

PUBLIC SUBMISSION

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Docket: ONDCP-2021-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0020

Comment from HTWWS

Submitter Information

Email: (b)(6)

Organization: HTWWS

General Comment

There need to be reparations going directly to the Black community in the form of direct payments and coming from businesses that are currently profiting off of cannabis as many Black Americans sit in or have sat in jail/prison because of cannabis-related charges. Even still today LAPD is proportionately pulling over Black Americans for the alleged smell of cannabis per the officer's original reasoning for pulling the said black drivers over, only to find out that many a times no weed was found in the vehicle! The pretend "war on drugs" created by the American Govt has destroyed & disrupted the lives of many Black Americans! Black Americans make up over 30% of the unhoused population in LA County even though they are only 8% of the total population in LA County! #FakeEminentDomain

When it comes to addressing these systematic issues of Cannabis, I encourage the following;

1. Direct community investments in Black communities, support programs for youth crime & gang prevention.
2. Invest in community services by offering funding for housing & social service needs within Black / Brown communities.
3. Invest in direct cash payments to Black/Brown community members.
4. Make licensing easy/free for potential cannabis owners from the black/brown community.
6. When we talk about systematic issues please remember that they are generational, offer support to descendants of those affected by systematic abuse, those are still living within the conditions created by the systematic abuse.
5. Support small growers and require cities to respect voter mandate in regards to cannabis (Antelope Valley San Bernadino, etc. LA County Sheriff and the LA County Board of Supervisors violation.)
6. Push to legalize cannabis on a federal level; Push to support online e-commerce-to-delivery businesses.
7. Push for sales tax to be permanently used for affordable housing needs and direct community investments in the youth, eradicating poverty.

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Best,

www.HTWWS.org

PUBLIC SUBMISSION

As of: 8/6/21 1:30 PM
Received: July 07, 2021
Status: Pending_Post
Tracking No. kqt-py10-28xy
Submission Type: API

Docket: ONDCP-2021-0001

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Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0015

Comment from Al, Leibbrand

Submitter Information

Name: Al Leibbrand

Address:

Mankato, MN, 56001

Email: (b)(6)

Phone: (b)(6)

General Comment

More equity means federal reschedule or deschedle cannibus. So rules ,regs are uniform.

Profiling ,used by police need to stop. Etc.

Honest science, has to happen.nThe propaganda has to stop.

Slater, Sandy R. EOP/ONDCP

From: Cindy Brennan <(b)(6)>
Sent: Wednesday, July 7, 2021 11:04 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Cannabis Legalization

Hello, I am in favor of legalization of cannabis for a multitude of reasons. As a retired nurse, teacher/administrator, parent and citizen I have seen the harm that our present laws have caused to our nation. People who choose cannabis (a harmless plant) and who land in jail because of these draconian, racist laws are essentially given a life long penalty that affects their families, livelihoods and health for their entire lives.

No one has ever "overdosed" or died from this plant. It has been used worldwide for centuries. Only in America was it demonized for the sole purpose of removing brown and black people from communities. When Ronald Reagan asked for a report on its detriment on society he was told in writing that it was not a problem. He put the plant on the highest level of danger. Why?

Since then, our nation has suffered immeasurably. This horrific wrong needs to be fixed.

Many cancer, and other patients are using cannabis to help them. Please help these people instead of hurting them. This problem is easily solved.

Thank you,
C. Brennan

Sent from my iPhone

PUBLIC SUBMISSION

As of: 8/6/21 1:37 PM
Received: July 07, 2021
Status: Pending_Post
Tracking No. kqt-zu1c-gsmk
Submission Type: API

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Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0021

Comment from Alexander, Fabian

Submitter Information

Name: Alexander Fabian

Address:

Oakland, CA, 94609

Email: (b)(6)

General Comment

Drug policy in the United States has been inequitable and enforced inequitably by design. From Harry Anslinger's anti-mexican diatribes to John Elichman's: "You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin. And then criminalizing both heavily, we could disrupt those communities," Ehrlichman said. "We could arrest their leaders. raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did." We should not require rhetoric to sway you, the data of 40 years of policy failure speaks volumes.

