

Your Government Is Lying To You (Again) About Marijuana

*A Refutation of the Drug Czar's "Open Letter to
America's Prosecutors"*

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Preface

It will come as no surprise to most Americans to learn that our federal officials tend to exaggerate the potential dangers of marijuana in order to justify our nation's criminal drug policies. But recently, the White House's anti-marijuana propaganda campaign has taken on an increasingly alarmist and extremist tone - arguably crossing over any reasonable line of probity. The Bush Administration's latest rhetoric does not qualify as a mere exaggeration; they are flat-out lying to the American public. They are purposely misrepresenting the available research in an attempt to justify federal and state policies that result in the arrest of more than 650,000 Americans annually on minor marijuana possession charges.

Specifically, in an "open letter" to America's prosecutors (dated November 1, 2002), ONDCP Deputy Director Scott Burns insists, "Nationwide, no drug matches the threat posed by marijuana," and urges law enforcement officials to "aggressively prosecute" marijuana violators. The letter further advocates prosecutors "tell the truth" about marijuana, and then lists more than a dozen unsubstantiated, misleading and fallacious statements regarding cannabis - including the allegation that marijuana is more addictive than "alcohol, cocaine, heroin, methamphetamine, ecstasy, and all other illegal drugs combined." Apparently the Drug Czar's office has forgotten about the very real risks of truly dangerous drugs such as heroin, methamphetamine, crack and powder cocaine - as well as

tobacco and alcohol, two legal but far more lethal drugs than marijuana.

NORML has decided it is time to blow the whistle on this shameful exercise in government propaganda by launching our own "marijuana truth" campaign. The first salvo in this campaign is presented here: a point-by-point refutation of the ONDCP's "open letter" to America's prosecutors. We invite all who are interested in learning the truth about marijuana to read the Drug Czar's letter, and then read NORML's rebuttal, and decide for yourself who is lying about marijuana and why.

NORML believes there is nothing to be gained by exaggerating marijuana's harmfulness. On the contrary, by overstating marijuana's potential harms, our policy-makers and law enforcement community undermine their credibility, and their ability to effectively educate the public of the legitimate harms associated with more dangerous drugs. In addition, exaggerating the dangers associated with the responsible use of marijuana results in the needless arrest of hundreds of thousands of good, productive citizens each year in this country. We cannot any longer remain silent and permit this taxpayer-funded propaganda to occur without a challenge.

Finally, if you believe the Drug Czar has been lying to the public about marijuana, then please join us in protesting their behavior by sending an e-mail telling them how you feel. And while you are at it, please let your representatives in Congress know you oppose

spending tax dollars on
counterproductive, exaggerated
anti-marijuana propaganda.
(Prewritten letters are
available from NORML at:
capwiz.com/norml2).

Let's reel-in the government
propaganda machine, and begin an
honest public education campaign
about the minimal risks

presented by marijuana. In
essence, let's allow the science
(as opposed to the rhetoric) to
dictate our public policy
regarding marijuana. As you
will see, the facts speak for
themselves.

Keith Stroup
NORML Executive Director

ALLEGATION #1

"There is a serious drug problem in this country."

TRUTH

America does have a serious drug problem, and our public policy needs to better address this issue with health and science-based educational programs, and by providing more accessible treatment to those who are drug-dependent. *Unfortunately, the bulk of our nation's current anti-drug efforts and priorities remain fixated on arresting and jailing drug consumers - particularly recreational marijuana smokers.*

In this sense, there is a serious drug enforcement problem in this country. Despite the notion that America's drug war focuses primarily on targeting so-called hard drugs and hard drug dealers, data compiled by the FBI reports that *nearly half of all drug arrests in America are for marijuana only.*¹

In 2001, the last year for which statistics are available, law enforcement arrested an estimated 723,627 persons for marijuana violations.² *This total far exceeds the total number of arrests for all violent crimes combined, including murder, manslaughter, forcible rape, robbery, and aggravated assault.*³ Today, it is estimated that taxpayers spend between \$7.5 and \$10 billion dollars annually arresting and prosecuting individuals for marijuana violations⁴ - monies that would be far better served targeting violent crime, including terrorism.

Since 1992, approximately **six million Americans have been arrested on marijuana charges**, a greater number than the entire populations of Alaska, Delaware, the District of Columbia, Montana, North Dakota, South Dakota, Vermont, and Wyoming combined.⁵ Nearly 90 percent of these total arrests were for simple possession, not cultivation or sale.⁶

Despite the fact that reported adult use of marijuana has remained relatively constant for the past decade, annual

¹ Federal Bureau of Investigation. 2002. *Uniform Crime Report: Crime in the United States, 2001*. US Department of Justice: Washington, DC. p. 232, Table 4.1: Arrest for Drug Abuse Violations.

² Ibid.

³ Ibid. Combined Tables 4.1: Arrest for Drug Abuse Violations and Table 29: Estimated Arrests, United States, 2001.

⁴ NORML. 1997. *Still Crazy After All These Years: Marijuana Prohibition 1937-1997: A report prepared by the National Organization for the Reform of Marijuana Laws (NORML) on the occasion of the sixtieth anniversary of the adoption of the Marijuana Tax Act of 1937*. Washington, DC.

⁵ Federal Bureau of Investigation combined *Uniform Crime Reports*, 1993-2002 and US Census Bureau, April 1, 2000 state population data. (available online at: www.census.gov/population/cen2000/tab05.txt)

⁶ Federal Bureau of Investigation combined *Uniform Crime Reports*, 1993-2002.

marijuana arrests have more than doubled since 1991.⁷ Arrests for cocaine and heroin have declined sharply during much of this period,⁸ indicating that *increased enforcement of marijuana laws is being achieved at the expense of enforcing laws against the possession and trafficking of more dangerous drugs.*

Rather than stay this course, federal officials ought to take a page from their more successful public health campaigns discouraging teen pregnancy, drunk driving, and adolescent tobacco smoking – all of which have been significantly reduced in recent years. America has not achieved these results by banning the use of alcohol or tobacco, or by targeting and arresting adults who engage in these behaviors responsibly, but through honest, fact-based public education campaigns. There is no reason why these same common sense principles and strategies should not apply to marijuana and responsible adult marijuana use.

