

## HISTORICAL PERSPECTIVE ON MARIJUANA-USE PUBLIC POLICY

C. E. Edwards  
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During the past decade, the United States has been experiencing renewed efforts to change perceptions of marijuana from that of a dangerous, addictive drug of abuse<sup>1</sup> to one where the message is that marijuana is a medicine that treats illnesses. The individual state 'medicalization' efforts, in contravention of federal law and international treaties, are dedicated to normalizing and eventually legalizing the use of marijuana and other drugs.<sup>2</sup>

The foundations of public policy should be built upon valid research findings and available historical experience. Therefore, it is appropriate to review the experiences of U. S. states and other countries that have embraced the message that marijuana is a harmless herb and a medicine. Inherent within the consideration of any change in public policy is a responsibility to arrive at an effective public policy based upon considerations for long-term impact of such a policy change.

### United States Historical overview:

About the year 1900, between 2% and 5% of adults in the U.S. were addicted to drugs - many to morphine which was commonly found in medications. Reductions in the addiction rate were

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<sup>1</sup>For a sampling of data addressing the dangers of marijuana use, see: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Office of Applied Studies. National Findings from the 2004 National Survey on Drug Use and Health, Treatment Episode Data Set 1992-2002, DAWN Report 2002; Haney et al, Psychopharmacology (2003) 165:157-165 "Nefazodone decreases anxiety during marijuana withdrawal in humans"; Scientific American, December 12, 2000 "Marijuana Firmly Linked to Infertility"; British Journal of Pharmacology (2003) 140, 547-557 "Tetrahydrocannabinol-induced neurotoxicity depends on CB1 receptor-mediated c-Jun N-terminal kinase activation in cultured cortical neurons"; American Journal of Psychiatry, March 2004 "Cannabis use linked to early-onset schizophrenia,"; Research Report 2002, Psychosis - Key Research Findings. Institute of Psychiatry London.

<sup>2</sup>Some examples: "Quotes from the Drug Culture", Drug Watch Oregon, transcribed by Sandra Bennett. 1) Richard Cowen, former director of NORML at a taped 1993 session during the 50<sup>th</sup> anniversary conference celebrating the discovery of LSD: "The key to it is medical access. Because, once you have hundreds of thousands of people using marijuana medically under medical supervision, the whole scam is going to be bought....So that once there's medical access, if we continue to do what we have to do, and we will, then we'll get medical, then we'll get full legalization." Video also cited by Accuracy in Media "Video Exposes Medical Marijuana as Hoax", By Cliff Kincaid, June 30, 2005 [http://www.aim.org/aim\\_column\\_archive/A2005063/](http://www.aim.org/aim_column_archive/A2005063/) Video available at DAMMADD web site <http://www.sorosmonitor.com> 2) Eric Sterling, Criminal Justice Policy Foundation at a 1991 NORML conference in a program instructing the audience on how to use medicalization to achieve legalization of marijuana: "Packaging is important and messages get packaged." 3) Kevin Zeese, President, Common Sense for Drug Policy taped at a 1997 Boston Pot Rally: "And we've gotta be looking at issues we have today that can be won. The medical marijuana issue, no doubt, is one." The video also shows children using marijuana, children being sold marijuana and being taught how to use and roll marijuana cigarettes. 1997 Boston Pot Rally video, available at PRIDE-Omaha, Inc.

attributed to passage of the 1906 Pure Food and Drug Act.”<sup>3</sup>

The Pure Food and Drug Act of 1906 did three things:

- 1). It created the Food and Drug Administration (FDA) to approve all foods and drugs meant for human consumption - for the protection and safety of the U.S. population.
- 2) It stipulated that certain drugs could only be sold by prescription.
- 3) It required labeling of any medicine containing opiates, cannabis or cocaine.

In 1914, the U.S. passed the Harrison Act - the first federal law to criminalize non-medical use of drugs. This Act applied to narcotic substances (opium and its derivatives as well as the coca leaf and its derivatives) - not marijuana.

From 1915 to 1927, a number of U. S. states passed marijuana prohibition laws.<sup>4</sup> The federal government did not take action on marijuana until about 1937 when it passed the Marihuana<sup>5</sup> Tax Act. That act required every person importing, cultivating, and dealing in marijuana to register and pay an occupational tax. The Act did not criminalize possession or usage of marijuana. Penalties for violating the Act included a fine and imprisonment.

Growing concern about drug use, specifically marijuana, in the U. S. became apparent by the mid-1960s. Up until that time marijuana had relatively few users. In 1967, a national telephone poll conducted by the Gallup Organization found that 5 percent of college students reported lifetime use of marijuana. By 1969, the lifetime use of marijuana among the adult population and male high school seniors stood at 22 percent . In contrast, by 1970, in a new poll of college students, Gallop found this group’s lifetime use had risen to 43 percent in just three years. By 1971, 51 percent of college students reported lifetime use.<sup>6</sup>

In 1970, the Comprehensive Drug Abuse Prevention and Control Act was passed. It prohibited therapeutic use of marijuana/cannabis as a medicine, and created a system of scheduling drugs according to medical usefulness and potential for abuse. Marijuana was classified as a Schedule I drug with good reason.<sup>7</sup>

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<sup>3</sup>Whitebread, Charles Professor of Law, USC Law School. “The History of the Non-Medical Use of Drugs in the United States”, A Speech to the California Judges Association 1995 annual conference. <http://www.druglibrary.org/schaffer/history/whiteb1.htm>

<sup>4</sup>A sampling of states: Utah and Wyoming (1915); Texas (1919); Iowa (1923); Nevada (1923); Oregon (1923); Washington (1923); Arkansas (1923); and Nebraska (1927). These laws tended to be specifically targeted against the Mexican-American population as marijuana was introduced into the U. S. by people coming from Mexico.

<sup>5</sup>Marijuana was originally spelled with an ‘h’ in the U.S..

