1. INCLUSION OF SUPPLEMENT PURCHASES IN NUTRITIONAL ASSISTANCE PROGRAMS
(RESOLUTION 905-I-12)

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 905-I-12 AND
REMAINDER OF REPORT FILED
See Policies H-150.937, H-440.898 and D-150.985

Resolution 905-I-12, introduced by the Medical Student Section and referred by the House of Delegates, asked:

That our American Medical Association (AMA) (1) support the addition of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs; and (2) work with United States Department of Agriculture and other appropriate organizations to encourage and procedurally facilitate the implementation of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs.

INTRODUCTION

The Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, provides a basic safety net to millions of people by providing monthly benefits to eligible low-income families to purchase food. SNAP allows for the purchase of food items that the household can eat and for the purchase of seeds or plants that produce foods for human consumption. SNAP benefits do not extend to purchases of medicines or dietary supplements such as vitamins or minerals.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides Federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant women, breast-feeding and non-breast-feeding postpartum women, and to infants and children up to age five years who are found to be at nutritional risk. Foods eligible for purchase under WIC are determined on a state level, but generally include bread and grains, cereals, milk and cheese, fruits and vegetables, and infant food and formula; often only store (generic) brands are eligible. As with SNAP, vitamins and other dietary supplements are not covered under WIC, which stresses the importance of maintaining adequate intake of nutrients such as folate through a healthy diet.

This report examines the potential inclusion of vitamin and mineral supplements as eligible items under the SNAP and WIC programs. Although Resolution 905-I-12 focused on folic acid supplements, the Council believes it is most appropriate to examine the inclusion of supplements in general, since optimal health is dependent on achieving recommended levels of several nutrients. The Council acknowledges the importance of folic acid in reducing the occurrence of neural tube defects (NTDs), and briefly discusses the special case of folic acid in this report. It is worth noting that the Council has previously examined the relationship of folic acid to NTDs, as well as the need to expand fortification programs to include corn-based products.1,2

METHODS

Literature searches were conducted in the PubMed database for English-language articles published between 1995 and August 2013 using the search terms “supplemental nutrition assistance program,” “SNAP,” “food stamp,” “WIC,” and “women infants children,” along with the terms “supplements,” “vitamin,” and “mineral.” Additionally, a Google search was conducted using the same search terms. A comprehensive report examining the potential use of SNAP benefits to purchase supplements,4 as well as several evaluations of the SNAP and WIC programs,4,5 were identified and relied upon for many of the report’s key discussion points.
NUTRIENT INTAKE

Recommended Nutrient Intake for Individuals

Recommended Dietary Allowances (RDAs), which represent the average daily dietary intake level sufficient to meet the nutrient requirements of nearly all (97-98%) healthy individuals in a group, have been established for nearly all nutrients and life stages, and are published by the Institute of Medicine’s Food and Nutrition Board. Individual nutrient needs vary; RDA levels are set to provide a safety factor for each nutrient, so recommended levels generally exceed the actual requirements of most individuals. Even when nutrient intake is below the RDA, the nutrient needs of any given individual may still be met. A well-balanced, healthy diet is recommended for achieving recommended nutrients levels, however in certain circumstances, supplements may be useful in providing one or more nutrients that otherwise may be consumed in less than recommended amounts. For example, it is recommended that pregnant women consume 600 μg of folate daily to reduce the risk of the pregnancy being affected by an NTD, but many will find it difficult to consume that level through food. A daily folic acid supplement is therefore often recommended.

Average Nutrient Intake of Americans

According to National Health and Nutrition Examination Survey (NHANES) data, 87.2%-98.3% of the general population achieves adequate intake of 10 essential vitamins and minerals including folate (Table). Adequate intake of vitamin C, potassium, vitamin A, magnesium, and vitamin E are achieved by 68.8%, 57.8%, 55.4%, 44.1%, and 8.3% of the total population, respectively (Table). When nutrient intake is considered according to income level and participation in SNAP, those in higher income groups achieve adequate nutrient intake in significantly higher proportions for 15 vitamins and minerals examined than those in the SNAP program. The magnitude of difference varies; for example, vitamin E, magnesium, and vitamin A have the largest differences, while for iron, niacin, vitamin B₁₂ and riboflavin, the differences are smaller (Table).

In contrast, few significant differences in nutrient intake exist among WIC program participants and non-participant higher-income individuals. Similar proportions of WIC participant children and children of higher-income parents meet recommended nutrient intake (Table), and few differences have been found in the nutrient intake of pregnant WIC participants compared with pregnant non-WIC participants.

INCLUSION OF VITAMIN AND MINERAL SUPPLEMENTS IN THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

Data showing that fewer SNAP participants achieve adequate nutrient intake than do higher-income individuals suggests that the use of vitamin and mineral supplements among participants may be beneficial. In 1999, the USDA’s Food and Nutrition Service issued a Congressionally-mandated report examining the merits of inclusion of vitamin and mineral supplements as eligible items under the SNAP program. The report acknowledged small gaps in the nutrient intake of SNAP participants and recognized that vitamin and mineral supplements may be beneficial for some participants, but for a number of reasons summarized below, did not explicitly endorse the inclusion of supplements as a SNAP benefit.

Health Benefits of Supplement Inclusion in SNAP

It is well known that nutrient intake affects health, but evidence establishing links between small nutrient deficiencies and chronic degenerative diseases is more complex. While evidence supports the use of supplements in certain circumstances, their effectiveness varies across the nutrients in question and population subgroup. Another complicating factor is the difficult task of determining the health benefit of supplements apart from nutrients acquired from food intake, especially given that many foods are fortified with vitamins and minerals.

To inform its report, the Food and Nutrition Service convened an expert panel to explore supplement inclusion in SNAP. The panel recognized the benefits of nutritional supplements in certain subpopulations, but it found no existing evidence indicating that the subgroups that might benefit most from nutritional supplements would actually
Economic Benefits of Supplement Inclusion in SNAP

A paucity of evidence exists examining the economic benefits of including supplement purchases in the SNAP program. Cost-benefit analyses have suggested that nutritional supplements can reduce health care costs due to hospitalizations for birth defects, low birthweight premature births, and coronary artery disease; however, those findings are based on narrow population subgroups and therefore cannot be generalized to the larger population of SNAP participants. Studies more directly addressing the economic benefit of supplement inclusion in SNAP would need to include factors such as which supplements could be purchased, who would buy them, and how dietary patterns might change as a result.