ALLEGATION #2

"Nationwide, no drug matches the threat posed by marijuana."

TRUTH

This statement is pure hyperbole. *By overstating marijuana's potential harms, our policy-makers and law enforcement community undermine their credibility, and their ability to effectively educate the public of the legitimate harms associated with more dangerous drugs like heroin, crack cocaine and methamphetamine.*

In fact, almost all drugs – including those that are legal – pose greater threats to individual health and/or society than does marijuana. According to the Centers for Disease Control, approximately 46,000 people die each year from alcohol-induced deaths (not including motor vehicle fatalities where alcohol impairment was a contributing factor), such as overdose and cirrhosis.⁹ Similarly, more than 440,000 premature deaths annually are attributed to tobacco smoking.¹⁰ By comparison, marijuana is non-toxic and cannot cause death by overdose.¹¹ In a

⁷ Ibid.

⁸ Bureau of Justice Statistics. 2000. *Drugs and Crime Facts*. Table: Number of Arrests by Drug Type, 1982-1999. US Department of Justice: Washington, DC. See also: NORML News Release. *Drug War Priorities Shift From Hard Drugs To Marijuana Arrest Figures Reveal*. July 8, 1999. (available online at: www.norml.org/index.cfm?Group_ID=4015)

⁹ Center for Disease Control *National Vital Statistics Report*. September 16, 2002.

¹⁰ Center for Disease Control *Morbidity and Mortality Weekly Report*. April 2002. (available online at: www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm#tab1)

¹¹ Australian National Drug and Alcohol Research Centre. 1994. *The Health and Psychological Consequences of Cannabis Use*. Canberra: Australian Government Publishing Service. See specifically: Chapter 9, Section 9.3.1 Acute Effects: "There are no recorded cases of fatalities attributable to cannabis, and the

large-scale population study of marijuana use and mortality published in the *American Journal of Public Health*, marijuana use, even long-term, "showed little if any effect ... on non-AIDS mortality in men and on total mortality in women."¹²

After an exhaustive, federally commissioned study by the National Academy of Sciences Institute of Medicine (IOM) in 1999 examining all of marijuana's potential health risks, authors concluded, "Except for the harms associated with smoking, the adverse effects of marijuana use are within the range tolerated for other medications."¹³ (It should be noted that many risks associated with marijuana and smoking may be mitigated by alternative routes of administration such as vaporization.) The IOM further added, "There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use."¹⁴ A recent, large-scale case-controlled study affirmed this finding, concluding that "the balance of evidence ... does not favor the idea the marijuana as commonly used in the community is a major causal factor for head, neck, or lung cancer."¹⁵

Numerous studies and federally commissioned reports have endorsed marijuana's relative safety compared to other drugs, and recommended its decriminalization or legalization.¹⁶ Virtually all of these studies have concluded that *the criminal classification of cannabis is disproportionate in relation both to its inherent harmfulness, and to the harmfulness of other substances.*¹⁷ Even a pair of editorials by the premiere British

extrapolated lethal dose from animal studies cannot be achieved by recreational users." See also: National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. National Academy Press: Washington DC.

¹² S. Sidney et al. 1997. Marijuana Use and Mortality. *American Journal of Public Health* 87: 1-4.

¹³ National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. p. 5.

¹⁴ Ibid. p. 199.

¹⁵ D. Ford et al. 2001. Marijuana use is not associated with head, neck or lung cancer in adults younger than 55 years: Results of a case cohort study. In: National Institute on Drug Abuse (Eds) *Workshop on Clinical Consequences of Marijuana: Program Book*. National Institutes of Health: Rockville, MD: p. 10.

¹⁶ Studies include but are not limited to: Canadian House of Commons Special Committee on the Non-Medical Use of Drugs. 2002. *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy*. Ottawa; Canadian Special Senate Committee on Illegal Drugs. 2002. *Cannabis: Our Position for a Canadian Public Policy*. Ottawa; United Kingdom's Advisory Council on the Misuse of Drugs. 2002. *The Classification of Cannabis Under the Misuse of Drugs Act of 1971*. London; British House of Commons Home Affairs Committee. 2002. *Third Report*. London; Jamaican National Commission on Ganja. 2001. *A Report of the National Commission on Ganja*. Kingston; Australian National Drug and Alcohol Research Centre. 1994. *The Health and Psychological Consequences of Cannabis Use*; First Report of the National Commission on Marijuana and Drug Abuse. 1972. *Marihuana: A Signal of Misunderstanding*. Washington, DC: US Government Printing Office.

¹⁷ House of Commons Home Affairs Committee. 2002. *Third Report*. See specifically: Note 118.

medical journal, *The Lancet*, acknowledge: "The smoking of cannabis, even long-term, is not harmful to health."¹⁸ ... It would be reasonable to judge cannabis as less of a threat ... than alcohol or tobacco."¹⁹ *Indeed, by far the greatest danger to health posed by the use of marijuana stems from a criminal arrest and/or conviction.*

ALLEGATION #3

"60 percent of teenagers in treatment have a primary marijuana diagnosis. This means that the addiction to marijuana by our youth exceeds their addiction rates for alcohol, cocaine, heroin, methamphetamine, ecstasy and all other drugs combined."

TRUTH

This statement is purposely misleading. Although admissions to drug rehabilitation clinics among adolescent marijuana users have increased dramatically since the mid-1990s, *this rise in marijuana admissions is due exclusively to a proportional increase in teens referred to drug treatment by the criminal justice system.*²⁰ **Primarily, these are teens arrested for pot possession, brought before a criminal judge (or drug court), and ordered to rehab in lieu of jail or juvenile detention.** As such, this data is in no way indicative of whether the person referred to treatment is suffering from any symptoms of dependence associated with marijuana use; most individuals admitted to treatment do so simply to avoid jail time. In fact, *since 1995, the proportion of admissions from all sources other than the criminal justice system has actually declined, according to the Federal Drug and Alcohol Services Information System (DASIS).*²¹ Consequently, DASIS reports that today, "over half (54 percent) of all adolescent marijuana admissions [are] through the criminal justice system."²² (Referrals from schools and substance abuse providers comprise another 22 percent of all admissions.)²³

ALLEGATION #4

¹⁸ Editorial: "Deglamorising Cannabis." November 11, 1995. *The Lancet* 346.

