National Drug Control Strategy

1999

Office of National Drug Control Policy

The U.S. medical-scientific process has not closed the door on marijuana or any other substance that may offer therapeutic benefits. However, both law and common sense dictate that the process for establishing substances as medicine be thorough and science-based. By law, laboratory and clinical trial data are submitted to medical experts in the DHHS, including the FDA, for evaluation of safety and efficacy. If scientific evidence, including results of adequate and well controlled clinical studies demonstrates that the benefits of a drug product outweigh associated risks, the substance can be approved for medical use. This rigorous process protects public health. Allowing marijuana or any other drug to bypass this process is unwise.

Permitting hemp cultivation would result in de facto legalization of marijuana cultivation because both hemp and marijuana come from the same plant — *Cannabis sativa*, which contains THC, the active ingredient in marijuana. Chemical analysis is the only way to differentiate between cannabis variants intended for hemp production and hybrids grown for their psychoactive properties.[8] In June 1998, a New Hampshire magistrate determined that the Controlled Substances Act unambiguously prohibits the cultivation of hemp. The magistrate found that hemp is marijuana under the statute's definition.

According to a Department of Agriculture review of university studies, hemp is unlikely to be a sustainable, economically viable alternative crop given the uncertainty of demand and market prices. The current U.S. market for hemp products is small, and the potential seems high to reach a situation of oversupply quickly in this niche market. For every proposed use of industrial hemp, competing raw materials and proven manufacturing practices already exist. The ready availability of other lower cost raw materials is a major reason for a 50 percent drop in worldwide hemp production since the early 1980s.

Given concerns about encroaching efforts to justify legalization of harmful psychoactive drugs, the *1999 Strategy* outlines specific steps to counter the potential harm such activities pose. Such measures, which have been elaborated throughout this document, include:

(1) Presenting information that demonstrates the harm caused by substance abuse.

(2) Teaching youth that substance abuse is detrimental to their health and well-being.

(3) Supporting established scientific procedures to ensure that only safe and effective drugs are used for the treatment of medical ailments.

(4) Informing state and local government as well as community coalitions and civic organizations about the techniques associated with the drug legalization movement.

(5) Ensuring the rule of law.

(6) Working with the international community to reinforce mutual efforts against drug legalization.

2. PREVENTING DRUG ABUSE

Preventing or delaying use of psychoactive drugs, alcohol, and tobacco among adolescents is a critical, national public health goal. The simplest and most cost-effective way to lower the human and societal costs of drug abuse is to prevent it in the first place. More than 255 million Americans do not use illegal drugs. Some sixty-one million Americans who once used illegal drugs have now rejected them; many suffered as a result of drug abuse. Accidents, addiction, criminal involvement, damaged relationships, impaired judgement, and lost educational or employment opportunities were common. Of the fourteen million Americans who currently use illegal drugs, some four million are chronic abusers. Preventing America's sixty-eight million children from using drugs, alcohol, and tobacco will help safeguard our society. Preventing drug abuse is one of the best investments we can make in our country's future. Doing so is preferable to dealing with the consequences of drug abuse through law enforcement or drug treatment.

Prevention is most promising when it is directed at impressionable youngsters. Adolescents are most susceptible to the allure of illicit drugs. Delaying or preventing the first use of illegal drugs, alcohol, and tobacco is essential. Not only does hazardous drug use put young people at risk of negative short-term experiences, but those who do not use illegal drugs, alcohol, or tobacco during adolescence are less likely to develop a chemical-dependency problem. Like education in general, drug prevention is demonstrably most effective among the young. In addition to deterring some

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provide symptomatic relief, the crude plant does not meet the modern expectation that medicines be of known quality and composition. Nor can smoked marijuana guarantee precise dosage. If there is any future for cannabinoid medications, it lies with agents of certain composition and delivery systems that permit controlled doses. Medical marijuana must conform to classical pharmacological practices that characterize clinical research.

The United Nations' International Narcotics Control Board (INCB), which ensures an adequate world supply of drugs for medical purposes, has stressed that research must not become a pretext for legalizing cannabis. If the drug is determined to have medicinal value, the INCB maintains that its use needs to be subjected to the same stringent controls applied to cocaine and morphine. "Should the medical usefulness of cannabis be established," the 1998 INCB annual report states, "it will be a drug no different from most narcotic drugs and psychotropic substances. Those drugs, however, must continue to be used for medical purposes only, in line with the requirements of the international drug control treaties."[26] The INCB report concluded: "Political initiatives and public votes can easily be misused by groups promoting the legalization of all use of cannabis for recreational use under the guise of medical dispensation."[27]

"Industrial" Hemp

Under the Controlled Substances Act, the definition of marijuana includes all parts of the Cannabis sativa plant except for the sterilized seeds, fiber from stalks, and oil or cake made from the seeds.[28] However, all hemp products that contain any quantity of THC are considered Schedule I controlled substances and cannot be imported into the United States or cultivated domestically without DEA registration and permits.