<sup>6</sup>Harrison Lana D.; Backenheimer, Michael; and Inciardi, James A. (1995), Cannabis use in the United States: Implications for policy. <http://www.cedro-uva.org/lib/harrison.cannabis.03.html>

<sup>7</sup>Criteria for placement on Schedule I of the CSA: (1)The drug has a high potential for abuse; (2) The drug has no currently accepted medical use in treatment in the U. S.; (3) There is a lack of accepted safety for use of the drug under medical supervision. 21 USC Sec. 812 01/22/02 (Title 21 - Food and Drugs Chapter 13 - Drug Abuse Prevention and Control Subchapter I - Control and Enforcement Part B - Authority To Control; Standards and Schedules. <http://www.dea.gov/pubs/csa/812.htm#c>

In 1971, The National Commission on Marihuana and Drug Abuse (Shafer Commission) conducted the first national survey of drug use among the general population. Results showed:

- ◆ 14% of youth aged 12-17, and 15% of adults aged 18 and older had tried marijuana.
- ◆ 27% of those aged 16-17 years, 40% of those aged 18-21 years, 38% of those aged 22-25 years reported lifetime use of marijuana.
- ◆ 41% of the adults and 45% of youth reported they no longer used marijuana,
- ◆ 2% of the adults and 4% of youth reported using marijuana several times a day.<sup>8</sup>

The Commission conducted its next national survey in 1972 finding:

- ◆ Less than 5% of the U.S. population reported using an illicit drug other than marijuana.
- ◆ 5% of junior high, 11% of high school, and 8% of college students reported daily cannabis use.
- ◆ 24 million people had smoked marijuana at least once, 8 million people were using it regularly, and at least 500,000 people were consuming it daily.<sup>9</sup>

Preceding this enormous surge in marijuana use were changes in public policy such as decriminalization legislation, lenient laws, lax enforcement and judicial opinion (Alaska) of existing state (11 states) and federal laws. Marijuana use peaked in 1979 when at least 30 million Americans smoked marijuana as compared to just a few hundred thousand users in the early 1960s.<sup>10</sup>

In 1977, then-President Jimmy Carter asked Congress to replace all federal criminal penalties for possession of less than one ounce of marijuana with a \$100 fine with the effect being that marijuana would essentially be decriminalized at the federal level. The proposal died in Congress.<sup>11</sup>

During the period that 11 states and the President were actively creating the perception that marijuana was not a harmful drug, marijuana use increased. By the end of the 1970s, an estimated 50 million individuals had tried marijuana. One in ten high school seniors smoked pot daily, nearly four in ten were current smokers.<sup>12</sup>

President Carter appointed Lee Dogoloff<sup>13</sup> as the new drug policy advisor to begin the arduous task

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<sup>8</sup>Harrison, Cannabis use.

<sup>9</sup>Ibid.

<sup>10</sup>Demers, John, et al., Non-Medical Marijuana: Rite of Passage or Russian Roulette? White Paper, The National Center on Addiction and Substance Abuse, Columbia University, July 1999, p. 17-18. Available online at <http://www.rism.org/isg/dlp/ganja/analyses/CASAWhitePaperMarijuana.pdf>

<sup>11</sup>The Carter Administration stopped urging decriminalization following the departure of Dr. Peter Bourne, Special Assistant for Health Issues and the lead official on drug policy reform. His writing a false prescription and allegations of cocaine use at a party prompted Bourne's resignation which left the Administration in no position to appear soft on drugs.

<sup>12</sup>Demers, et al., Non-Medical Marijuana, p. 21.

<sup>13</sup>Mr. Dogoloff, an active opponent of the marijuana legalization movement of the 1970s, was instrumental in the formation of the National Federation of Parents for a Drug Free Youth. He went on from the Carter administration to found the American Council for Drug Education (ACDE) and continues his commitment to drug prevention to this day.

of strengthening anti-drug policies. Joined by parents and others, alarmed at the levels of drug use, they took action. State and federal anti-drug policies were strengthened leading to a decline in marijuana use until the early 1990s. Marijuana smoking (monthly) among young adults aged 18 to 25, dropped from 36 percent in 1979 to 11 percent by 1992 but rose to 12.8 percent by 1997.<sup>14</sup> As of 2004, current (monthly) marijuana use in the country stood at 14.6 million users (6.1% of the population).<sup>15</sup>

#### Marijuana as medicine in the U.S.:

In the 1980s, over a period of several years, the FDA allowed a limited number of seriously ill patients to use smoked marijuana. The program was terminated in 1992 when the Public Health Service stated there was no scientific evidence that the drug was assisting patients, and issued a warning that using smoked marijuana as a form of medical therapy may actually be harmful to some patients.<sup>16</sup>

As of January 2006, 13 U. S. states have passed some form of legislation or ballot initiative allowing marijuana for alleged medical use – AK, AZ, CA, CO, HI, ME, MD, MT, NV, OR, RI, VT, WA.<sup>17</sup> There are also states with current campaigns and legislative support to allow the use of marijuana as a medicine or to legalize use for adults, and/or to decriminalize possession of the drug (CO, IL, MA, MI, MS, MN, NV, NJ, NY, WA, WI).<sup>18</sup>

Nationally, on average, 5.1 percent of persons aged 12 years or older reported being current marijuana users 1999 through 2001. That increased to 6.18 percent of the population reporting current marijuana use in both 2002 and 2003.<sup>19</sup>

**States with the most marijuana users:** Of the 13 states that have passed legislation or ballot

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<sup>14</sup>Demers, et al., Non-Medical Marijuana, p. 26.

<sup>15</sup>U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Office of Applied Studies. National Findings from the 2004 National Survey on Drug Use and Health, Highlights, p. 1

<sup>16</sup>U.S. Congress, House of Representatives, Committee on Government Reform, Subcommittee on Criminal Justice, Drug Policy, and Human Resources. Mark E. Souder, Chairman. “Medical” Marijuana Background, August 6, 2005 <http://www.reform.house.gov>

<sup>17</sup>Data is available on three of the states that had previously decriminalized marijuana: CA (1975); Maine (1975); Oregon (1973). One study showed that when Oregon, Maine and California decriminalized marijuana, teenage use did not increase significantly. The surveys underlying that report have been criticized for lack of controls for historical and demographic factors, such as gender, income and education, and for employing vague measurement criteria to estimate prevalence of marijuana use. The surveys did not reflect the impact of changing the legal status of marijuana on long-term usage rates and the study failed to recognize that even small annual increases become significant when they accumulate over time. Other states decriminalizing in the 1970s period: Alaska, Colorado, Minnesota, Mississippi, Nebraska, New York, North Carolina, Ohio.

<sup>18</sup>Edwards, C. E. “Marijuana Initiatives/Legislation: 1970s to the Present” Arizona H.I.D.T.A. Demand Reduction Office, March 1, 2006 edition. Listing available upon request.