¹⁹ Editorial: "Dangerous Habits." November 14, 1998. *The Lancet* 352.

²⁰ The DASIS (Drug and Alcohol Services Information System) Report. March 29, 2002. *Treatment Referral Sources for Adolescent Marijuana Users*. US Office of Applied Studies, Substance Abuse and Mental Health Services Administration: Washington, DC.

²¹ Ibid: Figure 1: Number of Adolescent Marijuana Admissions, by Referral Source: 1992-1999.

²² Ibid.

²³ Ibid.

"We may never rid this country of every crack pipe or marijuana plant. However, research proves that we have made substantial success in reducing drug use in this country."

TRUTH

In fact, marijuana enforcement has had no discernable long-term impact on marijuana availability or use. According to the most recent survey by the National Center on Addiction and Substance Abuse at Columbia University, *teenagers report that marijuana has surpassed tobacco and alcohol as the easiest drug to obtain.*²⁴ This result is hardly surprising, given that annual federal data compiled by the University of Michigan's Monitoring the Future project reports that an estimated 85 percent of 12th graders say that marijuana is "fairly easy" or "very easy to get."²⁵ This percentage has remained virtually unchanged since the mid-1970s²⁶ - despite remarkably increased marijuana penalties, enforcement, and the prevalence of anti-marijuana propaganda since that time.

The percentage of adolescents experimenting with marijuana has also held steady over the long-term. According to annual data compiled by Monitoring the Future, 47.3 percent of 12th graders reported having used marijuana in 1975.²⁷ *Despite billions of dollars spent on drug education efforts (such as the federally funded DARE program) since that time, today's number (for the Class of 2001) remains virtually unchanged at 49 percent.*²⁸

In addition, according to data compiled by the federal National Household on Drug Abuse survey, an estimated 2.4 million Americans tried marijuana for the first time in the year 2000, up from 1.4 million in 1990 and .6 million in 1965.²⁹ *Not surprisingly, nearly one out of every two American adults now acknowledges they have used marijuana, up from fewer than one in three in 1983.*³⁰

²⁴ Associated Press. "Teens Say Buying Dope Is Easy." August 19, 2002.

²⁵ Monitoring the Future. 2002. *2002 Data From In-School Surveys of 8th, 10th, and 12th Grade Students*. Ann Arbor: Michigan. See specifically: Drug and Alcohol Press Release and Tables: Specific Drugs - Figure 2: Marijuana: Trends in Annual Use, Risk, Disapproval, and Availability for 8th, 10th, and 12th Graders. (available online at: monitoringthefuture.org/data/02data.html#2002data-drugs)

²⁶ Ibid.

²⁷ Monitoring the Future. 2001. *2001 Data From In-School Surveys of 8th, 10th, and 12th Grade Students*. Ann Arbor: Michigan. See specifically: Drug and Alcohol Press Release and Tables: Data Tables - Figure 4: Long-Term Trends in Lifetime Prevalence of Use of Various Drugs for 12th Graders. (available online at: monitoringthefuture.org/data/01data.html)

²⁸ Ibid.

²⁹ US Department of Health and Human Services. 2002. *2001 National Household Survey on Drug Abuse*. US Office of Applied Studies, Substance Abuse and Mental Health Services Administration: Washington, DC. See specifically: Chapter 5: Trends in Initiation of Substance Use: Marijuana. (available online at: www.samhsa.gov/oas/nhsda/2k1nhsda/vol1/CHAPTER5.HTM#fig5.1)

³⁰ Results from a *Time Magazine/CNN* telephone poll of 1,007 adult Americans age 18 or older, conducted October 23-24, 2002.

ALLEGATION #5

"The truth is that marijuana is not harmless."

TRUTH

This statement is correct; marijuana isn't harmless. In fact, no substance is, including those that are legal. (As such, our nation does not base its laws on the presumption that something must be "harmless" to be legal. Such a standard would justify the criminalization for almost every imaginable activity, since virtually none are totally harmless.)

Any risk presented by marijuana smoking falls within the ambit of choice we permit the individual in a free society.³¹ As such, marijuana's relative risk to the user and society does not support criminal prohibition or the continued arrest of more than 700,000 Americans on marijuana charges every year. As recently concluded by the Canadian House of Commons in their December 2002 report recommending marijuana decriminalization, *"The consequences of conviction for possession of a small amount of cannabis for personal use are disproportionate to the potential harm associated with the behavior."*³²

ALLEGATION #6

"As a factor in emergency room visits, marijuana has risen 176 percent since 1994, and now surpasses heroin."

TRUTH

This statement is also purposely misleading, as it wrongly suggests that marijuana use is a causal factor in an alarming number of emergency room visits. It is not.

Federal statistics gathered by the Drug Abuse Warning Network (DAWN) do indicate an increase in the number of people "mentioning" marijuana during hospital emergency room visits. (This increase is hardly unique to marijuana however, as the overall number of drug mentions has risen dramatically since the late 1980s - likely due to improved federal reporting procedures.³³) However, a marijuana "mention" does not mean that marijuana caused the hospital visit or that it was a factor in

³¹ "Penalties against drug use should not be more damaging to an individual than use of the drug itself. Nowhere is this more clear than in the laws against the possession of marijuana in private for personal use." Presidential address to Congress by Jimmy Carter. August 2, 1977.

³² Canadian House of Commons Special Committee on the Non-Medical Use of Drugs. 2002. *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy*. p. 131.

³³ John P. Morgan and Lynn Zimmer. 1997. *Marijuana Myths, Marijuana Facts: A Review of the Scientific Evidence*. The Lindesmith Center: New York. p. 131.

leading to the ER episode, only that the patient said that he or she had used marijuana previously.

For every emergency room visit related to drug use (so-called "drug abuse episodes"), hospital staff list up to five drugs the patient reports having used recently, regardless of whether or not their use of the drug caused the visit. The frequency with which any drug is mentioned in such visits is generally proportional to its frequency of use, irrespective of its inherent dangers.

