



Statement from ONDCP Director R. Gil Kerlikowske

*Why Marijuana Legalization Would Compromise Public Health and
Public Safety*

Annotated Remarks¹

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Thank you for inviting me here today to address your conference. I especially want to thank Chief Rob Davis for that introduction.

Furthermore, I'd like to congratulate and thank your new President, Susan Manheimer.

I also want to acknowledge my friend, Barney Malekian, and congratulate him on his appointment as the COPS Director. I believe our appointments speak very clearly about the level of support and respect this Administration has for local law enforcement.

¹ A few data points have been updated from the original version of the speech to ensure data accuracy.

You have been at the forefront of some very controversial issues, and I appreciate your leadership. Other states look to California for guidance, and your thoughtful and timely efforts on drug issues ranging from medical marijuana to pseudoephedrine are important for the health and safety of all Americans.

When President Obama asked me to serve as Director of National Drug Control Policy, he explained that one of my first duties would be drafting his Administration's first *National Drug Control Strategy*, laying out the policies and programs best suited to curb drug use and its consequences.

But the President didn't want a traditional policy paper, with a few people from Washington putting their ideas down and then submitting to Congress a plan that would be forgotten or disregarded by the field. Instead, he asked me to travel the country and sit down with people on every side of this issue.

Since my confirmation, I've visited 37 cities in 19 states, as well as 8 foreign countries, holding roundtable discussions and meeting with hundreds of drug prevention and treatment experts, local officials, law enforcement, parents, teachers, community groups, academics, and young people.

We also convened a working group made up of the 35 Federal agencies with a role in the anti-drug effort. The group's task was to develop a coordinated approach at the Federal level. These months of consultations across the country helped highlight an important truth – that public safety and public health are

threatened by drug use and its consequences. Addressing these challenges requires a balanced, comprehensive, and evidence-based approach.

The Administration's Drug Control *Strategy*, which will be released soon, will build on the hard-won knowledge we already have, but it will also incorporate new information and new tools that experience in the trenches and our best research have provided us.

The scope of our country's drug problem is disturbingly clear: drug overdoses outnumber gunshot deaths in America and are fast approaching motor vehicle crashes as the leading cause of accidental death. It's hard to believe since we seem to hear much more about H1N1, the Toyota recall, and texting while driving.

We are also deeply concerned about two relatively recent threats to public safety and public health: prescription drug abuse and drugged driving.

Prescription drug abuse harms the people who take these pills and those close to them. While we must ensure access to medications that alleviate suffering, it is also vital that we do all we can to curtail diversion and abuse of pharmaceuticals.

Past-year initiation of non-medical prescription drug use has surpassed the rate for marijuana.² Moreover, between 1997 and 2007, treatment admissions for prescription painkillers increased

² *Results from the 2008 National Survey on Drug Use and Health: National Findings*, Substance Abuse and Mental Health Services Administration (SAMHSA), 2009

more than 400 percent. The latest data from the Monitoring the Future study show that seven out of the top ten drugs used by teens are prescription drugs.³

And between 2004 and 2008, the number of visits to hospital emergency departments involving the non-medical use of narcotic painkillers increased 111 percent.⁴

Because prescription drugs are legal, they are easily accessible, often from a home medicine cabinet. Further, some individuals who misuse prescription drugs, particularly teens, believe these substances are safer than illicit drugs because they are prescribed by a healthcare professional and sold behind the counter. This is not the drug that people buy behind a gas station wrapped in tin foil, and so people think it is somehow safer.

We know from the latest National Survey on Drug Use and Health that most people who abuse these drugs are getting them from friends and family or from a doctor.⁵

As law enforcement professionals and community leaders, you can help spread an important message to parents and other adults: If you have unused prescription drugs in your home, dispose of them properly. I also know that many of you have initiated take-backs with the community to help this problem, and I applaud you for that.

³ *Treatment Episode Data Set (TEDS) Highlights - 2007*, SAMHSA: National Admissions to Substance Abuse Treatment Services.

⁴ *Drug Abuse Warning Network (DAWN)*, SAMHSA, 2010. Found at <https://dawninfo.samhsa.gov/>

⁵ See Supra note 1.

Another priority for us this year is drugged driving.

A Department of Transportation study released in December showed that 1 in 8 nighttime weekend drivers tested positive for an illicit drug (1 in 6 when you include illicit drugs or pharmaceuticals).⁶

This study highlighted the alarming prevalence of drugged driving, and I've made anti-drugged driving efforts a top priority.