If the federal government seeks to introduce equity into its drug enforcement policy, the simplest and most effective method would be simply to end it. Legalize cannabis, psilocybin, MDMA, Ketamine and decriminalize cocaine,heroin,fentanyl etc. Portugal has been an extremely instructive case study on de-carceral drug policy. Release all those incarcerated for drug crimes and automatically strike convictions & re-instate the franchise. The Drug War was an ethnic cleansing campaign, and will be remembered as such, much like Apartheid. There as here, there is room for Truth and Reconciliation, but only if the Federal Government has the courage to understand its own actions and make amends.

Slater, Sandy R. EOP/ONDCP

From: James Zervas <(b)(6)>
Sent: Wednesday, July 7, 2021 12:17 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Equity in cannabis industry

Rules should not favor corporations over individual citizens. The license to sell cannabis should be no more difficult to obtain than for selling alcohol.

Slater, Sandy R. EOP/ONDCP

From: Ryan Adams <(b)(6)>
Sent: Wednesday, July 7, 2021 9:49 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] You Want Equity? End Your Failed Drug War

Hello,

So you want equity for all regarding drugs? Federally end the failed War on Drugs that Nixon started. Legalize the possession and consumption of marijuana for adult use and decriminalize the possession of any and all drugs nationwide.

When you lock up non violent offenders for drugs you're creating a divide between the country and it's citizens. You're especially bringing divide in low income communities where minority groups get targeted by police simply for being there.

Legalize weed nationwide and decriminalize possession of all drugs you cowards!

Slater, Sandy R. EOP/ONDCP

From: Samuel McCarty <(b)(6)>
Sent: Wednesday, July 7, 2021 11:19 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Executive Order (E.O.) 13985 community input

OGC@ondcp.eop.gov

Hello,

My name is Sammy McCarty. I'm a white man who wants to offer input on what I've noticed on while volunteering in prison both here in Minnesota at a medium security prison and briefly in a Texas super-max.

I candidly cannot comment on you how you're spending money regarding marijuana enforcement. What I can tell you is the results I saw both in prison and in the communities I ministered in.

Rural populations, largely electing conservative politicians, are using what I call, "disproportionate justice" regarding marijuana enforcement. Minnesota's Lincoln county, arrests 144 BIPOC for every white person arrested. (ACLU linked below) These arrests are obviously racially biased as statistically marijuana usage is equal among all races. (ACLU linked below)

In the cities of both states, local politicians have done marginally better at protecting their BIPOC populations from the Draconian drug laws that are being heavily enforced in rural areas. This, coupled with fewer opportunities for recently released people in the rural areas regarding employment opportunities has caused an exodus from rural areas of the targeted people of color which meets the UN standard for declaring our marijuana enforcement as ethnic cleansing. (Link below to UN)

Marijuana arrests made up 52% of drug arrests, the majority of seized property by police and have been used as a tool of the government to harm these communities.

The "one" white person who is arrested is in my experience someone who has an income of less than \$30,000 a year.

However you are spending money it is targeting poor and BIPOC.

<https://www.un.org/en/genocideprevention/ethnic-cleansing.shtml>

<https://www.aclu.org/issues/smart-justice/sentencing-reform/war-marijuana-black-and-white>

<https://graphics.aclu.org/marijuana-arrest-report/MN>

~Sammy McCarty CCST II

(b)(6)

Slater, Sandy R. EOP/ONDCP

From: Stephen Zyszkiewicz <(b)(6)>
Sent: Wednesday, July 7, 2021 1:56 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] petition to deschedule cannabis
Attachments: petition.pdf

Hello,

Can you help me to understand if someone will send me a denial of my petition to deschedule cannabis? Last year it only took from January 3 petition to April 21 to receive the denial.

This year I sent it in on January 3 again, but I have not heard a response.

The DEA specifically said in Zyszkiewicz v DEA and Sisley v DEA they wanted me to go through the petition process again before I can appeal it in court again.

For the appeals court it has to be done within 30 days for me to appeal, but for this process it seems like the DEA can take as long as they want.

So I just appreciate any insight or any other person I should contact about this?