It is foolish for anyone - especially those in the administration's anti-drug office - to suggest or imply that marijuana is in any way potentially more dangerous to one's health than heroin. *Marijuana is mentioned to hospital staff more frequently than heroin, not because it's more dangerous, but simply because a far greater percentage of the population uses marijuana than uses heroin.* (It is also worth noting that alcohol is by far the drug most frequently reported to DAWN, even though it is reported only when present in combination with another reportable drug.³⁴)

Moreover, marijuana is rarely mentioned independent of other drugs. In fact, *marijuana mentions alone accounted for less than 4 percent of all drug-related hospital emergency department visits* (a level on par with common household pain relievers like Acetaminophen), and only about one quarter of one tenth of one percent of all emergency room visits.³⁵

ALLEGATION #7

"Smoked marijuana leads to changes in the brain similar to those caused by the use of cocaine and heroin."

TRUTH

Allegations that marijuana smoking alters brain function or has long-term effects on cognition are reckless and scientifically unfounded. Federally sponsored population studies conducted in Jamaica, Greece and Costa Rica found no significant differences in brain function between long-term smokers and non-users.³⁶ Similarly, a 1999 study of 1,300 volunteers published in *The American Journal of Epidemiology* reported "no significant differences in cognitive decline between heavy users, light

³⁴ Drug Abuse Warning Network. 2002. *Detailed Emergency Department Tables From the Drug Abuse Warning Network, 2001*. Office of Applied Studies, Substance Abuse and Mental Health Services Administration: Washington, DC.

³⁵ Analysis of 2001 DAWN data by Richard Cowan. (available online at: www.marijuananeews.com/news.php3?sid=575)

³⁶ E. Russo et al. 2002. Chronic cannabis use in the Compassionate Investigational New Drug Program: an examination of benefits and adverse effects of legal clinical cannabis. *Journal of Cannabis Therapeutics* 2: 3-57. See Specifically: Previous Chronic Cannabis Use Studies.

users, and nonusers of cannabis" over a 15-year period.³⁷ Most recently, a meta-analysis of neuropsychological studies of long-term marijuana smokers by the National Institute on Drug Abuse reaffirmed this conclusion.³⁸ In addition, a study published in the *Canadian Medical Association Journal* in April reported that even former heavy marijuana smokers experience no negative measurable effects on intelligence quotient.³⁹

Claims specifically charging that marijuana leads to brain changes similar to those induced by heroin and cocaine are based solely on the results of a handful of animal studies that demonstrated that THC (delta-9-tetrahydrocannabinol, the main psychoactive ingredient in marijuana) can stimulate dopamine production under certain extreme conditions, and that the immediate cessation of THC (via the administration of a chemical blocking agent) will initiate some mild symptoms of withdrawal. These findings have little bearing on the human population because, according to the US Institute of Medicine, "The long half-life and slow elimination from the body of THC ... prevent[s] substantial abstinence symptoms" in humans.⁴⁰ As a result, such symptoms have only been identified in rare, unique patient settings - limited to adolescents in treatment for substance abuse, or in clinical research trials where volunteers are administered marijuana or THC daily.⁴¹

ALLEGATION #8

"One recent study involving a roadside check of reckless drivers (not impaired by alcohol) showed that 45 percent tested positive for marijuana."

TRUTH

Conveniently, there is no citation given for this report. However, this claim appears to be derived from a lone 1994 (hardly "recent") study published in the *New England Journal of Medicine* examining marijuana prevalence - not marijuana-associated culpability - in drivers arrested for reckless

³⁷ C. Lyketsos et al. 1999. Cannabis use and cognitive decline in persons under 65 years of age. *American Journal of Epidemiology* 149: 794-800.

³⁸ I. Grant et al. 2001. Long-Term neurocognitive consequences of marijuana: a meta-analytic study. In: National Institute on Drug Abuse (Eds) *Workshop on Clinical Consequences of Marijuana: Program Book*. National Institutes of Health: Rockville, MD. p. 12. See specifically: Abstract: "The 13 studies that met our criteria yielded no basis for concluding that long-term cannabis use is associated with generalized neurocognitive decline, with the possible exception of slight decrements in the area of learning new information."

³⁹ P. Fried et al. 2002. *Current and former marijuana use: preliminary findings of a longitudinal study of effects on IQ in young adults*. *Canadian Medical Association Journal* 166: 887-891. See specifically: Abstract: "A negative effect was not observed among subjects who had previously been heavy users but were no longer using the substance. We conclude that marijuana does not have a long-term negative impact on global intelligence."

⁴⁰ National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. p. 58.

⁴¹ Ibid. p. 91.

driving.⁴² It should be noted that the drivers who tested positive for "marijuana" in this study actually tested positive for traces of a non-psychoactive marijuana metabolite during a urinalysis performed at the scene. Since marijuana metabolites remain present in the urine for days or even weeks after past use,⁴³ their detection is not indicative of intoxication or impairment, and it is misleading for the ONDCP to imply otherwise. While it is never safe or appropriate to drive under the influence of any substance – including marijuana – neither is it sound public policy to sanction sober drivers as if they are impaired based solely on the presence of inactive metabolites.

As to the broader question of marijuana's acute impact on driving performance, while it is well established that alcohol increases accident risk, evidence of marijuana's culpability in on-road driving accidents is much less convincing.

Although marijuana intoxication has been shown to mildly impair psychomotor skills, this impairment does not appear to be severe or long lasting.⁴⁴ In driving simulator tests, this impairment is typically manifested by subjects decreasing their driving speed and requiring greater time to respond to emergency situations.⁴⁵

Nevertheless, this impairment does not appear to play a significant role in on-road traffic accidents. A 2002 review of seven separate crash culpability studies involving 7,934 drivers reported, "*Crash culpability studies have failed to demonstrate that drivers with cannabinoids in the blood are significantly more likely than drug-free drivers to be culpable in road crashes.*"⁴⁶ This result is likely because subjects under the

⁴² D. Brookoff et al. 1994. Testing reckless drivers for cocaine and marijuana. *The New England Journal of Medicine* 331: 518-522.