<sup>19</sup>Wright, Douglas and Sathe, Neeraja State Estimates of Substance Use from the 2002–2003 National Surveys on Drug Use and Health. DHHS Publication No. SMA 05-3989, NSDUH Series H-26. Rockville, MD. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Office of Applied Studies, 2005. <http://oas.samhsa.gov/2k3State/toc.htm>

initiatives allowing marijuana for alleged medical use, eight of those states<sup>20</sup> are ranked in the top ten states<sup>21</sup> for past month marijuana use by persons aged 12 or older. All top-ten ranked states, without exception, are states that have passed laws to allow marijuana use or have had active campaigns promoting a message that marijuana is medicine.<sup>22</sup> Rates of marijuana use in every one of these states' exceeded the national average reported for past month marijuana use in both 2002 and 2003.

In all, 22 states and the District of Columbia exceeded the national average of the population reporting current marijuana use.<sup>23</sup> Eleven of those states have passed laws/initiatives to allow marijuana use and all of the remaining states and the District of Columbia, with the exception of Delaware, have had bills or ballot initiatives attempted.

Not surprisingly, the same trend is observed in the data for any illicit drug use. Of the 13 states that have passed legislation or ballot initiatives allowing marijuana for alleged medical use, 12 are ranked in the top 20 states for any illicit drug use in the past month by persons aged 12 or older.<sup>24</sup>

In all, 23 states and the District of Columbia exceeded the national average of 8.25 percent of the population reporting any current illicit drug use in both 2002 and 2003. Twenty-one of those 23 states and the District of Columbia have had bills or ballot initiatives attempted.<sup>25</sup>

Another factor that should be weighed in considering changes to public policy on drug use, is the perception of risk. Perceived risk has been demonstrated to be a leading indicator of changes in drug use in that when perceived risk decreases, drug use increases. The inverse has also been demonstrated.<sup>26</sup>

An individual's perception of the risks of substance use has been shown to be related to whether he

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<sup>20</sup>AK, CO, ME, MT, NV, OR, RI, VT

<sup>21</sup>Wright, State Estimates of Substance Use. Appendix B, Table B-3. Note: the District of Columbia is included in the first 10 ranked localities listed. As it is not a state, the first 10 *states* encompass a ranking of one through eleven localities on the table. States in order of highest to lowest in marijuana use are: NH, AK, VT, RI, MT, OR, CO, ME, MA, NV.

<sup>22</sup>While not yet passing a marijuana as medicine bill, Massachusetts has had a number of non-binding local initiatives as well as a history, since 1991, of numerous marijuana bills and has a marijuana as medicine bill pending. New Hampshire has had marijuana use bills since 1998, passing a bill to allow physicians to prescribe marijuana if FDA approved.

<sup>23</sup>Wright, State Estimates of Substance Use. Appendix B, Table B-3 Marijuana Use in Past Month by Age Group and State. Listed in order of ranking highest to lowest: NH, AK, VT, DC, RI, MT, OR, CO, ME, MA, NV, WA, NM, NY, MI, HI, CT, DE, MO, FL, CA, OH, MN

<sup>24</sup>Ibid. Appendix B, Table B-1 Any Illicit Drug Use in Past Month, by Age Group and State. MD was the exception, ranking 33rd.

<sup>25</sup> Exceptions are DE, KY

<sup>26</sup>Johnston Ph.D., Lloyd D., et al., Monitoring the Future, National Results on Adolescent Drug Use: Overview of Key Findings, 2003, (NIH Publication No. 04-5506). Bethesda, MD: National Institute on Drug Abuse, June 2004, p. 10 <http://www.monitoringthefuture.org/pubs.html>

or she actually uses the substance (e.g., Bachman, Johnston, & O'Malley, 1998). In a study completed in 2000, it was found that “. . . changes in youth perceptions of the harms associated with regular marijuana use had a substantial impact on both the contraction in use during the 1982 through 1992 period and the subsequent expansion in use after 1992.”<sup>27</sup> This finding supports documented parallels between marijuana use among youth and the periods of active promotion for marijuana medicalization and legalization in the U.S..

Each year the Substance Abuse and Mental Health Services Administration conducts a National Survey on Drug Use and Health (NSDUH), formerly the National Household Survey on Drug Abuse, that includes questions about perceived risks in using various drugs. These annual surveys also showed that drug use is correlated with attitudes and beliefs about drugs. Rates of drug use in the NSDUH were much higher in populations that did not perceive great risk of harm than in populations that did perceive great risk of harm. Historically, perceived risk has declined from a high in 1988 of about 50 percent to its current level of only 39.7 percent of the population.<sup>28</sup>

**States with lowest perception of risk in using marijuana:** Of the 13 states that have passed legislation or ballot initiatives allowing marijuana for alleged medical use, eight<sup>29</sup> are rated in the top 10 states with the *lowest perception* of risk in using marijuana once a month among persons aged 12 or older.<sup>30</sup>

Following aggressive media campaigns portraying marijuana as a medicine and passage in 1996 (AZ and CA) of the first of the most-recent efforts to legalize marijuana under the guise of ‘medical’ use, the U.S. Dept. of Health and Human Services, using data from its annual NSDUH, looked specifically at responses to questions measuring attitudes or perceptions about the harms in using marijuana for AZ and CA. Responses from those surveyed in AZ and CA were then compared to those in other states. The findings: In 1997 Californians and Arizonans were *less likely* than other Americans to perceive great risk in using marijuana.<sup>31</sup>

**Alaska:** After the 1975 state Supreme Court ruling [Ravin v. State, 537 P.;2d 494 (Alaska 1975)] which stated that personal marijuana possession and use was part of a fundamental state constitutional right to privacy, and subsequent legislation establishing a 4-ounce possession limit,

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<sup>27</sup>Pacula, R. et al. Research Paper Series, No. 1 Marijuana and Youth; University of Illinois at Chicago. October 2000. [http://www.impactteen.org/imp\\_yes.htm](http://www.impactteen.org/imp_yes.htm)

<sup>28</sup>U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Advance Report Number 5. Perceived Availability and Risk of Harm of Drugs: Estimates from the National Household Survey on Drug Abuse 1985-1992. March 1994. Also see subsequent years, 1993-2004.

<sup>29</sup>AK, CO, ME, MT, OR, RI, VT, WA

<sup>30</sup>U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Outcome Measures (NOMs), Perceptions of Great Risk of Harm from Smoking Marijuana Once a Month, by Age Group (12 or Older), 2002-03 <http://www.nationaloutcomemeasures.samhsa.gov/outcome/PerceivedRiskUseMain.asp?selectMap=0&new=0>

<sup>31</sup>U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Office of Applied Studies. National Household Survey on Drug Abuse: Preliminary Results 1997, Rockville, MD April 1999. <http://oas.samhsa.gov/nhsda/nhsda97/nhsda976.htm#E10E6>

marijuana use among adolescents rose rapidly and the age of first use moved lower until in 1988, the number of those 12- to 17-years of age in the state who were smoking marijuana stood at more than twice the national average.<sup>32</sup> In 1990, an Alaskan grass-roots parent movement successfully re-criminalized marijuana use through the ballot initiative process.