Thank you for your help!
Steve

<https://www.scribd.com/document/513754818/2021-Petition-to-Deschedule-Cannabis>

January 3, 2021

Stephen Zyszkiewicz (b)(6)

Timothy J. Shea
Acting Administrator
Department of Justice
Drug Enforcement Administration 8701 Morrissette Drive Springfield, Virginia 22152

Re: Petition to deschedule cannabis/marijuana/delta-9- tetrahydrocannabinol

PLEASE KINDLY DESCHEDULE MARIJUANA OR PROVIDE A DENIAL (LAST TIME I RECEIVED DENIAL WITHIN 4 MONTHS)
THANK YOU!!!

Dear Acting Administrator Shea:

Relief Requested

I hereby petition the DEA to deschedule cannabis (marijuana) in all its forms: THC (including delta-9-tetrahydrocannabinol) and CBD (all naturally occurring equivalents, cannabinoids, terpenes in cannabis/hemp), hashish, marijuana, marihuana, flowering tops and leaves of Indian hemp (cannabis sativa), hemp, cannabis indica cannabis ruderalis, cannabis sativa L., every extract and concentrate, crude or purified, compound, manufacture, salt, derivative, preparation, seeds, stalks, plants, cuttings, cannabis indica Lam., etc.

Legal basis for relief

Pursuant to 21 USCS 811, 812 any interested party can petition for removal and rescheduling. In November 2016, California voters passed Adult Use of Marijuana Act. The intent was to insure a comprehensive regulatory system that takes production and sales away from an illegal market. AUMA and the state legislature found that the majority of USA produced cannabis comes from California. Therefore natural marijuana and delta-9-tetrahydrocannabinol is a medicine and does not belong in Schedule I or as a scheduled controlled substance at all.

Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. However, marijuana does not fit this definition. Therefore natural marijuana and delta-9-tetrahydrocannabinol is a medicine and does not belong in Schedule I or as a scheduled controlled substance at all.

Currently, 35 states, the District of Columbia, and 4 of 5 territories (Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands) have legalized medical marijuana. Out of 56 states/territories/DC, only 16 still consider medicinal cannabis (delta-9-tetrahydrocannabinol) illegal. Therefore natural marijuana and delta-9-tetrahydrocannabinol is a medicine and does not belong in Schedule I or as a scheduled controlled substance at all.

The FDA allows CBD and THC pharmaceuticals. Therefore natural marijuana and delta-9-tetrahydrocannabinol is a medicine and does not belong in Schedule I or as a scheduled controlled substance at all.

The federal government also allows a small number of patients to receive actual marijuana as well as Investigational New Drug (IND) Compassionate Use program since 1975. Therefore natural marijuana and delta-9-tetrahydrocannabinol is a medicine and does not belong in Schedule I or as a scheduled controlled substance at all.

Petitioner's standing as a medicinal cannabis patient, refugee, and religious user of cannabis
Petitioner moved to California in 2005 from Wisconsin seeking medical, political, and legal asylum and safety with regard to using cannabis medicinally. Unfortunately, the California system did not then provide a truly sound legal way to grow, sell, and obtain marijuana and to this day in 2021, California cities/counties ban its sale in more than 75% of cities/counties, limiting "safe access" to marijuana to less than 25% of the population of California and less than 1,100 licensed sellers of marijuana (delivery or storefront). The black market for marijuana thrives as the dominant way to obtain marijuana not only within California, but extending to the midwest, southwest, south, eastern states, and even internationally including "legal" and "illegal" states. The high taxes, fees, regulation and complete bans imposed by the state governments (even in "legal" states) create a system where once again, everyday people living in poverty or middle class will turn to the black market to obtain marijuana. In some cases, even high income individuals how could afford excessive taxation have no way to obtain marijuana

legally if they wanted to such as Clovis, California or Sunnyvale, California which prohibit even licensed marijuana businesses to deliver to adults or patients living in their cities. The end result is that average folks don't trust the government to provide a legal way to obtain marijuana, and end up creating their own system from cultivation to end user sales (colloquially "drug dealing", "slanging"). This illegal system is glorified openly in hip-hop/rap as an underground culture from the San Francisco Bay Area to Milwaukee, Wisconsin as a way to make money and to provide this natural alternative medicine and also is celebrated as medicine and genuine religious sacrament by Rastafarians, Oklevueha Native American Church, International Church of Cannabis and many others.