⁴³ C. Dackis et al. 1982. Persistence of urinary marijuana levels after supervised abstinence. *American Journal of Psychiatry* 139: 1196-1198. See specifically: Discussion: "Urinary excretion of cannabinoids persist for roughly 3 weeks after supervised abstinence."

⁴⁴ Studies include but are not limited to: Canadian Special Senate Committee on Illegal Drugs. 2002. *Cannabis: Our Position for a Canadian Public Policy*. See specifically Chapter 5: Driving Under the Influence of Cannabis; UK Department of Environment, Transport and the Regions (Road Safety Division). 2000. *Cannabis and Driving: A Review of the Literature and Commentary*. Crowthorne, Berks: TRL Limited; A. Smiley. 1999. Marijuana: On-Road and Driving Simulator Studies. In: H. Kalant et al. (Eds) *The Health Effects of Cannabis*. Toronto: Center for Addiction and Mental Health. pp. 173-191; House of Lords Select Committee on Science and Technology. 1998. *Ninth Report. Cannabis: The Scientific and Medical Evidence*. London: The Stationary Office. See specifically Chapter 4: Section 4.7.

⁴⁵ B. Sexton et al. 2000. *The influence of cannabis on driving: A report prepared for the UK Department of the Environment, Transport and the Regions (Road safety Division)*. Crowthorne, Berks: TRL Limited; UK Department of Environment, Transport and the Regions (Road Safety Division). 2000. *Cannabis and Driving: A Review of the Literature and Commentary*; A. Smiley. 1999. Marijuana: On-Road and Driving Simulator Studies.

⁴⁶ G. Chesher and M. Longo. 2002 Cannabis and alcohol in motor vehicle accidents. In: F. Grotenhermen and E. Russo (Eds) *Cannabis and Cannabinoids: Pharmacology, Toxicology, and Therapeutic Potential*. New York: Haworth Press. pp. 313-323.

influence of marijuana are aware of their impairment and compensate for it accordingly, such as by slowing down and by focusing their attention when they know a response will be required. This reaction is the opposite of that exhibited by drivers under the influence of alcohol, who tend to drive in a more risky manner proportional to their intoxication.⁴⁷

Today, a large body of research exists analyzing the impact of marijuana on psychomotor skills and actual driving performance. (Much of this research is available online through NORML's website at: www.norml.org/index.cfm?GroupID=5450.) This research consists of driving simulator studies, on-road performance studies, crash culpability studies, and summary reviews of the existing evidence. To date, the result of this research is fairly consistent: Marijuana has a measurable yet relatively mild effect on psychomotor skills, yet it does not appear to play a significant role in vehicle crashes, particularly when compared to alcohol. As summarized by the Canadian Senate's exhaustive 2002 report: "*Cannabis: Our Position for a Canadian Public Policy*," "*Cannabis alone, particularly in low doses, has little effect on the skills involved in automobile driving.*"⁴⁸

ALLEGATION #9

"The truth is that marijuana is addictive. ... Marijuana users have an addiction rate of about 10%, and of the 5.6 million drug users who are suffering from illegal drug dependence or abuse, 62 percent are dependent on or abusing marijuana."

TRUTH

Marijuana use is not marijuana abuse. According to the US Institute of Medicine's 1999 Report: "*Marijuana and Medicine: Assessing the Science Base*," "Millions of Americans have tried marijuana, but most are not regular users, ... [and] few marijuana users become dependent on it."⁴⁹ In fact, *less than 10 percent of*

⁴⁷ Ibid.; A. Smiley. 1999. Marijuana: On-Road and Driving Simulator Studies; United Kingdom's Advisory Council on the Misuse of Drugs. 2002. *The Classification of Cannabis Under the Misuse of Drugs Act of 1971*. See specifically: Chapter 4, Section 4.3.5: "Cannabis differs from alcohol; ... it seems not to increase risk-taking behavior. This may explain why it appears to play a smaller role than alcohol in road traffic accidents."

⁴⁸ Canadian Special Senate Committee on Illegal Drugs. 2002. *Cannabis: Our Position for a Canadian Public Policy*. p. 18.

⁴⁹ National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. pp. 92-96.

*marijuana users ever exhibit symptoms of dependence (as defined by the American Psychiatric Association's DSM-III-R criteria.)*⁵⁰ By comparison 15 percent of alcohol users, 17 percent of cocaine users, and a whopping 32 percent of cigarette smokers statistically exhibit symptoms of drug dependence.⁵¹

Marijuana is well recognized as lacking the so-called "dependence liability" of other substances. According to the IOM, "Experimental animals that are given the opportunity to self administer cannabinoids generally do not choose to do so, which has led to the conclusion that they are not reinforcing or rewarding."⁵² Among humans, most marijuana users voluntarily cease their marijuana smoking by their late 20s or early 30s - often citing health or professional concerns and/or the decision to start a family.⁵³ Contrast this pattern with that of the typical tobacco smoker - many of whom begin as teens and continue smoking daily the rest of their lives.

That's not to say that some marijuana smokers do not become psychologically dependent on marijuana or find quitting difficult. But a comprehensive study released this fall by the Canadian Senate concluded that this dependence "is less severe and less frequent than dependence on other psychotropic substances, including alcohol and tobacco."⁵⁴ Observable withdrawal symptoms attributable to marijuana are also exceedingly rare. According to the Institute of Medicine, these symptoms are "mild and short lived"⁵⁵ compared to the profound physical withdrawal symptoms of other drugs, such as alcohol or heroin, and unlikely to persuade former smokers to re-initiate their marijuana use.⁵⁶

ALLEGATION #10

"Average THC levels rose from less than 1% in the late 1970s to more than 7% in 2001, and sinsemilla potency increased from 6% to 13%, and now reach as high as 33%"

TRUTH

This statement is both factually inaccurate and purposefully misleading. No population en masse has ever smoked marijuana averaging less than one percent THC since such low potency marijuana would not induce euphoria. In fact, in many nations,

⁵⁰ Ibid. p. 95, Table 3.4: Prevalence of Drug Use and Dependence in the General Population

⁵¹ Ibid.

⁵² Ibid. p. 57.

⁵³ Ibid. p. 92. See also: Canadian Special Senate Committee on Illegal Drugs. 2002. *Cannabis: Our Position for a Canadian Public Policy*. p. 16.