Determination of Supplement Eligibility and Administrative Implementation

The Food and Nutrition Act of 2008 defines eligible items for purchase under the SNAP program. Eligible items are any food or food product for home consumption, and seeds and plants that produce food for consumption by SNAP households. The following items are not eligible for purchase with SNAP benefits: alcoholic beverages; tobacco products; hot food and any food sold for on-premises consumption; and nonfood items such as pet foods, soaps, paper products, medicines, vitamin and mineral supplements, household supplies, grooming items, and cosmetics. A change in the eligibility status of vitamins and supplements would require legislative action.

If vitamin and mineral supplements were authorized as eligible items for purchase under SNAP, a clear definition of what constitutes an eligible product would be needed. A supplement is defined by the Dietary Supplement Health and Education Act (DSHEA) of 1994 as a product taken by mouth that contains a “dietary ingredient” intended to supplement the diet. The definition is broad, and includes vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissues, glandulars, and metabolites. It is estimated that more than 55,000 dietary supplements are available for purchase. Options for product eligibility could range from making eligible all supplements carrying a supplement facts label (and therefore considered by the FDA to be a supplement), to limiting eligibility to only vitamin and mineral supplements with established health benefits. While the latter may seem like the most reasonable option, its implementation would be difficult given the number of supplement products that contain ingredient combinations; it is difficult to determine whether many of these combination products are primarily vitamin or mineral supplements with established health benefits. Retailers selling supplements would also face challenges in distinguishing eligible and ineligible supplement products.

Changes to the SNAP Program Model

SNAP exists to provide assistance to low-income Americans in purchasing food items; it focuses on achieving adequate nutrient intake through a healthful diet. The introduction of dietary supplements as eligible items calls into question whether the existing food model would remain adequate for defining a healthful diet, estimating associated food costs, and determining benefit amounts. Currently, SNAP participants are provided with education focusing on the purchase, preparation, and consumption of a combination of foods that are consistent with maintaining a healthful diet. If supplements were eligible items, recipients would need to be provided with guidance on how to use information in the marketplace to make supplement purchases that meet their individual needs and represent good value. Additionally, it is questionable whether the ability to purchase supplements without a concomitant increase in monetary benefits to support such purchases would enable families to continue purchasing enough healthy food to meet basic hunger needs.

PROPOSED IMPROVEMENTS TO THE SNAP PROGRAM

Several barriers have been identified as standing in the way of SNAP participants eating nutritiously. For example, food markets and/or restaurants that offer a good selection of healthy, value-oriented foods are often located far from participants. SNAP participants, like most Americans, face widespread marketing of unhealthy foods, and the food industry and other corporate interests have pushed back on program changes designed to place emphasis on healthier food choices. Healthier foods are often more expensive, and working families lack the time to plan meals and shop. Lower health literacy among people with less education has generally been noted, and the nutrition education component of SNAP receives modest funding. Further, the USDA does not currently collect point-of-
purchase data about the foods that are bought by SNAP recipients or make publicly available information about
where benefits are redeemed; these data are important in understanding how to improve nutrition among SNAP
participants.7

The SNAP (and former Food Stamp) program has been evaluated a number of times throughout its existence, with
several recommendations having been made to strengthen its mission to alleviate hunger and improve the nutritional
status of low-income Americans. In 2012, the Center for the Study of the Presidency and Congress (CSPC)
developed a comprehensive evaluation of the SNAP program, including ten recommendations intended to
reformulate SNAP as a program that serves both as an invaluable safety net for low-income households and also as a
tool to fight the concurrent threats of food insecurity, poor nutrition, and obesity that are prevalent in contemporary
American society.7 The recommendations largely echo those of other evaluations and include protection of funding
levels for SNAP; integration of strategies to align purchases to the 2010 Dietary Guidelines for Americans;11
focusing attention on children’s health; incentivizing the purchase of fruits, vegetables, and whole grains; and
establishing stronger food stocking standards for SNAP retailers.7,8 The full set of CSPC recommendations can be
found in the Appendix. Notably, neither the CSPC nor an additional expert group that recently evaluated the SNAP
program recommended the inclusion of supplement purchases as a way to strengthen the program.7,8

Since 1994, nearly a dozen bills seeking to include the purchase of supplements as a SNAP benefit have been
introduced in Congress, many as part of the Farm Bill reauthorizations.10 The supplement provisions of the various
bills either were never passed by both chambers or were dropped in the conference process. The bills generated
opposing views from stakeholders. The Council for Responsible Nutrition (a trade organization representing the
supplement industry) and a number of individual nutrition experts supported several of the bills, arguing that vitamin
and mineral supplements can provide a vital safety net when food intake is inadequate.21 The American Academy of
Pediatrics (AAP), American Heart Association, the Food Research and Action Center, and several individual
nutrition experts opposed the bills, believing that the ability to purchase supplements without a concomitant increase
in monetary benefits to support such purchases would ultimately reduce the amount of healthy food purchased and
increase the chance that families would be hungrier more often and for longer durations.21

AMA POLICY ON SUPPLEMENTAL NUTRITION PROGRAMS

The AMA has historically been supportive of improvements to supplemental nutrition programs that would increase
nutrient intake. Policy D-150.983 (Food Stamp Incentive Program) supports legislation that would provide a
meaningful increase in the value of food stamps when used to purchase fruits and vegetables. Similarly, Policy
H-150.937 (Reducing the Price Disparity Between Calorie-Dense, Nutrition-Poor Foods and Nutrition-Dense Foods)
supports programs that would extend SNAP and WIC benefits to fruit and vegetable purchases at farmer’s markets.
Adequate funding for programs that seek to improve nutrition and obesity, such as the WIC and SNAP programs,
also is supported by the AMA (H-150.937; H-245.979, Opposition to Proposed Budget Cuts in WIC and Head
Start).