DEA's lack of enforcement of marijuana prohibition

The petitioner notes the Drug Enforcement Administration does not follow up on tips or actively seek to put marijuana sellers in federal prison, despite marijuana being widely available in any populated place in the United States. It would be trivial to find illegal marijuana growers in Northern California or illegal sellers in Milwaukee, Wisconsin. The DEA claims that any production or sale of marijuana is a federal felony offense but does not actively seek to bring people to justice, creating both a sense of comfort and distrust with everyday citizens.

Prison and incarceration

The policy of keeping marijuana scheduled has subjected this petitioner to violent arrests and incarceration and humiliation in being labeled a drug addict or "narcotics" offender. For a normal everyday person, the system is impossible to deal with legally to obtain a business license to grow or sell marijuana. The State of California requires a narcotics offender to register with the police every time one moves, which is inconvenient if not impossible to deal with. The court system provides little justice or actual logical thought on the matter. The jail and prison system are filled with mentally ill, gang members, drug addicts, and criminals where violence is the norm, not to mention the requirement to be in either a gang or join members of your own racial/ethnic background against members of other races when violence occurs. Meth, heroin, and marijuana are commonly available in California state prison. Marijuana can be smoked in the open in prison, and while not a criminal offense, it is not technically allowed in prison and must be smuggled in through visitors and correctional officers.

Large illegal marijuana market is commonplace, law enforcement is lax as remaining illegal states wait for federal descheduling

The petitioner notices that it is cheaper to obtain black marijuana California marijuana in Wisconsin (illegal state) from illegal sellers than to drive to Illinois to obtain marijuana from dispensaries which only a few cities allow a small number of businesses. High taxes and overregulation mean the limited legal supply in Illinois is out of reach for most people. Currently living in Wisconsin, the petitioner prefers to obtain higher quality black market marijuana from illegal growers in Northern California: Humboldt, Trinity, and Mendocino counties (Emerald Triangle). On top of that, there is a much higher risk of Wisconsin law enforcement doing a traffic stop to check for marijuana than to ship it USPS or FedEx directly from California to Wisconsin. In Wisconsin, the petitioner would be considered a 3rd time offender and not eligible for a \$50 Milwaukee County misdemeanor ticket and no jail time. Instead, the petitioner would be facing Wisconsin state prison if Wisconsin law enforcement ever found him in possession of a personal or large bulk amount of marijuana or marijuana products. The state government of Wisconsin provides no legal protection for marijuana users and sellers, although in the City of Milwaukee the police have ceased enforcement of marijuana laws such as undercover buy-busts and concentrate on violent crime. Federal and state governments are not

actively enforcing marijuana laws, but are not providing a legal framework either.

Religious, medicinal use and court system

Petitioner was in California state prison from October 2018 to January 2020 serving a 3 year sentence for selling cannabis in line with the state's older model (nonprofit medical cannabis patient collectives), the Compassionate Use Act of 1996 (Prop 215) before the expiration of this older nonprofit collective model on January 9, 2019. The petitioner was at the time of arrest and is a religious user of marijuana and a member of the International Church of Cannabis in Denver, Colorado and Oklevueha Native American Church. However, during the criminal trial held in October 2018 at Fresno Superior Court in Fresno, California the petitioner was forbidden by Judge Petrucelli and prosecutor Ashley Paulson to mention anything about medical or religious use, his nonprofit cannabis collective, or the clearly posted text of the first amendment, doctor's recommendation for cannabis, California state marijuana patient card, sales tax seller's permit from California Board of Equalization, or membership cards for the two aforementioned churches all displayed prominently in plain view in the bedroom where Fresno Police narcotics detectives obtained the medicinal cannabis products (all clearly labeled, tested, and from licensed distributors and growers). This situation clearly shows how states have failed to legalize marijuana or to allow any real defense to patients acting out of necessity (now 24 years after California legalized medical cannabis).

CBD/hemp/delta-8 THC available over-the-counter while delta-9 THC remains illegal

Many states allow CBD as well, and CBD is generally sold over the counter as a health supplement thanks to the 2018 farm bill and lack of psychoactive activity in CBD as compared to THC. However, delta-8-tetrahydrocannabinol is sold in this same way and considered a "hemp" rather than a marijuana product. Delta-8-tetrahydrocannabinol (delta-8 THC) provides a similar psychoactive effect to the banned delta-9-tetrahydrocannabinol (delta-9 THC), but is considered less psychoactive to delta-9-THC.