⁵⁴ Canadian House of Commons Special Committee on the Non-Medical Use of Drugs. 2002. *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy*. p. 17.

⁵⁵ National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. p. 6.

⁵⁶ Ibid. pp. 83-101.

marijuana of one percent THC or less is legally classified as an agricultural fiber crop.

Although annual marijuana potency data compiled by the University of Mississippi's Research Institute of Pharmaceutical Sciences does show a slight increase in marijuana's strength through the years (from about 3 percent to 5 percent), this increase is not nearly as dramatic as purported by the White House Office of National Drug Control Policy.⁵⁷ *In addition, quantities of exceptionally strong strains of marijuana or sinsemilla (seedless marijuana) are inordinately expensive, comprise only a small percentage of the overall marijuana market, and are seldom used by the population at large - particularly younger adults.*

It's worth noting however, that more potent marijuana is not necessarily more dangerous. Marijuana poses no risk of fatal overdose, regardless of THC content, and since marijuana's greatest potential health hazard stems from the user's intake of carcinogenic smoke, it may be argued that higher potency marijuana may be slightly less harmful because it permits people to achieve desired psychoactive effects while inhaling less burning material.⁵⁸ In addition, studies indicate that marijuana smokers distinguish between high and low potency marijuana and moderate their use accordingly,⁵⁹ just as an alcohol consumer would drink fewer ounces of (high potency) bourbon than they would ounces of (low potency) beer.

ALLEGATION #11

"The truth is that marijuana and violence are linked."

TRUTH

Absolutely not. No credible research has shown marijuana use to play a causal factor in violence, aggression or delinquent behavior, dating back to former President Richard Nixon's "First Report of the National Commission on Marihuana and Drug Abuse" in 1972, which concluded, "In short, marihuana is not generally viewed by participants in the criminal justice community as a major contributing influence in the commission of delinquent or criminal acts."⁶⁰

⁵⁷ University of Mississippi Potency Monitoring Project *Quarterly Reports*. Oxford. See also: Dan Forbes. "The Myth of Potent Pot." *Slate*. November 19, 2002.

⁵⁸ John P. Morgan and Lynn Zimmer. 1997. *Marijuana Myths, Marijuana Facts: A Review of the Scientific Evidence*. p. 139.

⁵⁹ S. Heishman et al. 1989. Effects of tetrahydrocannabinol content on marijuana behavior, subjective reports, and performances. *Pharmacology, Biochemistry and Behavior* 34: 173-179.

⁶⁰ First Report of the National Commission on Marihuana and Drug Abuse. 1972. *Marihuana: A Signal of Misunderstanding*. p. 75.

Most recently, the Canadian Senate's 2002 "Discussion Paper on Cannabis" reaffirmed: "Cannabis use does not induce users to commit other forms of crime. Cannabis use does not increase aggressiveness or anti-social behavior."⁶¹ In contrast, research has demonstrated that certain legal drugs, such as alcohol, do induce aggressive behavior.

"Cannabis differs from alcohol ... in one major respect. It does not seem to increase risk-taking behavior," the British Advisory Council on the Misuse of Drugs concluded in its 2002 report recommending the decriminalization of marijuana. "This means that cannabis rarely contributes to violence either to others or to oneself, whereas alcohol use is a major factor in deliberate self-harm, domestic accidents and violence."⁶²

ALLEGATION #12

"The truth is that we aren't imprisoning individuals for just 'smoking a joint.' ... Nationwide, the percentage of those in prison for marijuana possession as their most serious offense is less than half of one percent (0.46%), and those generally involved exceptional circumstances."

TRUTH

This statement is grossly inaccurate and misleading. Police have arrested some six million Americans for marijuana violations since 1992, and now average more than 700,000 arrests per year.⁶³ The overwhelming majority of these arrests - approximately 88 percent - are for simple possession only, not marijuana cultivation or sale.⁶⁴

While not all of those individuals arrested are eventually sentenced to long terms in jail, the fact remains that the repercussions of a marijuana arrest alone are significant - including (but not limited to):

- probation and mandatory drug testing;
- loss of driving privileges;
- loss of federal college aid;
- asset forfeiture;
- revocation of professional driver's license;
- loss of certain welfare benefits such as food stamps;

⁶¹ Canadian Special Senate Committee on Illegal Drugs. 2002. *Discussion Paper on Cannabis*. Ottawa. p. 4.

⁶² United Kingdom's Advisory Council on the Misuse of Drugs. 2002. *The Classification of Cannabis Under the Misuse of Drugs Act of 1971*. See specifically: Chapter 4, Section 4.3.6.

⁶³ See footnotes 2 and 5.

⁶⁴ Federal Bureau of Investigation. 2002. *Uniform Crime Report: Crime in the United States, 2001*. Table 4.1: Arrest for Drug Abuse Violations.

- removal from public housing;
- loss of child custody; and
- loss of employment.

In other words, whether or not marijuana offenders ultimately serve time in jail, the fact is that hundreds of thousands of otherwise law-abiding citizens are having their lives needlessly destroyed each year for nothing more than smoking marijuana.

Specific totals on marijuana offenders behind bars are seldom available because federal statistics do not categorize drug offenders by drug type or drug offense. However, according to a 1997 Bureau of Justice Statistics survey of federal and state prisoners (available online on the Office of National Drug Control Policy's own website at:

www.whitehousedrugpolicy.gov/drugfact/marijuana), approximately 19 percent federal and 13 percent of state drug offenders are incarcerated for marijuana offenses.⁶⁵ Based on those statistics, a 1999 paper published by the Federation of American Scientists estimated that nearly 60,000 inmates (roughly 1 in every 7 drug prisoners) were incarcerated for marijuana offenses at that time.⁶⁶ Since then, some experts estimate that this number has grown to more than 75,000 marijuana prisoners.⁶⁷

ALLEGATION #13

"The truth is that marijuana is a gateway drug. ... People who used marijuana are 8 times more likely to have used cocaine, 15 times more likely to have used heroin, and 5 times more likely to develop a need for treatment of abuse or dependence on ANY drug."