**Arizona:** Several ballot initiatives 1996, 1998. This state is the only one that required a physician's *prescription*. To date, most physicians have been unwilling to write a prescription. According to the most recent biennial youth survey data,<sup>33</sup> the current usage rates for marijuana are higher than the national rates for 8<sup>th</sup> and 12<sup>th</sup> graders. Rates of lifetime use are also higher in Arizona than for the national sample. The executive summary for the report offers an explanation: "When students were asked how much of a risk (health and otherwise) there was in using marijuana, students in Arizona generally believed that it was less harmful to try marijuana once or twice and to smoke marijuana regularly than students nationwide. The greatest difference is seen in the perceived harm of smoking marijuana regularly. For all grades of the Arizona students surveyed, there was a perception that marijuana was less harmful than was the perception of their national counterparts. . . . Such results could potentially explain the higher experimental and lifetime marijuana use rate for Arizona youth, since (generally) students who are not afraid of using substances, and who believe they will not be harmed by using substances, tend to use substances more than students who perceive harm in using a substance."

**California:** As was the case in Arizona, Californians have been subjected to ballot initiatives supporting the medical use of marijuana beginning in 1996. There have been aggressive media campaigns exposing the state's population to messages that marijuana is medicine and not a harmful, addictive drug. There have been highly-publicized court cases and over a decade of publicity surrounding the use of marijuana as a medicine.

California conducts biennial surveys on drug use by 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> grade-level students. According to the most recent CA survey data available (2003/2004)<sup>34</sup> on current (past 30 days) use of marijuana by students, it was found that for 7<sup>th</sup> graders there was no change from the 1999-2000 levels; for 9<sup>th</sup> graders there was only a slight decrease (2.4% to 2.2%) in current use of marijuana; and for 11<sup>th</sup> graders there was an increase (4.4% to 4.8%) over the 1999-2000 percentages but a decrease from a spike (5.3%) in current marijuana use found in the 2001-2002 survey.

These surveys also contain questions as to the perception of harms in marijuana use. For many years, California students have demonstrated a decrease in the perception that marijuana is harmful and

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<sup>32</sup>Demers, et al., Non-Medical Marijuana, p. 17-18. citing: Segal, Bernard, et al. Center for Alcohol and Addiction Studies, University of Alaska. Patterns of Drug Use: School Survey (1983); Also Segal, et al. Drug-Taking Behavior Among Alaska Youth (1988): A Follow-up Study 1989.

<sup>33</sup>Arizona Criminal Justice Commission, Arizona Youth Survey, State Report 2004. Compiled by Bach Harrison, L.L.C. p. viii. <http://www.azcjc.gov/publications/publications.asp?ServId=1003>

<sup>34</sup>Austin Ph.d., Gregory and Skager, Ph.D., Rodney, 10th biennial California Student Survey Drug, Alcohol and Tobacco Use 2003-04. Sacramento, CA:California Attorney General's Office, Summer 2004. <http://safestate.org/index.cfm?navid=254>

the survey data presented in the 2003-04 report continues that trend for all three grade levels surveyed. In fact, California students in all three grade levels perceived the occasional use of cigarettes to be more harmful than the occasional use of marijuana.

**Oregon:** Initiative passed in 1998 and has a cardholder program. Since enactment, more than 10,000 people in the state have obtained official cards allowing use of marijuana for alleged medical reasons. This is about 20 times the number of people that officials had predicted. According to Pam Salsbury, manager of the state's medical marijuana office, the number of cardholders has doubled in less than two years and about 80 to 100 new or renewal applications arrive on a typical day. The most commonly-reported debilitating condition in applications to the OMMP, is severe pain.<sup>35</sup>

### **Sampling of International Experiences**

Some countries have modified public policy on marijuana and other drugs. While there are numerous studies, surveys and reports available relating to the consequences of accepting drug use as a norm in society, it is not the purpose of this paper to include the voluminous available literature. Therefore, a sampling of those experiences is presented for comparative purposes only.

**Australia:** In 1985 Australia changed its public policy on marijuana, focusing on public health and so-called harm-reduction policies. Following that change, some states adopted marijuana decriminalization laws and some eventually 'medicalized' marijuana use - all leading to marijuana being the most commonly used drug in Australia.<sup>36</sup> After years of a 'soft' approach to marijuana, Prime Minister John Howard is now criticizing health experts for adopting what he terms a "relaxed" attitude to marijuana and is calling on states and territories to abandon a decade of decriminalization and to introduce tougher laws to deter marijuana users.<sup>37</sup> In Australia, there is growing concern over the strong links between marijuana use and mental illnesses. According to Ian Hickie, one of the authors of a recent report on the crumbling mental health system in Australia, in a newspaper interview: "the increasing use of recreational drugs was a major issue for public policy, because the evidence now seemed conclusive that use of cannabis and several other substances wrongly thought of as harmless 'party drugs' contributed both to psychotic mental illnesses such as schizophrenia and to non-psychotic complaints including anxiety and depression."<sup>38</sup>

**Canada:** In the Summer of 1999, the House of Commons passed a marijuana for medical use bill.<sup>39</sup> The Health Canada agency created regulations (Marijuana Medical Access Regulations, 2000) and

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<sup>35</sup>"Medical Marijuana Use on the Rise," Associated Press, (Portland, OR) January 24, 2005. Article posted at SFGate.com.

<sup>36</sup>Child and Youth Health, South Australia, Cannabis Nov 2005. The report notes that cannabis is the most commonly used illegal drug in Australia.  
<http://www.cyh.com/HealthTopics/HealthTopicDetails.aspx?p=240&np=158&id=2012> [By the age of 20 years, 60% of Australians have now used cannabis and about 7% are daily users.]

<sup>37</sup>"PM gets tough on marijuana dangers," Sunday Telegraph, (New South Wales) by Tony Vermeer. December 18, 2005 <http://www.news.com.au/story/0,10117,17596296-2,00.html>

<sup>38</sup>"Weak drug laws blamed for madness," The Australian, by Adam Cresswell, Simon Kearney and Jeremy Roberts, October 29, 2005.