SPECIAL CONSIDERATION FOR FOLIC ACID

Folic acid reduces the occurrence of NTDs, including spina bifida and anencephaly.22-25 Citing its protective effect,
the US Public Health Service in 1992 recommended that all women of child-bearing age consume 400 µg of folic
acid daily, through both foods rich in folate and vitamin supplementation.26 To further promote folic acid intake, the
FDA mandated in 1996 that all enriched grain products sold in the US must be fortified with folic acid by 1998.27
Following implementation of the fortification mandate, the number of pregnancies in the US affected by an NTD
decreased by 36%, from approximately 4,000 per year during 1995-1996 to 3,000 per year during 1999-2000.28,29
The percentage of the population with low serum folate declined from 21 percent in 1988-1994 to less than one
percent in 1999-2000.30 A list of foods high in folate, as well as popular breakfast cereals fortified with folic acid,
can be found on the Web sites of the National Institutes of Health Office of Dietary Supplements and the Centers for
Disease Control and Prevention (CDC), respectively.31,32 Most state Medicaid programs cover the purchase of folic
acid supplements for beneficiaries.33

The medical community has collectively supported folic acid supplementation and fortification strategies. The
United States Preventive Services Task Force, American Congress of Obstetricians and Gynecologists, American
Academy of Family Physicians and American Academy of Neurology recommend that women of child-bearing age
take a 400 µg/day folic acid supplement, and the AAP endorses the US Public Health Service
recommendation.12-15,34 The AMA supports “broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of neural tube defects” (H-440.898), and has urged manufacturers to fortify corn-grain products (D-150.985).

The CDC recently evaluated the effectiveness of current approaches to increasing folic acid intake.35 It found that supplementation alone has not been effective since approximately half of pregnancies are unplanned; however, fortification has been highly effective since it makes folic acid accessible to all women of child-bearing age without requiring the behavior changes associated with daily supplement use or dietary improvement.35 Based on its findings, the CDC recommends expansion of fortification efforts, including for corn-based foods that are staples in the Hispanic population, which continues to experience higher rates of NTDs than other racial/ethnic groups in the US.35

CONCLUSIONS

A smaller proportion of SNAP participants achieves adequate nutrient intake compared to higher-income individuals. Among WIC program participants, few differences in nutrient intake have been noted compared to higher-income individuals. The inclusion of supplement purchases under the SNAP program has been proposed as a mechanism to improve nutrient intake among participants, but for a number of reasons, the administrators of the program have not instituted such benefits. Although the Council sees merit in the idea of using supplements to increase nutrient intake of SNAP participants, it believes that improvements proposed as a result of extensive SNAP program evaluations are more likely to increase nutrient intake while also addressing food insecurity and obesity. Consistent with AMA policy, the Council believes that the SNAP and WIC programs are essential for ensuring the health of millions of Americans, and supports improvements that will address contemporary nutrition needs. Regarding folic acid, the Council strongly supports continued efforts to ensure that all women of child-bearing age reach recommended levels. Since supplementation alone has been mostly unsuccessful in widely increasing folic acid intake, the Council believes that the addition of folic acid supplements as eligible items in supplemental nutrition programs is not appropriate at this time.

RECOMMENDATION

The Council on Science and Public Health recommends that the following statement be adopted in lieu of Resolution 905-I-12, and that the remainder of the report be filed.

1. That our American Medical Association support improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity.

2. That our AMA reaffirm Policy D-150.985, which urges fortification of all grain products, including those that are corn-based, as a means to increase folic acid intake in all women of child-bearing age.

3. That our AMA reaffirm Policy H-440.898, which encourages education of women on the need to achieve adequate folic acid intake.

APPENDIX - Center for the Study of the Presidency and Congress (CSPC) Recommendations for Improving Nutrition among SNAP Participants, released in 2012.7

1. Protect Current Funding Levels for SNAP
   A reduction in SNAP spending would jeopardize the health and well-being of the 1 out of 7 Americans for whom SNAP is a food lifeline—nearly half of whom are children. Cuts would hurt the working poor, strain already-stressed charitable safety net programs, and threaten the frail economies of low-income communities.

2. Collect Data on SNAP Purchases
   Require the US Department of Agriculture (USDA) to collect and make public data on SNAP product purchases to help improve participants’ nutritional quality as well as to increase the program’s effectiveness, efficiency, and transparency.
3. Identify a Set of Integrated Strategies that Would Help Align SNAP Purchases with the 2010 Dietary Guidelines for Americans
   As a complement to other USDA nutrition assistance programs, especially WIC and the National School Meal Program, identify and test a set of transformative improvements for SNAP that would build program infrastructure to promote healthier nutrition for low-income Americans.

4. Focus Attention on Children’s Health in SNAP
   Half of all youth in the United States will have been enrolled in SNAP at some time before their 19th birthday. SNAP is a missed opportunity for improving children’s nutrition and preventing obesity. Adequate nutrition is essential to their development, learning, and growth. Strengthen nutrition in SNAP to improve children’s health by pilot-testing a defined food package for youth.

5. Use Incentives to Make Fruits, Vegetables, and Whole Grains the EasyChoice
   Encourage public and private support for programs that incentivize the purchase and/or reduce the price of nutrient-dense foods in grocery stores and farmers’ markets.

6. Establish Stronger Food Stocking Standards for SNAP Retailers
   Strengthen stocking standards for a variety of healthy foods (e.g. fruits and vegetables) in order to be certified as a SNAP retailer.

7. Provide States with Flexibility to Evaluate Fresh Approaches to SNAP
   The USDA should grant states greater flexibility for waivers to pilot test and evaluate program changes in SNAP that would improve nutrition (e.g. pilot projects to assess the feasibility of incentivizing the purchase of healthy foods and/or limiting the purchase of high-calorie, nutrient-poor products with SNAP benefits).

8. Promote Innovation in SNAP
   Establish a Center for Health and Nutrition Innovation at the USDA, headed by a Chief Public Health Officer, to promote novel strategies and support pilot projects that enhance healthy nutrition for SNAP beneficiaries. Apply information technology and social media to promote healthy food choices.

9. Create a Partnership to Move SNAP towards Health
   Establish a strong partnership between the USDA and the US Department of Health and Human Services (as occurs with the Dietary Guidelines for Americans) to ensure that promoting health is central to the mission of this federal nutrition assistance program.

10. Establish a National Strategy of Fresh Approaches to Strengthen SNAP
    Create a National Strategy for strengthening SNAP under the auspices of a Federal Interagency Taskforce. The plan should identify the actions needed to promote research, program policy change, technological innovation, and evaluation that will improve nutrition and prevent and reduce obesity and its health damaging consequences among SNAP beneficiaries.