TRUTH

Nonsense. According to the Canadian Senate's 2002 study: "Cannabis: Our Position for a Canadian Public Policy," "Cannabis itself is not a cause of other drug use."⁶⁸ This finding concurs with the conclusions of the US National Academy of Science's Institute of Medicine 1999 study, which stated that marijuana is not a "gateway drug to the extent that it is a cause or even that it is the most significant predictor of serious drug abuse."⁶⁹ (The IOM further noted that underage smoking and alcohol abuse

⁶⁵ Bureau of Justice Statistics. 1999. *Substance Abuse and treatment of State and Federal Prisoners, 1997*. US Department of Justice: Washington, DC.

⁶⁶ C. Thomas. 1999. Marijuana arrests and incarceration in the United States. *FAS Drug Policy Analysis Bulletin* 7.

⁶⁷ Marijuana Policy Project Press Office. "Marijuana Arrests Near All-Time High in 2001." October 28, 2002. Washington, DC.

⁶⁸ Canadian Special Senate Committee on Illegal Drugs. 2002. *Cannabis: Our Position for a Canadian Public Policy*. p. 15.

⁶⁹ National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. p. 101.

typically precede marijuana use.⁷⁰) Statistically, for every 104 Americans who have tried marijuana, there is only one regular user of cocaine, and less than one user of heroin, according to annual data compiled by the federal National Household Survey on Drug Abuse.⁷¹

Clearly, for the overwhelmingly majority of marijuana smokers, pot is a 'terminus' rather than a gateway.⁷²

However, among the minority of marijuana smokers who do graduate to harder substances, it's marijuana prohibition rather than the use of marijuana itself that often serves as a doorway to the world of hard drugs. The more users become integrated in an environment where, apart from marijuana, more dangerous drugs can also be obtained, the greater the chances they will experiment with those harder substances. Therefore, if the Office of National Drug Control Policy truly wished to address the (limited) association between marijuana and the use of other drugs, it would support policies separating marijuana from the criminal black market.

ALLEGATION #14

"The truth is that marijuana legalization would be a nightmare in America. After Dutch coffee shops started selling marijuana in small quantities, use of the drug nearly tripled ... between 1984 and 1996. While our nation's cocaine consumption has decreased by 80 percent over the past 15 years, Europe's has increased ... and the Dutch government has started to reconsider its policy."

TRUTH

This statement is inaccurate and greatly distorts the well-documented European drug policy experience. Most European countries - including Belgium, Germany, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland - do not criminally arrest marijuana users.⁷³ (A comprehensive breakdown of European marijuana and drug laws is available online from the NORML website at: www.norml.org/index.cfm?Group_ID=5445.) Yet virtually every European nation, including the Netherlands, have

⁷⁰ Ibid. p. 6. "Because underage smoking and alcohol use typically precede marijuana use, marijuana is not the most common, and is rarely the first, 'gateway' to illegal drug use."

⁷¹ Federal Household data, as cited in John P. Morgan and Lynn Zimmer. 1997. *Marijuana Myths, Marijuana Facts: A Review of the Scientific Evidence*. p. 36, Figure 4-2: Very Few Marijuana Users Become Regular Users of Cocaine.

⁷² United Kingdom's Advisory Council on the Misuse of Drugs. 2002. *The Classification of Cannabis Under the Misuse of Drugs Act of 1971*. See specifically: Chapter 4, Section 4.6.2: "Even if the gateway theory is correct, it cannot be a particularly wide gate as the majority of cannabis users never move on to Class A [hard] drugs."

⁷³ European Monitoring Centre for Drugs and Drug Addiction. 2002. *European Legal database on Drugs: Country Profiles*. (available online at: eldd.emcdda.org/databases/eldd/country_profiles.cfm) See also: NORML. 2002. *European Drug Policy: 2002 Legislative Update*. Washington, DC. (available online at: www.norml.org/index.cfm?Group_ID=5446)

drastically lower rates of marijuana and drug use among their adult and teen population compared to the United States.⁷⁴ *In fact, the national drug policy trends in Europe are currently moving toward more liberal marijuana laws, and away from US-styled drug policy.*⁷⁵ For example, Great Britain announced last summer that Parliament would formally downgrade marijuana in 2003 so that its possession is no longer an arrestable offense.⁷⁶

As to the White House Office of National Drug Control Policy's specific claims regarding Dutch marijuana use, the truth is that *lifetime reported use of marijuana by Dutch citizens aged 12 and older is less than half of what is reported in America.*⁷⁷ In addition, Dutch policy-makers downgraded marijuana offenses in the mid-1970s; this makes it unlikely that any purported increase in Dutch marijuana use during the 1980s was directly attributable to the change in law. In fact, most experts agree that marijuana's illegality has little impact on marijuana use.⁷⁸ According to a 2001 study published in *The British Journal of Psychiatry*, "The Dutch experience, together with those of a few other countries with more modest [marijuana] policy changes, provides a moderately good empirical case that removal of criminal prohibitions on cannabis possession (decriminalization) will not increase the prevalence of marijuana or any other illicit drug; the argument for decriminalization is thus strong."⁷⁹

ALLEGATION #15

"The truth is that marijuana is not a medicine, and no credible research suggest that it is."

⁷⁴ European Monitoring Centre for Drugs and Drug Addiction. 2001. 2001 Annual Report on the State of the Drugs Problem in the European Union. Lisbon. See also: *New York Times*. "Study Finds Teenage Drug Use Higher in US Than in Europe." February 21, 2001.

⁷⁵ European Monitoring Centre for Drugs and Drug Addiction. 2001. *Decriminalisation in Europe: Recent developments in legal approaches to drug use*. Lisbon. See also: *Washington Post*. "Europe Moves Drug War From Prisons to Clinics." May 2, 2002.

⁷⁶ *United Press International*. "UK Govt Downgrades Cannabis." July 10, 2002.

⁷⁷ R. MacCoun and Peter Reuter. 2001. Evaluating alternative cannabis regimes. *British Journal of Psychiatry* 178: 123-128.