<sup>39</sup>"MPs Back Move Toward Legalized Medicinal Pot," Montreal Gazette, by David Gamble, May 26, 1999.

went into the business of supplying marijuana (2003). But as more-experienced drug dealers know, drug users are not responsible customers. As of January 2006, almost half of the people authorized to buy the government's marijuana were 90-days in arrears, owing Health Canada \$168,879 (Canadian).<sup>40</sup> The federal government has also created a program to have doctors dispense marijuana, but the Canadian Medical Association and the Canadian Medical Protective Association seriously questioned the proposal announced July 2003. In addition, then Health minister Anne McLellan said that while the government was not convinced of the medicinal benefits of marijuana, it was compelled to establish a dispensing plan as a result of a court ruling (*Hitzig v. Canada* 2003 CanLII 30796 (ON C.A.)) January 2003 invalidating the regulations as unconstitutional since they failed to resolve issues relating to the source and supply of the drug. In July, 2003 the Canadian Medical Association, in referring to the federal government's interim policy said: "Since the government has not made the case for the safety of the medical use of marijuana, the CMA strongly recommends that the physicians of Canada not participate in dispensing marijuana under existing regulations, and warns that those who do, do so at their professional and legal peril."<sup>41</sup>

Under the former government (a new government has just been elected), Canada moved in the direction of liberalizing its public policy. Under consideration by the federal government since 1999, was not only the medical use of marijuana, but decriminalization (de facto legalization), thus increasing its acceptability.<sup>42</sup> According to a study of young people in Canada released in 2004, its youth hold the distinction of topping all nations (Switzerland was second) in frequent marijuana use.<sup>43</sup> The lead researcher for this study, Dr. William Boyce of Queen's University, had the following to say about the study results: ". . . that its increased use is tied to the three As — affordability, availability and acceptability. In Canada, I think all three of those things come together so that it's actually used quite a bit by kids here. It's not so expensive, it's definitely available and with the legislation introduced in the last Parliament — and perhaps again in this one — that decriminalizes marijuana use, it certainly provides a signal to kids that this is not a highly illegal activity."<sup>44</sup>

**Colombia:** In 1994, a court ruling legalized possession of 20 grams of marijuana and one gram of cocaine and heroin for private use. Drug use increased 40% over a 10-year period according to Dr. Camilo Uribe (no relation to Colombian President Alvaro Uribe), a toxicologist and the president's adviser on drug matters. Dr. Uribe blames legalization for part of the increase, saying it made drugs more acceptable. "The court decision sent the completely wrong message -- that it's OK to do

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<sup>40</sup> "Health Canada going after medical pot users," Canadian Press (Ottawa). By Dean Beeby. February 5, 2006. Canoe Network <http://cnews.canoe.ca/CNEWS/Law/Marijuana/2006/02/05/1427232-cp.html>

<sup>41</sup> Spurgeon, David. Quebec, "Canadian doctors question marijuana for medicinal use." British Medical Journal Vol. 327 (July 19, 2003):122. <http://bmj.bmjournals.com/cgi/content/full/327/7407/122-d>

<sup>42</sup> Canada: Brief for the Senate Committee on Illegal Drugs, prepared by Colin Mangham, Ph.D., Institute for Health Promotion Research, UBC, Implications of a Liberalized Drug Policy in Canada. September 17, 2001. <http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-e/ille-e/presentation-e/mangham-e.htm>

<sup>43</sup> Health Canada, Ottawa, Ontario. Young People In Canada : Their Health And Well-being, Summary Report July 2004 [http://www.phac-aspc.gc.ca/dca-dea/publications/hbsc-2004/hbsc\\_summary\\_e.html](http://www.phac-aspc.gc.ca/dca-dea/publications/hbsc-2004/hbsc_summary_e.html)

<sup>44</sup> "Teens spurn tobacco, embrace pot. More adolescents smoke pot in Canada than anywhere else in the world." Canadian Press, Toronto Star. July 2004

drugs," he stated. The rationale for the 1994 Constitutional Court ruling for legalization: force the government to find more effective methods than law enforcement for combating drug abuse. Today, the country is experiencing addiction problems and the president is moving to restore total prohibition. The sale of drugs remains illegal, but suspected dealers can only be arrested if caught with more than the legal limit.<sup>45</sup>

**Denmark:** Christiania, an area of Copenhagen, 'founded' in September of 1971 by a group of squatters who took over a military-barracks complex in the center of Copenhagen, has been the center for much of the Scandinavian trade in cannabis, as well as other drugs even though "Christianites" officially banned so-called hard drugs, but allowed marijuana, in 1980. A study conducted by Denmark's Board of Public Health (2003) reveals that the number of drug users in the country, already at high levels, had increased noticeably 1998-2003. During that period, numbers rose by 25%, or 5000 people. As of 2003, there were an estimated 25,500 people suffering from physical, psychological and/or social damage from their drug abuse. Hashish is illegal in Denmark, but people who are caught for the first time in possession of a small amount of the drug are only cautioned. Brian Mikkelsen, the country's Justice Minister says that the cautioning has been interpreted by youth as a form of legalization of cannabis. In 2003, statistics from the Danish Institute of Public Health show that some 200,000 people in Denmark, aged 16 and over, smoke hashish at least once a year and an increasing number of youths are admitted into rehab every year because of cannabis abuse. As of mid-2004, Denmark began to tighten its cannabis law and to stop the drug sales and criminal elements in Christiania - described as a "derelict drug haven". In 2004, parliamentary bill L 205, an attempt to normalize Christiania, was introduced.<sup>46</sup> The end was beginning for Denmark's drug liberalization experiment.

**Great Britain:** In 2003, the UK government, upon recommendation of drug legalizers well-placed in the UK government<sup>47</sup>, downgraded the classification of marijuana (similar to the US method of 'scheduling' drugs - reclassification effective Jan. 29, 2004), leading its citizens to the perception that marijuana was not a harmful or addictive drug. Since that action: The UK Department of Health, in 2004, found that drug centers were reporting growing numbers of marijuana addicts, many of them still in their teens. It also reported figures showing that drug centers are reporting growing numbers of marijuana users coming to the centers with problems related to the drug. Nine percent of those attending clinics cited cannabis as the main reason they were attending, twice as many as a decade ago.<sup>48</sup> Home Secretary Clarke is now on record admitting "We misled public over downgrading cannabis." He has also confirmed that "there was an alarming lack of knowledge

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<sup>45</sup>"Colombia sinks in sea of legal cocaine, heroin," Los Angeles Daily News, by Housego, Kim. April 03, 2004

<sup>46</sup>L205 provided a timetable, extending into 2006, for a number of actions, such as registering of those in Christiania, the razing of existing buildings, land in the area passing into private ownership, etc. A critique of the bill may be found at <http://www.forsvarchristiania.dk/index.php?id=38>

<sup>47</sup>Mike Trace, former Deputy UK Anti-Drugs Co-ordinator (UKADC) exposed in late 2002 as a self-proclaimed "fifth columnist" for the drug legalization movement in Europe, working under the auspices of the George Soros Open Society Institute is one such supporter of drug legalization.