REFERENCES


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Table. Percentage of Americans achieving adequate intake of selected vitamins and minerals.4,5

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2. A CONTEMPORARY VIEW OF NATIONAL DRUG CONTROL POLICY

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-95.952, H-95.954, H-95.981, H-95.995, H-95.997 and H-95.998

Resolution 520-A-11, introduced by the Resident and Fellow Section and referred by the House of Delegates, asked:

That our American Medical Association (AMA) review the effectiveness of current drug policies pertaining to illegal drug use; review current availability of and access to evidence-based treatment for drug abuse and dependence; evaluate the effectiveness of current medical training for primary care physicians in evaluating and treating drug abuse; and monitor the work on this issue by both national and international organizations, including, but not limited to the National Institute of Drug Abuse, United Nations, World Health Organization, United Nations Office of Drugs and Crime, and Joint United Nations Programme on HIV/AIDS.

Policy H-95.990 states that our AMA: (1) promote physician training and competence on the proper use of controlled substances; (2) encourage physicians to use screening tools (such as NIDAMED) for drug use in their patients; (3) provide reference and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and (4) encourage physicians to query a state’s controlled substances databases for information on their patients on controlled substances, and that the Council on Science and Public Health (CASPH) report on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

Resolution 511-A-12 introduced by the California Delegation and referred by the House of Delegates asked:

That our AMA encourage the federal government to re-examine the enforcement-based approach to illicit drug issues (“war on drugs”) and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease.

Resolution 512-A-13 introduced by the California Delegation and referred by the House of Delegates asked:
That our AMA urge federal agencies to: (1) reschedule medical cannabis in order to encourage research leading to responsible regulation; (2) decriminalize medical use of cannabis; (3) build an appropriate public health framework for cannabis use; and (4) facilitate dissemination of information about risks and benefits of cannabis use.

This report focuses on areas of interest common to Resolution 520-A-11, 511-A-12, 512-A-13 and Substitute Resolution 907-I-11, namely issues around federal drug control policies and the so-called “war on drugs,” state-based cannabis activities, and access to treatment for substance use disorders, including addiction.

With respect to other elements contained in these resolutions, CSAPH is not in a position to examine the effectiveness of current medical training for primary care physicians in evaluating and treating drug abuse or to monitor the work on this issue by various national and international organizations. The Council has previously reported on issues relevant to prescribing controlled substances in an effort to reduce prescription drug abuse and diversion and the evaluation and treatment of patients with substance use disorders. Additionally, the AMA has continued to provide educational resources on pain management and responsible opioid prescribing, including guidance on screening patients for potentially risky behavior, and the appropriate structuring of care and ongoing monitoring of patients receiving controlled substances, including consulting state-based prescription drug monitoring programs (PDMPs). Recent policy changes allow the reporting of prescriptions for controlled substances from Veterans Affairs facilities to PDMPs. This report also does not address the separate issue of how to prevent fraudulent prescriptions for controlled substances. Please see previous reports from the Council for further information on cannabis including data on its potential therapeutic uses and public health risks.

METHODS

English-language reports were selected from a PubMed and Google search using the terms “war on drugs,” and “drug, marijuana, or cannabis” combined with “medicinal,” “legalization,” “decriminalization,” or “policy.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the US Drug Enforcement Administration, US Department of Justice, White House Office of National Drug Control Policy, Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Center for Substance Abuse Research, Pew Charitable Trusts, Brookings Institution, Rand Corporation, Drug Policy Alliance, Marijuana Policy Project, National Organization for the Reform of Marijuana Laws, American Society of Addiction Medicine, American Academy of Pediatrics, California Medical Association, and the Public Broadcasting System, CNN and Fox News.

RELEVANT AMA AND FEDERATION POLICY

Current AMA policy recognizes substance use disorders, including addiction, as diseases, opposes the legalization of cannabis or other drugs, and supports a federal drug policy that is weighted more toward demand reduction than a law enforcement approach (Policies H-95.976, H-95.981). Opposition to drug legalization exists “until the findings of comprehensive research into the potential effects, both positive and adverse, of relaxing existing drug prohibitions and controls can be adequately assessed” (Policy H-95.954). AMA policy supports a collaborative public-private effort to: (1) expand treatment programs for substance use disorders (including for pregnant women and prison inmates); (2) develop more effective drug education for youth; (3) develop community-based prevention programs for youth at risk; (4) offer needle and syringe exchange programs as a harm reduction approach; and (5) provide greater protection against discrimination of individuals with substance use disorders (Policies H-95.981, H-95.976, H-95.978, H-430.994, H-95.954). AMA policy on the use of cannabis for medicinal purposes supports the conduct of rigorous research and a regulatory environment which facilitates the development of cannabinoid-based medicinal products. While supporting the right of physicians to discuss the entire range of treatment options with their patients, including the potential use of cannabis, the AMA does not endorse state-based medical cannabis programs or agree that the scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product as regulated by the Food and Drug Administration.

Legalization of cannabis is opposed by the American Society of Addiction Medicine (ASAM) and the American Academy of Pediatrics. The California Medical Association (CMA) supports legalization of cannabis. Policy recommendations contained in a CMA white paper entitled “Cannabis and the Regulatory Void” seek to reschedule cannabis for medicinal use in order to encourage research leading to responsible regulation, regulate and tax recreational cannabis in a manner similar to alcohol and tobacco, and facilitate dissemination of information on the
risks and benefits of cannabis use. State medical associations in Washington and Colorado did not take a formal position on ballot initiatives in those states to legalize personal use of cannabis (see below), although the Colorado Medical Society issued a statement of concern for minors.

A SHORT HISTORY OF THE WAR ON DRUGS

Possession and the use of drugs including heroin, cannabis and cocaine were not illegal in the US in the early 20th century. The Harrison Tax Act of 1914 restricted the sale of heroin and was eventually used to restrict the sale of cocaine as well. Following the end of Prohibition in the 1930s, cannabis became a target as the US government and popular media began condemning the use of smoked cannabis, linking its use to homicidal mania “Reefer Madness.” The Marihuana Tax Act of 1937 introduced the first federal restrictions on cannabis. This federal law required industrial or medical users to register and pay a tax on cannabis of $1/ounce. Individuals using cannabis for recreational or other purposes were required to pay a tax of $100/ounce. A combination of the paperwork required of physicians who wished to use the drug in their practice, and regulations later imposed by the Federal Bureau of Narcotics designed to prevent diversion, quickly dampened enthusiasm for pursuing medical applications of cannabis. Secondary to governmental pressures, marijuana was removed from the US Pharmacopoeia in 1942.

