New DAWN: Why It Cannot Be Compared with Old DAWN” explains this in greater detail: <http://dawninfo.samhsa.gov/pubs/shortreports/>

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