We will be assessing how we can help states deal with this issue, and I will be meeting with leaders – from trainers of Drug Recognition Experts (DRE), to police chiefs, researchers, and policy makers –to see how the Administration can engage with them to reduce this threat.

This evening I'll be in Sacramento, meeting with 30 officers currently undergoing DRE training. I will encourage them in their efforts and sit down with them to better understand the issues they face in this area.

I know it is impossible to talk about drug policy issues ranging from prevention to policing, from drugged driving to treatment, without mentioning the role of the most commonly used illicit drug today – marijuana.

⁶ 2007 National Roadside Survey of Alcohol and Drug Use by Drivers: Drug Results, U.S. Department of Transportation, National Highway Traffic Safety Administration, December 2009. Accessible at <http://www.ondcp.gov/publications/pdf/07roadsidesurvey.pdf>

You all know the impacts of marijuana in this state— from the proliferation of marijuana being grown on public lands and indoor grows, to the negative effects of marijuana use among youth, the increasing influence of violent gangs on the marijuana trade, and the problems associated with medical marijuana dispensaries.

As I've said from the day I was sworn in, marijuana legalization – for any purpose – is a non-starter in the Obama Administration. I'd like to explain why we take this position.

First, on the medical marijuana issue, I believe that the science should determine what a medicine is, not popular vote.

We've seen the problems of medical marijuana here in this state but also in places like Colorado, too, where kids are given the message that since marijuana is a medicine, it must be safe.⁷

But we've also seen how localities are dealing with this, with success, through zoning, planning regulations, nuisance laws, and other mechanisms.

I recently met with officials from the Netherlands, they are closing down marijuana outlets – or “coffee shops” – because of the nuisance and crime risks associated with them. What used to be thousands of shops have now been reduced to a few hundred, and some cities are shutting them down completely.⁸

⁷ “Doctor says medical marijuana laws hurt teens,” NPR. *Talk of the Nation*, Feb, 10, 2010. Accessible at <http://www.npr.org/templates/rundowns/rundown.php?prgId=5&prgDate=02-10-2010>

⁸ “Government to scale down coffee shops,” Ministry of Health, Welfare, and Sport, Sept. 11, 2009. Accessible at <http://www.minvws.nl/en/nieuwsberichten/vgp/2009/government-to-scale-down-coffee-shops.asp>. Also see “Dutch border towns to close coffee-shops,” *Expatica*, October 24, 2008, http://www.expatica.com/fr/news/local_news/Dutch-border-towns-close-coffee_shops.html. It is also worth noting that research from MacCoun, R. and Reuter, P. (2001; *Drug War Heresies*, Cambridge University Press) shows that,

This brings me to the issue of outright legalization.

The concern with marijuana is not born out of any culture-war mentality, but out of what the science tells us about the drug's effects.

And the science, though still evolving, is clear: marijuana use is harmful. It is associated with dependence, respiratory and mental illness, poor motor performance, and cognitive impairment, among other negative effects.⁹

We know that over 120,000 people who showed up voluntarily at treatment facilities in 2007 reported marijuana as their primary

despite traditionally higher rates of marijuana use in the U.S., there was a tripling in lifetime marijuana use and a more than doubling of past-month use among 18- to 20-year-olds in the Netherlands from 1984 to 1996 – a time when the commercialization of Dutch coffee shops was rapidly expanding.

⁹ Moore and colleagues (2005) summed up the literature on respiratory illnesses and marijuana in the 7See Moore, B.A., et al, Respiratory effects of marijuana and tobacco use in a U.S. sample, *Journal of General Internal Medicine* 20(1):33-37, 2005. Also see Tashkin, D.P., Smoked marijuana as a cause of lung injury, *Monaldi Archives for Chest Disease* 63(2):93-100, 2005. Other evidence on the effect of marijuana on lung function and the respiratory system, and the link with mental illness, can be found in expert reviews offered by Hall W.D, and Pacula R.L. (2003), *Cannabis use and dependence: Public health and public policy*. Cambridge, UK: Cambridge University Press., and Room, R., Fischer, B., Hall, W., Lenton, S., and Reuter, P. (2009), *Cannabis Policy: Moving beyond stalemate*, The Global Cannabis Commission Report, the Beckley Foundation. Room et al. write, “Cannabis use and psychotic symptoms are associated in general population surveys and the relationship persists after adjusting for confounders. The best evidence that these associations may be causal comes from longitudinal studies of large representative cohorts.” Also see Degenhardt, L. & Hall, W. (2006), Is cannabis a contributory cause of psychosis? *Canadian Journal of Psychiatry*, 51: 556-565. A major study examining young people and, importantly, a subset of sibling pairs was released in February 2010 and concluded that marijuana use at a young age significantly increased the risk of psychosis in young adulthood. See McGrath, J., et al. (2010), Association between cannabis use and psychosis-related outcomes using sibling pair analysis in a cohort of young adults, *Archives of General Psychiatry*.