In the 1950s, mandatory minimum federal sentences for possession of cannabis, cocaine, and opiates were created and federal recommendations were crafted on how to address heroin addiction. In the 1960s, recreational drug use became more prevalent and fashionable among middle class Americans, eventually becoming representative of youthful rebellion, social unrest, and political dissent. In response, existing federal drug agencies and programs were consolidated into the Justice Department’s Bureau of Narcotics and Dangerous Drugs (BNDD) in 1968. Marijuana trafficking from Mexico was targeted in Operation Intercept in 1969, and criminal activities were intimately linked with drug use based on urine testing of every inmate entering the Washington, D.C. jail system, 44% of who tested positive for heroin. A growing problem with heroin addiction in soldiers deployed to Vietnam also was recognized.

The battle lines for the war on drugs were drawn in the early 1970s with passage of the Comprehensive Drug Abuse Prevention and Control Act (CDAPC). This act allowed police to conduct “no knock” searches for drugs and also included the Controlled Substances Act (CSA) which sought to regulate drugs by establishing five schedules based on their abuse potential and legitimate medical use. Schedule I is reserved for substances that are illegal based on their high potential for abuse and no accepted medical use. In 1971 the term “war on drugs” was used by President Richard Nixon, who declared that drug abuse was “public enemy number one in the United States.” The result was a dramatic increase in the size and presence of federal drug control efforts. The Drug Enforcement Administration (DEA) was established by consolidating the BNDD, relevant Customs and CIA anti-drug activities, and the short-lived Office of Drug Abuse Law Enforcement. The DEA remains a principal federal agency spearheading a law enforcement/criminal justice approach to federal drug policy in the US.

The last 40 years have witnessed an ebb and flow to the dynamics of the war on drugs. More aggressive federal antidrug legislation and activities were fueled by the increasingly violent activities of drug trafficking cartels operating out of Columbia and Mexico, including the assassination of prominent public officials, journalists, judges, and law enforcement personnel. Novel methods emerged for smuggling illicit drugs into the US; the size of some drug seizures was astonishingly large; and massive laboratory and cultivation complexes were uncovered. Anti-drug parent organizations and partnerships were formed, and illicit drugs were portrayed as an imminent danger to children. The “Just Say No” campaign, which was central to Nancy Reagan’s activism on the issue, emerged targeting white, middle class children.

In the legislative arena, the CDAPC was amended in 1978 to allow law enforcement to seize all money and/or “other things of value furnished or intended to be furnished by any person in exchange for a controlled substance [and] all proceeds traceable to such an exchange.” President Ronald Reagan created a cabinet level task force (South Florida Drug Task Force) combining agents from several federal agencies and the military to mobilize against drug traffickers; other regional task forces also were formed. The Antidrug Act of 1986 was passed, revisiting and creating new mandatory minimum penalties for drug offenses. This Act targeted the crack cocaine epidemic, in part, by establishing a 100:1 ratio for mandatory minimum 10 year sentences associated with possession of powdered (5,000 g) versus crack cocaine (50 g). This was significant because crack cocaine was considerably cheaper and had invaded the urban black community; powdered cocaine remained the domain of wealthier segments of society. Mandatory minimums have been subject to increased scrutiny over the years because they are generally
acknowledged to have contributed to creating significant racial disparities in the prison population. Attorney General Eric Holder recently announced an intention to move away from this approach to sentencing.

In 1989 the Office of National Drug Control Policy (ONDCP) was created. Initially the focus of the “drug czar” was on making illicit drug use socially unacceptable and the focus remained primarily on enforcement rather than treatment of individuals with substance use disorders, including addiction. The most recent appointee, Director Gil Kerlikowske, has distanced ONDCP from the “war on drugs” terminology and rebranded federal antidrug efforts as a harm reduction strategy. Although the Obama Administration has disavowed a “war on drugs” mentality, the 2013 budget for ONDCP is still weighted toward a supply reduction/law enforcement approach.12

CRIMINAL JUSTICE CONSEQUENCES OF THE WAR ON DRUGS

One out of every 100 American adults is behind bars in jail or prison, and the US houses nearly 25% of the world’s prisoners despite having less than 5% of the world’s population.13 Since the mid-1970s, the number of people behind bars has increased five-fold, peaking at 2.2 million in 2010. This trend has prompted dissatisfaction with US drug policy and support for drug legalization based on the belief that a sizable fraction of the prison population is nonviolent offenders who have been incarcerated because of drug violations.

The arrest rate for drug violations (i.e., selling, manufacturing, or possessing drugs) increased more than 2.5-fold from 1980 to 2006 reaching a peak of 633 arrests per 100,000 US residents. Although the arrest rate for drug violations has decreased modestly since 2006, it still remains nearly twice as high as rates of the early 1980s.14 More than 80% of drug arrests include charges for possession. There were more than 12.4 million arrests in the United States in 2011 according to data from the national Uniform Crime Reporting System.15 The highest number of arrests were for drug violations (1,531,251) followed by theft and driving under the influence. The majority of the drug arrests included a charge of possession and nearly one-half of these violations (700,000) involved cannabis.15 Although rates of drug use and selling are comparable across racial and ethnic lines, blacks and Latinos are far more likely to be criminalized for drug law violations than whites.16

While these statistics may be startling to some, a closer examination paints a somewhat different picture of who is actually being jailed for cannabis offenses, at least in state and federal facilities. For example, those in state and federal prison for cannabis offenses represent about 12.6% of those incarcerated for drug law violations and 3.2% of total state and federal prisoners.17 Despite the claim that state and federal prison overcrowding is being driven by the jailing of thousands of inmates for simple possession, a significant percentage of these inmates were originally charged with trafficking and plea bargained for a lesser sentence. According to an ONDCP analysis, 1.6% of the state inmate population was held for offenses involving only cannabis, and less than 1% of these prisoners were incarcerated with cannabis possession as the only charge.18 On a federal level, out of all drug defendants sentenced in federal court for cannabis crimes in 2001, the overwhelming majority were convicted for trafficking, according to the US Sentencing Commission. Only 2.3% received sentences for simple possession. The average possession charge for those in state or federal prison was more than 100 pounds.18 Similar findings were reported in other studies.19,20 These analyses exclude those among the more than 700,000 total inmates who are in local jails because of a marijuana arrest.

Importantly, nearly 3 million children are growing up in US households in which at least one parent is incarcerated, two-thirds of whom are jailed for nonviolent offenses, primarily drug offenses.21 Punishment for these drug law violations extends far beyond the criminal justice system, because of existing policies denying child custody, voting rights, employment, business loans, trade licensing, student aid and public housing and other public assistance to people with criminal convictions.