The DEA and federal government must deschedule to allow people legal access to marijuana in the few remaining illegal states

Many states like Wisconsin have not made any progress on changing marijuana laws, and possession remains a felony (3.5 year prison sentence). These states are waiting for the federal government to do their job of removing marijuana from the list of scheduled controlled substances. It is clear the DEA and federal government must do something instead of claiming that marijuana is not an enforcement priority like fentanyl or meth. Federal policy influences state policies and creates an often times racist War on Drugs which is now known to create violence in black/ brown communities, violence against and from law enforcement with black/brown

residents, and violence in Mexico and Central America and with those people who live undocumented in the United States. Federal policy helps to sustain modern day Jim Crow which makes it easy for law enforcement to do traffic stops for no reason, search the vehicle and send people to jail for marijuana possession. The situation creates a cycle of incarceration and probation which is impossible to escape, resulting in never ending fines, court dates, jail sentences, police searches and a criminal record stopping people from obtaining employment and housing all for nonviolent marijuana "crimes".

Conclusion

From the beginning, the government waged a war ("reefer madness") on "marihuana" with delta-9-THC producing a psychoactive effect. These laws have been carried on far too long now with no real purpose to somehow classify hemp as having less than 0.3% delta-9-THC, but allows delta-8-THC, CBD, and any other cannabinoids in hemp and CBD products. As well, the majority of United States territories and states have legalized delta-9-THC for medical or recreational use.

Petitioner finds the current situation of cannabis in Schedule I completely untenable. Apart from the legal states and territories, the FDA allows CBD and THC pharmaceuticals as well as IND Compassionate Use. There is CLEARLY no debate, the federal government recognizes medicinal use but fails to remove marijuana from the schedule.

Under the Constitution and 21 USCS 811, 812 the continued war on drugs must begin to be corrected by descheduling cannabis/marijuana/delta-9- tetrahydrocannabinol, that is, removing it completely from the Controlled Substances Act.

DATED: Respectively, 01/03/2021 Stephen Zyskiewicz

Stephen Zyszkiewicz

(b)(6)

Milwaukee, WI 53224

(b)(6)

(b)(6)

January 3, 2021

Timothy J. Shea
Acting Administrator
Department of Justice
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8701 Morrissette Drive
Springfield, Virginia 22152

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DATED:

Respectively,

01/03/2021

Stephen Zyszkiewicz

Slater, Sandy R. EOP/ONDCP

From: Amy Smith <(b)(6)>
Sent: Thursday, July 8, 2021 1:17 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] ONDCP cannabis policies

Hello,

I would like to encourage the ONDCP to support the legalization of cannabis nationally.

Cannabis has proven medical benefits and should be made easily available to all Americans.

The criminalization of marijuana has disproportionately affected lower income communities. For example, why should a white person like me have the privilege of using marijuana for medical relief, but a black or brown person from a different neighborhood nearby is arrested and thrown in jail for the same relief?

Because cannabis has been illegal for so long there are not enough studies being done on the benefits of using cannabis. The ones that have been done seem to agree that not only is it extremely effective but much safer than using opioids, for example, which are very addictive and harmful.

Just for context, I am 49 years old, a mother of 2 and college educated. I truly believe in the benefits of cannabis because I have used it for medical purposes for more than 25 years. And as a mom of teenagers I can honestly say I would feel much safer knowing my kids were using cannabis recreationally than using alcohol or other drugs. Alcohol is far more dangerous and potentially deadly.

Thank you very much for your time and consideration of my opinions.

Sincerely,
Amy Smith
Winter Springs, FL

Slater, Sandy R. EOP/ONDCP

From: Andrew Knox <(b)(6)>
Sent: Thursday, July 8, 2021 12:43 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Public comment on 86 FR 35828 - Document number 2021-14365

Greetings, Ladies and Gentlemen of the ONDCP-

I have been meaning to write directly to President Biden about drug policy, as he seems least enthusiastic about making sweeping changes, at least among Democratic thinkers. That said, this invitation to comment is welcomed, and I hope you will sincerely digest what we how work on the streets have to say about what would work better.