substance of abuse.¹⁰ Additionally, in 2008 marijuana was involved in 374,000 emergency visits nationwide.¹¹

Several studies have shown that marijuana dependence is real and causes harm. We know that more than 30 percent of past-year marijuana users age 18 and older are classified as dependent on the drug,¹² and that the past-year prevalence of marijuana dependence in the US population is higher than that for any other illicit drug. Those dependent on marijuana often show signs of withdrawal and compulsive behavior.¹³

Traveling the country, I've often heard from local treatment specialists that marijuana dependence is as a major problem at call-in centers offering help for people using drugs.

Marijuana negatively affects users in other ways, too. For example, prolonged use is associated with lower test scores and lower educational attainment because during periods of intoxication the drug affects the ability to learn and process

¹⁰ See Supra note 1.

¹¹ See Supra note 3.

¹² Compton, W., Grant, B., Colliver, J., Glantz, M., Stinson, F. (2004), Prevalence of Marijuana Use Disorders in the United States: 1991-1992 and 2001-2002, *Journal of the American Medical Association*, 291:2114-2121.

¹³ Budney, A.J. & Hughes, J.R. (2006), The cannabis withdrawal syndrome, *Current Opinion in Psychiatry*, 19: 233-238.; Budney, A.J., Hughes, J.R., Moore, B.A. & Vandrey, R. (2004), Review of the validity and significance of cannabis withdrawal syndrome. *American Journal of Psychiatry*, 161: 1967-1977.; Budney, A.J., Vandrey, R.G., Hughes, J.R., Moore, B.A. & Bahrenburg, B. (2007), Oral delta-9-tetrahydrocannabinol suppresses cannabis withdrawal symptoms, *Drug and Alcohol Dependence*, 86: 22-29.; Kouri, E.M. & Pope, H.G. (2000), Abstinence symptoms during withdrawal from chronic marijuana use, *Experimental and Clinical Psychopharmacology*, 8: 483-492.; Jones, R.T., Benowitz, N. & Herning, R.I. (1976), The 30-day trip: clinical studies of cannabis use, tolerance and dependence. In Braude, M. & Szara, S. (eds.), *The Pharmacology of Marijuana*. New York: Academic Press, Vol. 2, pp. 627-642.

information, thus influencing attention, concentration, and short-term memory.¹⁴

Advocates of legalization say the costs of prohibition – mainly through the criminal justice system – place a great burden on taxpayers and governments.

While there are certainly costs to current prohibitions, legalizing drugs would not cut the costs of the criminal justice system.

Arrests for alcohol-related crimes such as violations of liquor laws and driving under the influence totaled nearly **2.7 million in 2008**. Marijuana-possession arrests totaled around **750,000 in 2008**.¹⁵

Our current experience with legal, regulated prescription drugs like Oxycontin shows that legalizing drugs is not a panacea. In fact, its legalization widens its availability and misuse, no matter what controls are in place. In 2006, drug-induced deaths reached a high of over 38,000, according to the Centers for Disease Control – an increase driven primarily by the non-medical use of pharmaceutical drugs.¹⁶

Controls and prohibitions help to keep prices higher, and higher prices help keep use rates relatively low, since drug use, especially among young people, is known to be sensitive to price.¹⁷

¹⁴ For a review of the evidence on marijuana and educational attainment, see: Lynskey, M.T. & Hall, W.D. (2000), The effects of adolescent cannabis use on educational attainment: a review, *Addiction*, 96: 433-443.