While some disagreement persists about the actual percentage of people who are incarcerated for “simple possession” of cannabis, Attorney General Eric Holder recently announced sweeping plans designed to address overcrowding of prisons through drug sentencing reform including plans to divert low level drug offenders to treatment and community service programs and to implement an expanded prison program to allow for the release of some elderly, non-violent offenders. This policy shift was based on that fact that “problems in the prison system impose a significant economic burden totaling $80 billion in 2010 alone” and “human and moral costs that are impossible to calculate.” Annual direct (budgeted) expenditures devoted to the war on drugs are approximately $50 billion annually.
In view of the finite societal resources, historical trends of incarcerating nonviolent individuals for drug use offenses are not sustainable. Policies intended to reduce drug use through criminal arrest and supply reduction also have disproportionately affected minority populations and created unintended consequences related to criminal convictions including other disabling societal effects that may persist for a lifetime.

RELEVANT TRENDS AND ATTITUDES

Decriminalization Versus Legalization

Legalization is defined as “the complete removal of sanctions, making a certain behavior legal and applying no criminal or administrative penalties.” Decriminalization means to “eliminate criminal penalties for or remove legal restrictions.” To decriminalize does not mean that consequences are entirely lacking for a certain act or behavior.

US states and cities that have decriminalized personal use of cannabis typically issue a civil citation for possession of small amounts of cannabis punishable by a fine or community service. In some states such as New York, first time offenders may be granted an automatic adjournment of their case in contemplation of dismissal, meaning that if the offender commits no crimes and abides by any other conditions set by the court, the case is automatically dismissed after one year. In most locales, repeat offenders usually face escalating fines and/or misdemeanor charges; in some states or municipalities, repeat offenses may place individuals at risk for imprisonment or loss of driving privileges.

In an effort to deal with low level and repeat offenders, the city of Seattle created the “Law Enforcement Assisted Diversion” or LEAD program whereby offenders are diverted into community-based treatment and support services, instead of being processed through traditional criminal justice system avenues. After the initial diversion, the case manager works together with the participant to identify the factors that led that individual to being arrested for a drug offense and develop an intervention plan that may include help with housing, school, and employment. Additionally, states such as Texas, Georgia, South Carolina, Kansas, and several others have increased investments in treatment programs and drug courts, and counties have been given an expanded role in deciding whether to incarcerate low level offenders or connect them with drug counselors.

The experiences of other countries, especially Portugal, that have taken steps toward decriminalization in recent years also have been offered in support of the US taking a similar approach. The degree to which experiences in other countries can be expected to translate to US culture and citizen behavior is uncertain. Patterns of drug use and misuse, both with respect to illicit drug use and its intersection with prescription drug abuse in the US, are distinct. Consider that the US population currently consumes nearly 99% of the hydrocodone dispensed around the world for medicinal purposes.

Ongoing and emerging local and state-based activities have begun to move away from arrest and incarceration of individuals who possess and use cannabis for personal reasons, to a more public health based approach. Such an approach recognizes the broader need to address underlying personal issues and considers the view that substance misuse is a medical disorder. A public health based approach has the potential to both reduce individual harm while preserving the state’s interest in protecting the public from adverse consequences of individual drug use.

Legalization of Cannabis

The Brookings Institute recently noted the following:

In less than a decade, public opinion has shifted dramatically toward support for legalization of marijuana. Demographic change and widespread public experience using marijuana imply that opposition to legalization will never again return to the levels seen in the 1980s. The strong consensus that formed the foundation for many of today’s stringent marijuana laws has crumbled.

Recent polls indicate that for the first time, the majority of Americans (51%-54%) favor the legalization of marijuana public support (85%) for medicinal marijuana is overwhelming, although a majority believes that most individuals seeking medicinal cannabis are doing so just to “get high.” Support for legalizing marijuana is more common among men and is inversely proportional to age ranging from 65% approval among those 18 to 29 years of age to 31% among those 65 and older. A significant majority of Americans (66%) view the war on drugs as
a failure or believe that federal efforts to enforce marijuana laws “cost more than they are worth” (72%). An overwhelming majority of Americans (>90%) believe that individuals who possess or consume small quantities of cannabis for personal use should not face jail time. Opinions across the political spectrum on cannabis legalization are somewhat distinctive compared with other politically divisive issues with significant support existing across party lines. Conservative views are influenced by states rights considerations; women are more conservative than men on the issue, but less opposition is apparent than might be expected among today’s parents. Accordingly, public opinion is shifting rapidly toward favoring decriminalization or explicit legalization of cannabis. It is unlikely given the demographics of this trend that the US will witness a return to a “just say no” mentality for the personal use of this substance.

State Laws on Cannabis

As of October 1, 2013, nine states have cannabis available for medicinal use; 12 additional states have cannabis available for medicinal use and also have decriminalized possession. Four other states have decriminalized possession; and the states of Washington and Colorado took the additional step of legalizing possession of small amounts of cannabis for personal use. According to the Colorado constitution created both state-regulated and largely unregulated cannabis sectors. In the state-regulated sector, cannabis growers and distributors have to obtain licenses to do business. A largely unregulated sector also exists based on a repeal of penalties that allows individuals to grow small quantities of cannabis (up to 6 plants in a closed space at home), and to also distribute (but not sell) up to 1 ounce to others. The Washington state law bans all cannabis growing and distribution outside a regulated system with growers, processors, and retailers all requiring special licensing. The advent of state based legalization of cannabis has prompted review and analysis of how these state programs can co-exist with federal statutes that classify marijuana as illegal and raise a number of additional issues. Among them are possible diversion of product either out of state or to youth, profit motives, promotion, consistency with school and community prevention programs, potency, taxation and price effects on consumption, driving laws, and the need to have flexibility to review and revise the regulatory scheme based on experiences and data gathered after implementation. These questions remain legitimate even though Attorney General Holder announced that federal law enforcement would not interfere with the intent of state legalization (personal use of small amounts) even though other federal laws on possession and trafficking remain in force. Although public support for cannabis decriminalization or legalization has increased significantly in recent years, the experiences and consequence of state laws that decriminalize or legalize the personal use of cannabis must be closely examined as they are implemented to help inform further rational debate and policy initiatives.