First, I argue that the structure this country's drug policy is rooted in racism and classism. Anyone with a web browser can easily find testimony, public statements, and news from the time the Marijuana Tax Act of 1937, Opium Poppy Control Act, Controlled Substance Act of 1970 demonstrating animus toward people of color, gays, hippies, and various cultural and religious practices that legislators wanted to suppress.

Motives and the record of biased enforcement have combined over decades to bear these observations out. Substance use has not declined as a percentage of population, and use is relatively equal across most subpopulations, which only highlights that drug prohibition is working at Congress intended to target people based on race and class.

Overall I would rate drug prohibition as a major, worldwide human rights violation and would challenge the government to make scientific sense out of its classification scheme, all while providing for legal and safe consumption of two highly addictive and harmful substances - nicotine and alcohol.

Those are my criticisms. Here are some concrete proposals that would help.

1. Examine each scheduled substance for whether it really meets the criteria for its classification. For example, it is clearer and clearer that cannabis not only HAS medical uses, but it has broadly beneficial characteristics and no effective LD50.
2. Open up funding for studying the merits and negative effects of all drugs that haven't been adequately studied. Use foreign studies to supplement our current knowledge.
3. Recognize that you cannot eliminate demand for substances and forcing them to be produced by uncertified labs and processing plants in other countries without quality controls results in contamination of the supply chain, competitive violence, and health risks (sometimes severe including deadly overdose) to the consume. (Safe Supply)
4. Remove the federal prohibition on funds being used for syringes. Until we address the drivers of harmful substance use we must do everything possible to protect the health and well-being of people who do use.
5. Remove obstacles for doctors to provide evidence-based medication and behavioral supports to patients. This means removing limits on number of patients providers can accept for drug treatment.
6. Require treatment centers and outpatient programs to update their methods and treatment modes. The hegemony of 12-step programs is based on cost not effectiveness. Programs like Positive Psychology, Cognitive Behavioral Therapy, OCSB (Out of Control Sexual Behavior), CRAFT (Community Reinforcement and Family Training) are out there but are not being offered, despite clear evidence of their worth.
7. Safe Consumption/Overdose Prevention - in many areas, especially where many people have lost stable housing, there's no safe private place to inject or injects substances. We have bars and smoking lounges for tobacco and alcohol. Harder drugs require safe places so people don't overdose on a contaminated supply.
8. Destigmatize drug use - decades of drug propaganda has done nothing, and current policies drive people to the riskiest drugs from the riskiest sources, and information about less harmful and even helpful substances is currently prohibited and stigmatized, harming everyone involved.

9. Decriminalize possession. Offer help to people whose use has become chaotic or uncontrolled. Since our prison system is not designed to rehabilitate anyone, it's stupid to pretend that locking people up is going to help them make positive changes. Most people will do so if given multiple opportunities.
10. Also, don't demand people change on a timeline that they don't themselves set. It doesn't work.

Finally - stop putting people in jail for non-violent behavior. And change your policies that drive people to violent behavior. In my long experience, the worst threat has always come from law enforcement and the shady things people are required to do to hide their substance use.

I am a white guy with a job and an advanced degree, so luckily my one brush with the law ended well enough. I will let others tell you their worse experiences. I encourage you to believe them.

Andrew Knox
Albuquerque NM 87102

PUBLIC SUBMISSION

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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0019

Anonymous Comment

Submitter Information

Name: Anonymous Anonymous

General Comment

In order to create an equitable system, there needs to be clear research about past harms and past policies that interfere with a direction forward. If you create new policy that directly counters past rules, regulations, and policy across all three branches of government, the work moving forward is in null. Additionally, if the Federal Government wants to create policy that can have an impact on States, there needs to be a clear definition and roadmap to accomplish this. I strongly suggest looking to leading nonpartisan NGOs and Nonprofits that are leading the way with Drug Policy that use a lens of Anti-Oppression and Trauma informed harm-reduction. Additionally there needs to be a careful look into past judicial laws that have had an impact on BIPOC communities, particularly Black and Latin communities.