<sup>48</sup>"Alarm Bells: Addiction to cannabis on the rise in the UK" The Observer (London) Monday, Jun 14, 2004, Page 7.

about the health dangers posed by the drug among the general public.” The government of Great Britain has opened the door to discussing a reversal of the public policy on marijuana and Home Secretary Clark has ordered a complete review of the drugs classification system.<sup>49,50</sup>

**Italy:** In April 1993, by referendum, Italian citizens voted to de-criminalize the use of drugs, including marijuana for personal use. Sellers and traffickers were still subject to punishment, but users were not. According to then Prime Minister Gianfranco Fini in 2003, it was virtually impossible for law enforcement to distinguish between personal use and trafficking. Italy has re-criminalized all drugs. In November 2003, Italy’s government adopted a proposal making it an offence to possess and use even the smallest quantities of narcotics and abolished any distinction between what drug legalizers like to think of as “soft”(marijuana) and “hard” (cocaine, heroin, etc.) drugs. It also virtually reverses existing Italian law by starting from the principle that *it is drug use, rather than drug abuse, that must be stamped out*. The vote reflected the social reality of a country in which consumption of mild drugs has become increasingly common. According to a 2001 study by the European Monitoring Centre for Drugs and Drug Addiction, the EU’s official body for analyzing trends in drugs use, 9.4% of Italians between the ages of 15 and 34 had used cannabis in the previous year.<sup>51</sup>

**Netherlands:** The revised Dutch drug policy, often held up as an example by U.S. drug-legalization organizations, is based upon Parliament's 1976 acceptance of the recommendation of a commission headed by Pieter A. H. Baan, a psychiatrist and expert in rehabilitating drug addicts. The Baan Commission's report proposed distinguishing between so-called List One drugs-- those that present "an unacceptable risk (heroin, cocaine and LSD)"--and List Two drugs--cannabis products, such as hashish and marijuana--seen as less dangerous and softer. Essentially, Parliament de-penalized the possession of 30 grams of marijuana or hashish--enough, legislators calculated, to meet an average smoker's needs for three months.<sup>52</sup> The Dutch legalized the public sale, under certain restraints, of cannabis products and adopted a much more lenient policy toward all forms of drug use and abuse based on a philosophy of harm reduction. The country also (2003) authorized the use of marijuana for medical purposes.

As a direct result, it is now considered Europe's drug supermarket and the drug capital of western Europe. "Our liberal drug policy has been a failure, but its advocates are so rooted to their convictions they cannot bring themselves to admit it," says Dr. Franz Koopman, director of De Hoop (The Hope) drug rehabilitation center in Dordecht. "First, we banalized cannabis use. We have left our kids with the idea that it's perfectly all right to smoke it, and from there it was an easy step for

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<sup>49</sup>“We misled public over downgrading cannabis - Clarke.” The London Times by Rosemary Bennett, Deputy Political Editor, January 05, 2006. <http://www.timesonline.co.uk/article/0,,17129-1970798,00.html> Note: decision was made to leave the classification as is for the time being while reviews are done.

<sup>50</sup>“Ecstasy deaths warning as ministers poised to review drug classification system.” The Scotsman, by Michael Howie, February 2, 2006. <http://news.scotsman.com/index.cfm?id=165742006>

<sup>51</sup>“Italy's New Hard Line on Soft Drugs Sparks Row.” The Financial Times Limited (London) Barber, Tony November 15, 2003 <http://www.ft.com/>

<sup>52</sup>Collins, Larry. “Holland's Half-Baked Drug Experiment.” Foreign Affairs Vol. 78, No. 3. May/June 1999, Council on Foreign Relations, Inc.. <http://www.foreignaffairs.org/>

them to move to the notion that it's also okay to use mind-altering substances like ecstasy. It is that mentality that is behind the explosion in the use of these synthetics we've seen in the last three years, and [it] is a grave peril to this country just as it is to the rest of Europe."<sup>53</sup> Since importing cannabis was still illegal, the Dutch began to grow their own and produced a high-THC content marijuana.

As the coffee shops boomed between 1984 and 1996, marijuana use among Dutch youths aged 18 to 25 leapt by well over 200 percent. In 1997, there was a 25 percent increase in the number of registered cannabis addicts receiving treatment for their habit, as compared to a mere 3 percent rise in cases of alcohol abuse. In 1995, public Ministry of Justice studies estimated that 700,000 to 750,000 of Holland's 15 million people--about 5 percent of the population--were regular cannabis users. A 1998 study by Professor Pieter Cohen of the University of Amsterdam, disputes those figures, claiming that only 325,000 to 350,000 Dutch men and women are regular cannabis users. His survey discovered that those smokers are concentrated among the young in densely populated areas of Amsterdam, Utrecht, and Rotterdam. 1995-1999 data shows that these same areas have witnessed a skyrocketing growth in juvenile crime and the number of youths involved in acts of violence associated by many Dutch law enforcement officers with the abuse of 'soft' drugs.

Former Amsterdam Police Commissioner Jelle Kuiper declared more than 18 months ago, "As long as our political class tries to pretend that soft drugs do not create dependence, we are going to go on being confronted daily with problems that officially do not exist. We are aware of an enormous number of young people strongly dependent on soft drugs, with all the consequences that has." A few months later, his counterpart in The Hague, the de facto Dutch capital, echoed his views: "Sixty-five percent of the persistent rise we are seeing in criminality is due to juveniles, and above all, juvenile drug users."<sup>54</sup>

The Attorney General for The Netherlands severely criticized the cannabis policy as "an ineffective form of law enforcement". He further stated that "law enforcement struggles with an unworkable mandate." In an unpublished report prepared for The Netherlands' Supreme Court of Justice, J. Wortel, Director of Public Prosecutions and a career-long prosecutor states that even The Netherlands' official policy of tolerating small-scale sales and personal possession of cannabis is an "unworkable" policy that undermines other law enforcement activities and public health.<sup>55</sup>

The pot crop--a direct outgrowth of Holland's drug policy--comes from some 25,000 to 30,000 small-to medium-scale producers, most of them indoor growers. Under Dutch law, anyone may possess five plants for personal use which can yield 64.46 joints per day<sup>56</sup>. One ounce of leaves will yield about 30-40 joints. Cannabis grows fast; indoor growers can reap four crops a year.