Current Patterns of Marijuana Use

Marijuana continues to be the most commonly used illicit drug among US residents ages 12 and older. About 1 in 10 US adults used marijuana in the last year; more than 2/3 of new users reported that marijuana was the first drug they tried. Individuals under the age of 21 account for nearly a quarter of total days involving marijuana use. More than half of the individuals using marijuana under the age of 21 lack a high school education, and nearly half (46%) meet criteria for substance abuse/dependence problems. Marijuana was the most commonly used illicit drug in 2012 with 18.9 million past month users. Between 2007 and 2012, the rate of current use increased from 5.7 to 7.3%. Daily or almost daily use of marijuana (used 20 or more days within the past month) increased from 5.1 million persons in 2007 to 7.6 million persons in 2012. Nearly one in 4 high school seniors reported smoking marijuana in the last month, continuing an upward trend for the last 7 years, and one in 15 high school seniors today is smoking marijuana on a daily or near daily basis. These
trends are associated with a self-reported decrease in the perceived risks of harm from marijuana use; such views may be influenced by the prevalence of state-based initiatives on medicinal cannabis and legalization. High school seniors are more likely to smoke marijuana than cigarettes. Frequent marijuana use has been associated with increased use of other illicit drugs including cocaine, ecstasy, and prescription opioid analgesics. The earlier marijuana use is initiated, the higher the subsequent risk for drug abuse and dependence.

Cannabis use, especially heavier patterns of consumption, continues to trend upward for youth and young adults. Because the potency of cannabis products is much higher today than in the past, these trends are important for understanding potential harms in this population, including the percentage of these individuals who may eventually develop substance use disorders (see the following section).

Substance Dependence, Abuse, and Treatment

Developing a public health based approach to harmful drug use requires having treatment services available for those with substance use disorders, including addiction. In 2012, an estimated 22.2 million persons aged 12 or older were classified with substance dependence or abuse in the past year based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). This number has remained fairly steady for the last decade. The specific illicit drugs with the largest numbers of persons with past year dependence or abuse in 2012 were marijuana (4.3 million), opioid analgesics (2.1 million), and cocaine (1.1 million). The number of persons with marijuana dependence or abuse did not change between 2002 and 2012. Between 2004 and 2012, the number with opioid analgesic dependence or abuse increased from 1.4 million to 2.1 million, and between 2006 and 2012, the number with cocaine dependence or abuse declined from 1.7 million to 1.1 million. The number of persons with heroin dependence or abuse in 2012 (467,000) was approximately twice the number in 2002 (214,000).

These findings parallel those of national treatment admissions, which show that the majority of illicit drug admissions are for marijuana and that admissions for marijuana and opiates other than heroin have been increasing in recent years. The percentage of admissions to state-funded substance abuse treatment facilities has substantially increased for opiates other than heroin, increasing steadily since 1998 from 1.2% to 8.7% and for marijuana from around 6% in 1992 to 18.6% in 2010 with recent increases from 16.0% in 2007. In 2012, only about 11% of those persons aged 12 or older needing treatment for an illicit drug or alcohol use problem received treatment in a specialized facility. Among those who reported that they believed they needed treatment for their illicit drug or alcohol use problem, the primary reason for not receiving treatment was a lack of insurance coverage and inability to pay the cost. Correspondingly few US inmates with substance use disorders receive treatment while incarcerated. Nearly two-thirds (65%) of federal, state, and local inmates ages 12 and older were diagnosed with a substance use disorder in 2006, but only 11% received any kind of professional treatment while they were incarcerated.

While alcohol remains the number one substance of abuse requiring treatment intervention, the number of individuals who meet criteria for substance dependence or abuse for cannabis exceeds those for opioid analgesics and cocaine combined according to the National Survey on Drug Use and Health. The percentage of treatment admissions for cannabis as a primary substance of abuse has tripled over the last 20 years. Only a small percentage of those who need treatment are able to access and pay for it. These facts raise additional concerns about the potential public health impacts of cannabis legalization.

INTERSECTION OF ILLICIT DRUG USE WITH PRESCRIPTION DRUG ABUSE

Considerable attention has been devoted to escalating trends in prescription opioid analgesic use and abuse over the last 15 years. The statistics demonstrate a serious public health concern. As noted above, since 1998 the number of patients seeking substance abuse treatment for the primary abuse of prescription pain relievers has increased sevenfold. Drug overdose deaths in the United States also have increased steadily and now exceed 38,000 annually. Prescription drugs are involved in more than 57% of such deaths (~22,000) with opioids involved in 75% of the prescription drug overdose deaths reported in 2010 or about 43% of drug overdose deaths overall.

The estimated number of emergency department (ED) visits related to the nonmedical use of opioid analgesics increased 79% from 201,280 in 2006 to 359,921 in 2010, according to the most recent data from the Drug Abuse Warning Network (DAWN). The greatest increases were seen in buprenorphine, hydromorphone, and oxycodone-related ED visits. With respect to the broader public health impact, the proportion of individuals 12 and older who are using prescription pain relievers in a nonmedical fashion is substantially larger. For each ED visit, 15 others
use prescription pain relievers nonmedically some time in their lifetime. These trends have continued to increase for prescription opioids except for methadone for which there has been a decrease in unintentional overdoses since 2007.44

Because of these disturbing trends, state and federal authorities have cracked down on “pill mill” type activities; pharmaceutical distributors have been subject to increased scrutiny; and pharmacy chains have implemented new dispensing policies for opioid analgesics. As the sources of diverted prescription opioids diminish, the nation has witnessed a return to heroin use.36,45,46 The increasingly blurred lines between illicit and prescription drug abuse reinforce the need for a public health-centered approach to address these problems.

DISCUSSION

The problem of illicit drug use is exceedingly complex and no simple solution is evident. Neither the drug war (prohibition plus massive, undifferentiated enforcement) nor proposals for wholesale drug legalization represent a balanced, public health-oriented, approach.47

Federal drug policies over the last 40 plus years have not accomplished their objectives and represent a failed approach. The US stands out with higher levels of illicit drug use than other countries despite more punitive illicit drug policies. Advocates for decriminalization or drug legalization also point to the financial burdens imposed by a law enforcement and supply reduction approach, and the realization that the US cannot solve this problem by arresting hundreds of thousands of its citizens for drug violations, especially non-violent offenders and individuals whose only crime is personal use. A growing recognition exists that because the “drug markets for the three primary illicit substances (marijuana, cocaine and heroin) are mature, the continued emphasis on supply side strategies is inappropriate.” Furthermore, “a treatment-based approach is a more cost-effective approach of reducing use and has the additional benefits of reducing collateral harms associated with dependence and addiction.”48 Nevertheless, although the 2013 ONDCP budget requested modest increases for some treatment programs, the overall budget remains weighted toward supply reduction (59.2%) versus treatment, recovery, education, and prevention (40.8%).