Hemp products — fiber for use in the manufacture of cloth, paper, and other products as well as seed for birdseed — were authorized for importation during the last decade. Over the past two years, the Drug Enforcement Administration (DEA) received information that sterilized cannabis seed, not solely birdseed, has been imported for the manufacture of products intended for human consumption. DEA also learned from the armed forces and other federal agencies that individuals who tested positive for marijuana use subsequently raised their consumption of these products as a defense against positive drug tests. Consequently, the Administration is reviewing the importation of cannabis seeds and oil because of their THC content. NIDA is studying the effect of ingesting hemp products on urinalyses and other drug tests.

The government is concerned that hemp cultivation may be a stalking horse for the legalization of marijuana. According to a recent report by the Department of Agriculture, U.S. markets for hemp fiber (specialty textiles, paper, and composites) and seed (in food or crushed for oil) are, and will likely remain, small and thin.[29] U.S. imports of hemp fiber, yarn, and fabric and seed in 1999 could have been produced on less than 5,000 acres of land. Also, the potential exists for these markets to quickly become oversupplied. Uncertainty about long-run demand for hemp products and the potential for oversupply discounts the prospects for hemp as an economically viable alternative crop for American farmers.

Child Welfare Initiatives

The safety of children and families is jeopardized by the strong correlation between chemical dependency and child abuse. Several studies recently demonstrated that approximately two-thirds of more than 500,000 children in foster care have parents with substance-abuse problems.[30] A new federal law regarding adoption and child welfare, the Adoption and Safe Families Act (P.L. 105-89), requires that substance-abuse services be provided promptly for parents so that families are given realistic opportunities to recover from drug problems before children in foster care are placed for adoption.

In addition to compromising parental ability to raise children, substance abuse interferes with the acquisition and maintenance of employment. An estimated 15 to 20 percent of adults receiving welfare have substance-abuse problems that prevent them from working.[31] If drug prevention and treatment are not provided for this high-risk population, these families will remain extensively involved in the welfare and criminal-justice systems at great cost to society and with devastating consequences for children. Historically, welfare agencies have not played a direct role in addressing substance abuse and therefore may need assistance in identifying addiction and making appropriate referrals.

To address these issues, SAMHSA/CSAP's Parenting Adolescents and Welfare Reform Program focuses on the parenting adolescent (who often must rely on welfare) to prevent or reduce alcohol, tobacco, and drug use;

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AIDS patients and to control nausea in cancer patients receiving chemotherapy. The pill form of THC has been available for fifteen years and sold under the trade name Marinol. Dronabinol was rescheduled in 1999 to Schedule III of the Controlled Substances Act, making it easier for patients to obtain.

The Administration has provided information to states considering ballot initiatives on "medical marijuana" so that citizens will be informed about the ways such measures undermine the scientific process for establishing safe and effective medicines. These initiatives also contradict federal law and are potential vehicles for the legalization of recreational marijuana use. Ballot initiatives to date generally have not limited use of marijuana to a small number of terminally-ill patients, as most voters envisioned. Rather, they commonly allow marijuana to be obtained without prescription and used indefinitely without evaluation by a physician.

The U.S. medical and scientific communities have not closed the door on marijuana or any other substance that may offer therapeutic benefits. However, both law and common sense dictate that the process for establishing substances as medicine be thorough and science-based. Persons who intend to study or seek approval of marijuana for use in the cure, mitigation, treatment, or prevention of disease are subject to the "drug" and "new drug" provisions of the Federal Food, Drug, and Cosmetic Act (FDC Act) (21 USC 321 et seq.). The FDC Act requires an applicant to submit data from well-controlled clinical trials to the FDA for evaluation of the safety and efficacy of a proposed product. A New Drug Application (NDA) must contain sufficient information to satisfy the statutory standards for marketing approval. This rigorous process is in the interest of public health. Allowing marijuana, or any other drug, to bypass this process would be unwise and unlawful.