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<sup>53</sup>Ibid.

<sup>54</sup>Ibid.

<sup>55</sup>"I Believe Because It Is Absurd", NRC-Handelsbad (The Hague, Netherlands) June 24, 2005.

[http://www.norml.org/index.cfm?Group\\_ID=6579](http://www.norml.org/index.cfm?Group_ID=6579)

<sup>56</sup>Drug Availability Steering Committee, Drug Availability Estimates in the United States 2001. December 2002. <http://www.whitehousedrugpolicy.gov>

A 1997 report on drug use in the Netherlands by the government-financed Trimbos Institute acknowledged that "drug use is considered to be the primary motivation behind crimes against property"—[more than] 23 years after the Dutch policy was intended to stop such crimes.<sup>57</sup> After coffee shops started selling marijuana and the normalization of drug use set in, use of marijuana nearly tripled (from 15 percent to 44 percent) among 18-20 year old Dutch youth between 1984 and 1996.<sup>58</sup>

According to the 2004 National Drugs Monitor report on outpatient treatment data, the proportion of cocaine and cannabis clients among all drug clients has strongly increased in the past ten years, amounting to 20% in 2003 and 38% in 2004. The proportion of new cocaine and cannabis clients among all drug clients applying for help for the first time is even more pronounced (32% in 2003 and 41% in 2004) which would appear to indicate a rising popularity of marijuana or hash and increasing numbers of cannabis users who are seeking medical help. The Monitor also reported that both the lifetime and current (monthly) prevalence of cannabis use among students 12-18 years of age, in 2003, stands at more than double the number of students using cannabis in 1988.<sup>59</sup>

Top government officials are considering the tightening of Holland's current policy on cannabis.<sup>60</sup>

**European Union Attitudes and Perception of Harm:**<sup>61</sup> The average number of young people in the EU who say they perceive cannabis as very dangerous is 20.6 percent. The number is much higher in northern European countries with tighter policies: in Sweden 45 percent perceive the drug as very dangerous and in Finland 35 percent believe the same. Whereas, in the United Kingdom the number is 17 percent, in Belgium 14 percent and in the Netherlands 7.2 percent – all countries with lax public policy on drugs.<sup>62</sup>

#### Additional considerations when changing public policy on marijuana use:

1. Physicians who recommend marijuana may find they have no insurance coverage for the liability

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<sup>57</sup>Collins, "Holland's Half-Baked Drug Experiment."

<sup>58</sup>MacCoun, Robert and Reuter, Peter, "Interpreting Dutch cannabis policy: reasoning by analogy in the legalization debate." *Science*. 1997 Oct 3;278(5335):47-52.

<sup>59</sup>Trimbos, Reitox National Focal Point, The Netherlands Drug Situation 2004, Nationale Drug Monitor Report to the EMCDDA. Online at: <http://www.trimbos.nl/default13921.html>

<sup>60</sup>Health Minister Hans Hoogervorst is considering abandoning the legal sale of medicinal cannabis in pharmacies and closing the Office of Medicinal Cannabis. In response to questions from the Tweede Kamer (House of Representatives of the Dutch parliament) he said on 17 March 2005 (*NRC Handelsblad*, 18 March 2005) that he intends to decide on the future of the program after summer. A White Paper on Cannabis Policy was sent to Parliament April 23, 2004 in which the Government expressed its intention to tighten Dutch policy on cannabis. The main policy intentions are: National Action Plan to Discourage Cannabis Use, intensified enforcement of the laws and regulations on cannabis, more severe measures to curb drug tourism and firm action to curb large-scale production of cannabis. The white paper may be found at: [http://www.minvws.nl/images/BZ75398\\_tcm11-55962.pdf](http://www.minvws.nl/images/BZ75398_tcm11-55962.pdf)

<sup>61</sup>For information on EU drug use, see: Annual Report 2004: the state of the drugs problem in the European Union and Norway <http://annualreport.emcdda.eu.int/en/home-en.html>

<sup>62</sup> Mobiliserer mot narkotika, The Swedish National Drug Policy Coordinator, Is Cannabis a Harmless Drug? Connecting Research to Drug Control Policy, Stockholm. April 2003. [www.mobilisera.nu](http://www.mobilisera.nu).

exposure and potential claims by patients or third parties harmed by a patient's use of marijuana as recommended by a physician.<sup>63</sup>

2. "Most discussants of legalization or government distribution of addictive substances do not take account of predictable long-term growth in the population of addicted persons and/or the long-term addiction costs associated with this policy choice."<sup>64</sup>

3. The harms of marijuana to seriously or terminally ill persons must be considered. Dr. Donald P. Tashkin stated that consideration well when he said, "The most potent argument against the use of marijuana to treat medical disorders is that marijuana may cause the acceleration or aggravation of the very disorders it is being used to treat."<sup>65</sup>

A 2001 report by Dr. Tashkin showed that the use of marijuana as a medical therapy can and does have a very serious negative effect on patients with pre-existing immune deficits resulting from AIDS, organ transplantation, or cancer chemotherapy -- the very conditions for which marijuana has most often been touted and suggested as a treatment. "In view of the immuno-suppressive effect of THC, the possibility that regular marijuana use could enhance progression of HIV infection itself needs to be considered, although this possibility remains unexplored to date."<sup>66,67</sup>

Habitual marijuana smoking may cause a number of potentially harmful effects on the lung, including the following: (1) acute and chronic bronchitis; (2) extensive histopathologic alterations in the cells lining the bronchial passages that could impair mucociliary clearance or predispose to malignancy; (3) increased accumulation of inflammatory cells (alveolar macrophages) in the lung; and (4) impairment in the function of these important immune-effector cells, including their ability to kill microorganisms and to produce protective pro-inflammatory cytokines. The major potential pulmonary consequences of regular [defined as an average of one 'joint' per day] marijuana use are pulmonary infection and respiratory cancer.<sup>68</sup>

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<sup>63</sup>"The Potential Medical Liability for Physicians Recommending Marijuana as a Medicine." Educating Voices, Inc. (Naperville, IL) July 2003. [www.educatingvoices.org](http://www.educatingvoices.org)

<sup>64</sup>Charles, Robert B. "New Economic Thinking on Addiction and Legalization: Toward Sliding Price Elasticities of Demand for Addictive Substances and their Implications for Public Policy." Commissioned by The National Alliance for Model State Drug Laws (Arlington, VA) July 2003.