¹⁵ Federal Bureau of Investigation (2008) *Uniform crime reports*, Washington, DC. Available at: <http://www.fbi.gov/ucr/ucr.htm>

¹⁶ Heron M., Hoyert D., Murphy S., et al. *Deaths: Final data for 2006*. National vital statistics reports; vol 57 no 14. Hyattsville, MD, National Center for Health Statistics, 2009. See http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf

¹⁷ For example, see: Williams, J., Pacula, R., Chaloupka, F., and Wechsler, H. (2004), “Alcohol and Marijuana Use Among College Students: Economic Complements or Substitutes?” *Health Economics* 13(9): 825-843.; Pacula R., Ringel, J., Sutorp, M. and Truong, K. (2008), *An Examination of the Nature and Cost of Marijuana Treatment Episodes*. RAND Working Paper presented at the American Society for Health Economics Annual Meeting,

The relationship between pricing and rates of youth substance use is well-established with respect to alcohol and cigarette taxes. There is literature showing that increases in the price of cigarettes triggers declines in use.¹⁸

Marijuana has also been touted as a cure-all for disease and black market violence – and for California’s budget woes. Once again, however, there are important facts that are rarely discussed in the public square.

The tax revenue collected from alcohol pales in comparison to the costs associated with it. Federal excise taxes collected on alcohol in 2007 totaled around \$9 billion; states collected around \$5.5 billion.¹⁹

Durham, NC, June 2008. Jacobson, M. (2004), “Baby Booms and Drug Busts: Trends in Youth Drug Use in the United States, 1975-2000,” *Quarterly Journal of Economics* 119(4): 1481-1512.

¹⁸ See, for example, Chaloupka, F., “Macro-Social Influences: Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products,” *Nicotine & Tobacco Research*, 1999, and other price studies at <http://tigger.uic.edu/~fjc> and www.uic.edu/orgs/impacteen. Orzechowski & Walker, *Tax Burden on Tobacco*, 2006. USDA Economic Research Service, www.ers.usda.gov/Briefing/tobacco. Farelly, M., et al., *State Cigarette Excise Taxes: Implications for Revenue and Tax Evasion*, RTI International, May, 2003, http://www.rti.org/pubs/8742_Excise_Taxes_FR_5-03.pdf. Country tax offices. CDC, *Data Highlights 2006* [and underlying CDC data/estimates]. Miller, P., et al, “Birth and First-Year Costs for Mothers and Infants Attributable to Maternal Smoking,” *Nicotine & Tobacco Research* 3(1):25-35, February 2001. Lightwood, J. & Glantz, S., “Short-Term Economic and Health Benefits of Smoking Cessation - Myocardial Infarction and Stroke,” *Circulation* 96(4):1089-1096, August 19, 1997, <http://circ.ahajournals.org/cgi/content/full/96/4/1089>. Hodgson, T., “Cigarette Smoking and Lifetime Medical Expenditures,” *The Millbank Quarterly* 70(1), 1992. U.S. Census. National Center for Health Statistics.

¹⁹ See <http://www.taxpolicycenter.org/taxfacts/displayafact.cfm?Docid=399>

Taken together, this is less than 10 percent of the over \$185 billion in alcohol-related costs from health care, lost productivity, and criminal justice.²⁰

Alcohol use by underage drinkers results in \$3.7 billion a year in medical costs due to traffic crashes, violent crime, suicide attempts, and other related consequences.²¹

Tobacco also does not carry its economic weight when we tax it; each year we spend more than \$200 billion on its social costs and collect only about \$25 billion in taxes.²²

Though I sympathize with the current budget predicament – and acknowledge that we must find innovative solutions to get us on a path to financial stability – it is clear that the social costs of legalizing marijuana would outweigh any possible tax that could be levied. In the United States, illegal drugs already cost \$180 billion a year in health care, lost productivity, crime, and other expenditures.²³ That number would only increase under legalization because of increased use.

Rosy evaluations of the potential economic savings from legalization have been criticized by many in the economic

²⁰ Harwood, H. (2000), *Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update Methods and Data*. Report prepared for the National Institute on Alcoholism and Alcohol Abuse.

²¹ See Pacific Institute for Research and Evaluation (PIRE), 2009, *Underage Drinking Costs*. Accessed on March, 1, 2010. Available at <http://www.udetc.org/UnderageDrinkingCosts.asp>

²² State estimates found at supra note 27. Federal estimates found at https://www.policyarchive.org/bitstream/handle/10207/3314/RS20343_20020110.pdf, Also see <http://www.nytimes.com/2008/08/31/weekinreview/31saul.html?em> and <http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf>; Campaign for Tobacco Free Kids, see “Smoking-caused costs” on p.2.