American attitudes on cannabis have oscillated for much of the last century from sensationalized claims about maniacal effects (Reefer Madness) to the excesses of the 1960s, to the lines drawn in the sand by the “War on Drugs” and “Just Say No” mentality, and the current reversal of public opinion to favor medicinal use and decriminalization, if not legalization, of cannabis. Over less than a decade, “public opinion has shifted dramatically toward support for the legalization of marijuana, particularly among the young and men, and a prevailing attitude that marijuana is not a gateway to harder drugs or particularly harmful in the long run, especially compared with other legal addictive substance such as alcohol.”27 This rapid sea change from prohibition to legalization of marijuana is concerning to those who believe it is being contemplated without full deliberation and would add a third legal and hazardous addictive substance to join alcohol and tobacco, which albeit are regulated but cause substantial harms to health and costs to society.

Somewhat lost in the debate about legalization of cannabis are the recognized harms often dismissed under the rubric of “cannabis is much less harmful (much safer?) than alcohol. A recent editorial discusses the anticipated negative consequences of marijuana legalization and the fact that the growing body of scientific evidence about the harmful effects of marijuana use is often ignored. Cannabis is a psychoactive addictive substance.49 It is the most common illicit drug involved in drugged driving; 8.6 to 12% of fatally injured drivers test positive for cannabis, and more than 25% of seriously injured drivers test positive for cannabis, a percentage that is sharply higher in drivers under the age of 21.50-53 Legalization will diminish perceptions that cannabis use is potentially harmful. Particularly worrisome is that legalization may result in increased child and adolescent use. Early cannabis (or alcohol) use is related to later substance use disorders. Heavy cannabis use in adolescence causes persistent impairments in neurocognitive performance and IQ, and use is associated with increased rates of anxiety, mood, and psychotic thought disorders.54-56

Despite the allure that legalization has for potentially destroying the markets of international drug smuggling operations and domestic gang-related operations and for accumulating windfall profits from governmental regulation and taxation, at least with respect to marijuana, the RAND Corporation has concluded that from a cost benefit perspective, research and data are insufficient to predict if legalization of marijuana would ultimately be a net “good or bad” for US society.48 As noted by ASAM, the damage and societal costs attributable to alcohol and tobacco far exceed the tax revenues generated from the legal sale of these substances.7 No certainty exists about how
legalization in the US would affect the overall pattern of consumption of marijuana and the attendant mental and public health consequences. Of particular concern is heavy marijuana use in the teenage years. While acknowledging that any decriminalization or legalization initiative would apply to adults, a public health priority must include an emphasis on protecting children and adolescents.

The challenge in crafting effective policy is not a simple choice between incarceration for low level offenders and protecting public health and safety. Current drug policies have generally failed to achieve their stated objectives with respect to cannabis, and have arguably resulted in discriminatory effects on minority populations while fostering other undesired and unintended consequences for nonviolent offenders that persist after criminal arrest and incarceration. Current policies direct more public resources to punishment, a portion of which could be more appropriately directed to ensuring access to effective treatment. Policies should move away from arrest and incarceration of drug users by addressing drug misuse, addiction, and overdose through a public health framework, expanding access to treatment, and redirecting law enforcement resources to prevent serious and violent crime.

Given the above considerations, the Council recommends amending AMA policy with respect to cannabis and clarifying other aspects of policy relating to substance use more broadly. Substance use disorders are medical conditions deserving of treatment. Opposing drug legalization does not mean one opposes health-oriented drug policy reform.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolutions 520-A-11, 511-A-12, and 512-A-13 and the remainder of the report be filed:

1. That Policies H-95.995 and H-95.997 be amended by addition and deletion to read as follows:

H-95.995 Health Aspects of Cannabis Marijuana Use
Our AMA (1) discourages cannabis marijuana use, especially by persons vulnerable to the drug’s effects and in high-risk situations; (2) supports the determination of the consequences of long-term cannabis marijuana use through concentrated research, especially among youth and adolescents; and (3) supports the modification of state and federal laws to emphasize public health based strategies to address and reduce cannabis use, reduce the severity of penalties for possession of marijuana; (4) urges that educational efforts on the harms of cannabis use be extended to all segment of the population.

H-95.997 Cannabis Marijuana Intoxication as a Criminal Defense
Our AMA (1) recommends personal possession of insignificant amounts of that substance be considered a misdemeanor with commensurate penalties applied; (2) believes a plea of marijuana cannabis intoxication not be a defense in any criminal proceedings; and (3) urges that educational efforts be expanded to all segments of the population.

2. That Policy H-95.981 be amended by addition and deletion to read as follows:

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) encourage recognition that acknowledge that federal efforts to address illicit drug use via at supply reduction and enforcement have been ineffective should be accompanied by increased efforts to reduce the demand for illicit drugs; (2) renew and expand federal leadership to reduce the demand for illicit drugs; (3) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction including treatment on demand for intravenous drug abusers; (4) lead a coordinated approach to adolescent drug education; (5) develop community-based prevention programs for youth at risk; (6) continue to fund the Office of National Drug Control Policy appoint a high ranking official of the Executive Branch to coordinate federal drug policy; (7) encourage a variety of private initiatives and carefully evaluate the use of limited workplace drug testing; (8) extend greater protection against discrimination in the employment and provision of services to drug abusers; (9) make a long-term commitment to expanded research and data collection; (10) broaden the focus of national and local policy from drug abuse to substance abuse; and (11) recognize the complexity of the problem of substance abuse and oppose drug legalization.
3. That Policy H-95.954 be amended by addition and deletion to read as follows:

H-95.954 The Reduction of Medical and Public Health Consequences of Drug Abuse
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages the undertaking of comprehensive review of the risks and benefits of US state-based drug legalization initiatives, research into the potential effects, both positive and adverse, of relaxing existing drug prohibitions and controls and, that, until the findings of such reviews such research can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

4. That Policy H-95.998 be amended by addition and deletion to read as follows:

H-95.998 AMA Policy Statement on Cannabis (Marijuana)
Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale and possession of marijuana cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use handling of offenders should be individualized; and (4) additional research should be encouraged. (Modify HOD Policy)


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