<sup>65</sup>Tashkin, M.D., Donald P., "Effects of Smoked Marijuana on the Lung and Its Immune Defenses: Implications for Medicinal Use in HIV-Infected Patients." Journal of Cannabis Therapeutics, Vol. 1, No. 3/4 (2001): 87-102.

<sup>66</sup>Ibid.

<sup>67</sup>Tindall, B. et al., "The Sydney AIDS Project: Development of acquired immunodeficiency syndrome in a group of HIV seropositive homosexual men." Australian and New Zealand Journal of Medicine 18 (1988):8-15. Research concluded that among HIV-positive individuals, active marijuana use has been found to be a significant risk factor for rapid progression from HIV infection to AIDS and acquisition of opportunistic infections and/or Kaposi's sarcoma.

<sup>68</sup>Tashkin, M.D., Donald P., "Effects of marijuana on the lung and its immune defenses." Secretary's Youth Substance Abuse Prevention Initiative: Resource Papers, March 1997, Center for Substance Abuse Prevention, pp. 33-51. Abstract online at: <http://www.ukcia.org/research/EffectsOfMarijuanaOnLungAndImmuneDefenses.html>

“Infections of the lung are more likely in marijuana users due to a combination of smoking-related damage to the ciliated cells in the bronchial passages (the lung's first line of defense against inhaled microorganisms) and marijuana-related impairment in the function of alveolar macrophages (the principal immune cells in the lung responsible for defending it against infection). Patients with preexisting immune deficits due to AIDS or cancer chemotherapy might be expected to be particularly vulnerable to marijuana-related pulmonary infections”.<sup>69</sup>

4. The link between schizophrenia and psychosis and the use of marijuana began to become evident in the early 1980s. Research in recent years, including long-term studies,<sup>70</sup> have begun to prove the links observed over the past several decades. According to Thomas Edward Radecki, M.D., J.D., who has compiled a list of studies examining this link, “the research evidence is extremely strong, proving beyond a doubt that marijuana causes a large number of cases of schizophrenia in the modern world. Indeed, a number of studies have found marijuana has a stronger link to causing schizophrenia than other drugs.”<sup>71</sup>

5. “Simply put, there is no scientific evidence that qualifies smoked marijuana to be called medicine. Further, there is no support in the medical literature that marijuana, or indeed any medicine, should be smoked as the preferred form of administration.”<sup>72</sup> And in fact, at the request of the Office of National Drug Control Policy in 1997, the Institute of Medicine conducted a review of scientific evidence to date in an effort to assess possible benefits of using marijuana’s cannabinoid compounds (THC and canabidiol).<sup>73</sup> Its conclusions:

- ◆ Smoking marijuana is not recommended for any long-term medical use.
- ◆ The accumulated data indicate a potential therapeutic value for cannabinoid drugs, (not crude marijuana) particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation.
- ◆ The effects of cannabinoids on the symptoms studied are generally modest, and in most cases there are more effective medications.

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<sup>69</sup>Ibid.

<sup>70</sup>A sampling of studies: “Schizophrenia Increased in US Army After Marijuana”. Schizophrenia in US Army in Europe jumped from 1/1000 to 38/1000 over the 5-year period from 1967-1971. Tennant and Groesbeck, Arch Gen Psych 27:133-6, 1972; Dutch Prospective Study Found Causal Link with Major Increase in Schizophrenia from Marijuana: A three-year follow up of a Dutch cohort of 4045 people free of psychosis and 59 with a baseline diagnosis of psychotic disorder showed a strong association between use of cannabis and psychosis. Am J Epidemiol 2002; 156:319-327; New Zealand Study Finds Marijuana Triples Schizophreniform Disorder: A birth cohort of 1037 individuals born in Dunedin, New Zealand, in 1972-3 and studied for 26 years. Cannabis use is associated with an increased risk of experiencing schizophrenia symptoms, even after psychotic symptoms preceding the onset of cannabis use are controlled for, indicating that cannabis use is not secondary to a pre-existing psychosis. Secondly, early cannabis use (by age 15) confers greater risk for schizophrenia outcomes than later cannabis use (by age 18). British Medical Journal 2002; 325:1212-1213 ( 23 November )

<sup>71</sup>Radecki, MD, JD, Thomas E., Web site page: Marijuana, listing of research reports linking marijuana and schizophrenia disorders. <http://www.modern-psychiatry.com/marijuana2.htm>

<sup>72</sup>“A Haze of Misinformation Clouds Issue of Medical Marijuana,” Los Angeles Times, Op Ed by Andrea Barthwell, MD, July 22, 2003

<sup>73</sup>The National Academies of Science, Institute of Medicine, Marijuana and Medicine: Assessing the Science Base, Executive Summary. March 1999 <http://books.nap.edu/catalog/6376.html>

- ◆ Isolated cannabinoids will provide more reliable effects than crude plant mixtures.

Research and discovery of the harms associated with crude smoked marijuana use continues to support the wisdom of U.S. public policy on the illegality and scheduling of marijuana and to confirm that marijuana is a dangerous and addictive drug, subject to abuse. Additionally, it is now strongly implicated as a causative factor in the development of mental illnesses, particularly schizophrenia and psychosis, among users of marijuana.

“Bypassing the usual safety and efficacy process of the FDA is a dangerous and unnecessary precedent which widely enhances the availability and acceptance of marijuana. Smoking an impure and toxic substance is of questionable value in the modern medical armamentarium. It is no more reasonable to consider crude marijuana a medical treatment than it is to consider tobacco as medicine.”<sup>74</sup>

For community leaders, government officials and others to consider promoting a public policy that marijuana is medicine, leading to a natural conclusion that it is not a harmful and addictive drug, creates an obligation to perform due diligence before promoting or endorsing such a public policy. This paper has presented only a small sampling of available information as a means to encourage further study and research. There exists an abundance of studies and research supporting the harms of marijuana, as well as sufficient historical data to meet the due-diligence responsibility. While there may be conflicting interpretations of what certain data represent, having the benefit of historical experience over a long period of time allows for the observation of trends which are often more significant than data that is limited to just one or two years.

C. E. Edwards  
Arizona H.I.D.T.A.  
Demand Reduction Office  
azhidta@earthlink.net

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<sup>74</sup>Voth, M.D., FACP, Eric A. “A Peek Into Pandora’s Box: The Medical Excuse Marijuana Controversy.” Journal of Addictive Diseases. Vol. 22 (2003):27-46.