²³ *The Economic Costs of Drug Abuse in the United States, 1992-2002*, Office of National Drug Control Policy, Executive Office of the President, Washington, DC: (Publication No. 207303), 2004.

community. For example, the California Board of Equalization estimated that \$1.4 billion of potential revenue could arise from legalization. This assessment, according to a researcher out of the independent RAND Corporation is, and I quote, “based on a series of assumptions that are in some instances subject to tremendous uncertainty and in other cases not valid.”²⁴

Recent testimony from a RAND researcher concluded that “There is a tremendous profit motive for the existing black market providers to stay in the market, as they can still cover their costs of production and make a nice profit.”²⁵

Canada’s experience with taxing cigarettes showed that a \$2 tax differential per pack versus the United States created such a huge black market smuggling problem that Canada repealed its tax increases.²⁶

Legalizing marijuana would also saddle government with the dual burden of regulating a new legal market while continuing to pay for the negative side effects associated with an underground market whose providers have little economic incentive to disappear.²⁷

²⁴ Pacula, R. (2009). Legalizing Marijuana: *Issues to Consider Before Reforming California State Law*. Accessed at www.rand.org

²⁵ Ibid.

²⁶ Gruber J., Sen, A. & Stabile, M. (2003), “Estimating Price Elasticities When There is Smuggling: The Sensitivity of Smoking to Price in Canada,” *Journal of Health Economics* 22(5): 821-842.

²⁷ See Supra note 23.

Now that I've told you what the research says, let me tell you what this means in practical terms. Legalization means the price comes down, the number of users goes up, the underground market adapts, and the revenue gained through a regulated market will never keep pace with the financial and social cost of making this drug more accessible.

Now let's talk about what *will* work to reduce drug use.

The Office of National Drug Control Policy is pursuing a combined, coordinated public health and public safety strategy.

This strategy recognizes that the most promising drug policy is one that prevents drug use in the first place.

We have many proven methods for reducing the demand for drugs. The demand can be decreased with comprehensive, evidence-based prevention programs focused on adolescence, which science confirms is the peak period for drug-use initiation and the potential for addiction.

Our young people must be made aware of the risks of drug use – at home, in school, in sports leagues, in faith communities, in places of work, and in other settings and activities that attract youth.

This is vital because an individual who reaches age 21 without smoking, using drugs or abusing alcohol is virtually certain never to do so.

ONDCP's National Youth Anti-Drug Media Campaign can reinforce these efforts by connecting with youth through popular television shows, Internet sites, magazines, and films. Community anti-drug coalitions can provide an environment conducive to remaining drug-free. Expanding early intervention services for drug users and treatment options for the addicted will also be major components of our effort to reduce demand for drugs in this country.

Surveys of prevalence show that these efforts work. Drug use today remains comparatively low. Annual marijuana prevalence peaked among 12th graders in 1979 at 51 percent. By 2009, annual prevalence had fallen by about one-third. Similar statistics can be found for other age groups. However, we are seeing some troubling signs that have bubbled up in the last year or two. The perception that drugs are dangerous is dropping, and that usually predicts imminent increases in use.

At the same time, we've learned that trying to manage drug-addicted criminal offenders *entirely* through the criminal justice system results in a costly, destructive cycle of arrest, incarceration, release, and re-arrest.

Together, we can transform this situation through new collaborations between the criminal justice system and the treatment system. Drug courts are just one example of how these systems can work together.

Re-entry programs that provide addiction treatment, combined with intensive monitoring and swift and certain sanctions for violations – as evidenced by Hawaii’s HOPE program – are another example of the kind of scientifically supported cross-system initiatives we seek to expand, especially in the probation system, which represents a highly important but often under-utilized and forgotten role in drug and crime control.

We advocate further research on pre-arrest diversion programs like the one piloted in High Point, North Carolina. These programs threaten dealers in a community with credible sanctions, but also offer them other resources to change their lives. Research on these kinds of pre-arrest diversion programs is just emerging, but preliminary results have been positive.

We are also firm believers in the law enforcement techniques you employ every day, based on local assessments of needs and available resources.

A balanced approach based on a combination of public health and public safety strategies is the surest route to reducing drug use and its consequences. This approach employs best practices in prevention, treatment, and law enforcement with community partners. We know that working together has resulted in lowering crime and drug use.

Thank you for being on the front line of these issues. I look forward to supporting you to reduce drug use and its consequences.

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