⁷⁸ NORML. 2001. *Marijuana Decriminalization and Its Impact on Use: A Review of the Scientific Evidence*. (available online at: http://www.norml.org/index.cfm?Group_ID=3383) See also: National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. p. 104; E. Single et al. 2000. The Impact of Cannabis Decriminalisation in Australia and the United States. *Journal of Public Health Policy* 21: 157-186; E. Single. 1989. The Impact of Marijuana Decriminalization: An Update. *Journal of Public Health* 10: 456-466; L. Johnson et al. 1981. Marijuana Decriminalization: The Impact on Youth 1975-1980. *Monitoring the Future*, Occasional Paper Series, paper 13, Institute for Social Research, University of Michigan: Ann Arbor.

⁷⁹ R. MacCoun and Peter Reuter. 2001. Evaluating alternative cannabis regimes. *British Journal of Psychiatry*.

TRUTH

This allegation is a lie, plain and simple. According to a 2001 national survey of US physicians conducted for the American Society of Addiction Medicine, nearly half of all doctors with opinions support legalizing marijuana as a medicine.⁸⁰ Moreover, no less than 80 state and national health care organizations - including the American Public Health Association⁸¹ and *The New England Journal of Medicine*⁸² - support immediate, legal patient access to medical marijuana.⁸³ The medical community's support for medical marijuana is not based on "pseudo-science," but rather on the reports of thousands of patients and scores of scientific studies affirming pot's therapeutic value.

Modern research suggests that cannabis is a valuable aid in the treatment of a wide range of clinical applications. These include pain relief - particularly of neuropathic pain (pain from nerve damage) - nausea, spasticity, glaucoma, and movement disorders.⁸⁴ Marijuana is also a powerful appetite stimulant, specifically for patients suffering from HIV, the AIDS wasting syndrome, or dementia.⁸⁵ Emerging research suggests that marijuana's medicinal properties may protect the body against some types of malignant tumors and are neuroprotective.⁸⁶

Recent scientific reviews supporting marijuana's use as a therapeutic agent include a 1998 report by Britain's House of Lords Science and Technology Committee concluding: "The government should allow doctors to prescribe cannabis for medical use. ... Cannabis can be effective in some patients to relieve symptoms of multiple sclerosis, and against certain forms of

⁸⁰ Reuters News Wire. "Physicians divided on medical marijuana." April 23, 2001.

⁸¹ American Public Health Association Resolution #9513: "Access to Therapeutic Marijuana/Cannabis." The resolution states, in part, that the APHA "encourages research of the therapeutic properties of various cannabinoids and combinations of cannabinoids, and ... urges the Administration and Congress to move expeditiously to make cannabis available as a legal medicine."

⁸² Editorial: "Federal Foolishness and Marijuana." January 30, 1997. *New England Journal of Medicine* 336. See specifically: "Federal authorities should rescind their prohibition of the medical use of marijuana for seriously ill patients and allow physicians to decide which patients to treat. The government should change marijuana's status from that of a Schedule I drug ... to that of a Schedule II drug ... and regulate it accordingly."

⁸³ The complete list of health organization endorsing legal access to medical marijuana is available online at: www.norml.org/index.cfm?GroupID=3388.

⁸⁴ Studies include but are not limited to: Canadian Special Senate Committee on Illegal Drugs. 2002. *Cannabis: Our Position for a Canadian Public Policy*; Jamaican National Commission on Ganja. 2001. *A Report of the National Commission on Ganja*; National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*; House of Lords Select Committee on Science and Technology. 1998. *Ninth Report. Cannabis: The Scientific and Medical Evidence*; National Academy of Sciences, Institute of Medicine. 1982. *Marijuana and Health*. National Academy Press: Washington, DC.

⁸⁵ Ibid.

⁸⁶ National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*.

pain. ... This evidence is enough to justify a change in the law."⁸⁷

A 1999 review by the US Institute of Medicine (conducted at the request of the White House Office of National Drug Control Policy) added, "The accumulated data indicate a potential therapeutic value of cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation,"⁸⁸ and recommended the US government allow immediate single patient clinical trials where upon patients could legally use inhaled marijuana medicinally in a controlled setting.⁸⁹ It should be noted that the IOM also reviewed the medical efficacy of the legal synthetic THC drug Marinol, which it found to have "poor bioavailability," slow onset, and adverse effects such as "anxiety, depersonalization, dizziness, euphoria, dysphoria, [and] somnolence" in approximately one-third of patients who use it.⁹⁰ As such, authors noted that many patients prefer whole smoked marijuana over this legal alternative.

The most recent overview of marijuana's medical efficacy was conducted by the Canadian Senate's Special Committee on Illegal Drugs in 2002. Authors concluded, "There are clear ... indications of the therapeutic benefits of marijuana in the following conditions: analgesic for chronic pain, antispasm for multiple sclerosis, anticonvulsive for epilepsy, antiemetic for chemotherapy and appetite stimulant for cachexi."⁹¹

The study advised Parliament to revise existing federal regulations legalizing the drug to qualified patients so that any "person affected by one of the following [medical conditions]: wasting syndrome; chemotherapy treatment; fibromyalgia; epilepsy; multiple sclerosis; accident-induced chronic pain; and some physical conditions including migraines and chronic headaches, whose physical state has been certified by a physician or an individual duly authorized by the competent medical association of the province or territory in question, may choose to buy cannabis and its derivatives for therapeutic purposes."⁹²

Clearly, the policy issue of medical marijuana is a public health issue, and should not be held hostage by the war on drugs. Basic compassion and common sense demand that our nation allows

⁸⁷ House of Lords Press Office. "Lords Say, Legalise Cannabis for Medical Use." November 11, 1998. London.

⁸⁸ National Academy of Sciences, Institute of Medicine. 1999. *Marijuana and Medicine: Assessing the Science Base*. p. 3.

⁸⁹ Ibid. p. 8.

⁹⁰ Ibid. p. 203.

⁹¹ Canadian Special Senate Committee on Illegal Drugs. 2002. *Cannabis: Our Position for a Canadian Public Policy*. P. 19.

⁹² Ibid. See specifically: Proposals for Implementing the Regulation of Cannabis for Therapeutic and recreational Purposes, p. 51.

America's seriously ill citizens to use whatever medication their physicians deem safe and effective to alleviate their pain and suffering, and the scientific record supports their use of therapeutic cannabis.