In light of the need for research-based evidence, ONDCP asked the Institute of Medicine (IOM) in January 1997 to review all scientific evidence concerning the medical use of marijuana and its constituent cannabinoids. ONDCP felt that an objective, independent evaluation of such research was appropriate given the ongoing debate about the health effects of cannabis. The IOM published *Marijuana and Medicine: Assessing the Science Base* in March 1999.[14] This study is the most comprehensive summary of what is known about marijuana. It emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous analysis) as opposed to belief-based opinion (derived from judgment or intuition untested by science).

The IOM study concluded that there is little future in smoked marijuana as medication. Although marijuana smoke delivers THC and other cannabinoids to the body, it also contains harmful substances, including most of those found in tobacco smoke. The long-term harms from smoking make it a poor drug delivery system, particularly for pregnant women and patients with chronic diseases. In addition, cannabis contains a variable mixture of biologically active compounds. Even in cases where marijuana can provide symptomatic relief, the crude plant does not meet the modern expectation that medicines be of known quality and composition. Nor can smoked marijuana guarantee precise dosage. If there is any future for cannabinoid medications, it lies with agents of certain composition and delivery systems that permit controlled doses. Medical marijuana must conform to classical pharmacological practices that characterize clinical research.

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"Industrial" Hemp

For centuries, civilization has derived hemp products from the fibers and seeds of various fibrous plants, including the *Cannabis sativa* and jute plants, just to name a few. Until relatively recently, it was believed that hemp products had no harmful effects on society. They were thought not to contain any psychoactive ingredients, such as tetrahydrocannabinol (THC) or other controlled substances.

Such a belief formed the basis for a 1937 statutory definition of marihuana (also known as marijuana). In that definition, certain parts of the *Cannabis sativa* plant (specifically the fibers in the stalk and products derived from sterilized seeds) were excluded from the definition. However, in the enactment of the Controlled Substances Act in the early 70's, the Congress augmented the definitional exclusion. The enactment provides a separate provision that specifies that any material, compound, mixture or preparation that contains any quantity of tetrahydrocannabinol (THC) is a Schedule I substance, unless it is specifically excepted or listed in another schedule.

With what we know today, the mere fact that a product is derived from parts of the *Cannabis sativa* plant excluded from the definition of marijuana is not enough to establish that it is not a Schedule I controlled substance. Should the product contain THC or other controlled substances, the product is controlled, unless specific action has been taken under the Controlled Substances Act to place it in another schedule or to specifically except it from control. Schedule I substances and the plants from which they are derived cannot be imported into the United States nor cultivated domestically without DEA registration and permits.

Although hemp products — fiber for use in the manufacture of cloth, paper and other products, as well as sterilized seed for birdseed and other products — were authorized for importation during the last decade, over the past several years, the Drug Enforcement Administration (DEA) received information that sterilized cannabis seed, not solely birdseed, has been imported for the manufacture of products intended for human consumption. DEA has also learned, from the Department of Defense and other federal agencies, that individuals who tested positive for marijuana use subsequently raised their consumption of hemp products as a defense against their positive drug test. Consequently, the Administration is reviewing the importation of cannabis seeds and oil because of their THC content. We hope to have decisive DEA regulations addressing these issues in the very near future.

The government is also concerned that hemp cultivation may be a stalking horse for the legalization of marijuana. According to a recent report by the Department of Agriculture, U.S. markets for hemp fiber, yarn, fabric and seed in 1999 could have been produced on less than 5,000 acres of land. Further, the potential exists for these markets to quickly become oversupplied. Uncertainty about long run demand for hemp products and the potential for oversupply discounts the prospects for hemp as an economically viable alternative crop for American farmers.

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To address these issues, SAMHSA/CSAP's Parenting Adolescents and Welfare Reform Program focuses on the parenting adolescent (who often must rely on welfare) to prevent or reduce alcohol, tobacco, and drug use; improve academic performance; reduce subsequent pregnancies; and foster improvement in parenting, life skills, and general well-being. The Administration for Children and Families (ACF) has taken several steps to improve the delivery of substance abuse services to clients involved with child protection and welfare programs. Five states are implementing child welfare waiver demonstrations that test strategies to engage and retain clients in substance abuse treatment. Conferences and technical assistance workshops have been held around the nation, in cooperation with SAMHSA, to encourage improved partnerships between human services and substance abuse agencies and to highlight model programs. In addition, grants have been made to several schools of social work to develop cross-training curricula in these fields. Finally, research is being conducted on how to screen and assess substance abuse and other barriers to work and to evaluate a model of addressing clients' substance abuse problems.