There should be buy in across the Federal, State, Local, Territory, Tribal, and International (Canada + Mexico) to addressing this with a humane lens rather than the punitive lens that the United States is normally known for. If there isn't a clear understanding of the message, then you will get bad policy that needs to be rectified in a few years.

I strongly suggest socializing and moving with transparency with all stakeholders on this issue as Drug Policy has an impact on all facets of our daily lives and most sectors are impacted by the Policy directly or secondary.

PUBLIC SUBMISSION

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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0001

Anonymous Comment

Submitter Information

Name: Anonymous Anonymous

Email: (b)(6)

General Comment

- to follow FEDERAL Laws and have the DOJ and DEA enforce federal drug laws and oversight when states invoke drug sales practices and laws that are INconsistent with public health as documented by science (i.e. legalizing hallucinogens as "medicine", decriminalizing and legalizing CS I drugs, etc.)
- promote the Food and Drug Administration oversight and input on matter of these drugs (creation of REMS programs, document efficacy and adverse effects routinely)
- invoke the Controlled Substance Act laws to protect and promote public health
- invoke the Lady Bird Johnson beatification Act which PROHIBITS advertising controlled substances on highways receiving federal funding, for those not adhering to the law remove 10% of the federal highway funds from those states
- assure equity in the numbers of Controlled Substance sale sites in areas such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (there currently is an OVER ABUNDANCE of sale sites located in their areas - with obvious targeting of these hallucinogens' to these vulnerable populations)
- to assure FULL documentation of adverse health consequences in vulnerable populations by states' allowing targeting of addictive substances in their communities

Slater, Sandy R. EOP/ONDCP

From: Cory Richardson <(b)(6)>
Sent: Thursday, July 8, 2021 11:16 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Public comment on drug policy

The unethical treatment of American citizens that happen to live in alcohol motivated states that refuse to legalize cannabis, is just plain unconstitutional. To force financial hardships upon whole states by keeping cannabis illegal is just low. Millions of Americans are forced out of their states, to legally gain access to medical marijuana used for their debilitating health issues. We are wrongfully burdened with financial hardships. Forced out of state to gain the fundamental human right to health, just to get medicinal relief from our irreversible health issues. Thousands of dollars a year, wasted on getting rides out of state to legally purchase medical marijuana. Then the burden of having to do all of our products at once, before being driven home, (extremely over medicated due to federal laws prohibiting us bringing medicine back). Also the wasted time that is stolen from us just to get access to medical marijuana. It is truly heartbreaking and devastatingly exhausting. We never asked to be born in a state ran and fueled by the demonic recreational gateway drug alcohol. Groomed and doomed by our so called protectors of the state (republican representatives and senators). Groomed for a life of alcohol addiction and a diminished quality of life and health. Here in alcohol country wisconsin, if you don't booze you loose it seems. The only legislation that is passed is for easier access to the gateway drug alcohol or cheaper deadly pills. We dont deserve to be continually kick while we are down anymore. Lend us your hand! Help us up, and help us get the much needed, financial, medical, and time consuming relief that is taunting us from states that actually care about their constituents, and ethics. Our alcoholic states only care about power, greed, and keeping their beloved recreational gateway drug alcohol on top, and overly accessible to all. God bless and we pray daily for the demonic war on drugs to end and our fundamental human right to health be given back to us innocent American victims. Thank you for your time and please do all the exact same research done on cannabis, to the legal recreational gateway drug alcohol. It is truly the most destructive recreational drug available today. Full legalization of cannabis is the only way to repair the permanent damage forced upon our families and communities our whole lives.

Slater, Sandy R. EOP/ONDCP

From: David Grand <(b)(6)>
Sent: Thursday, July 8, 2021 2:29 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Marijuana/Marihuana/Hemp systemic barriers to opportunities for underserved communities

The actions and continued blocking of c Sativa and today a non bankable industry has not only help back green industry, minority innovation, drug development, and farming it has destroyed opportunities for rural America like Jackson county Florida and Early county Georgia that has suffered from a pandemic and even a hurricane . Young minorities today in the region arrested for something that today is driving all industry and impacting every single industry one way or another. Cannabis Sativa which is one species and hemp and marijuana all the same; it is just psychoactive chemicals that impact global policy. Today our companies war to just do business in America being a minority led start up with my partner MBA Michael Clinton, our doctors group all black medical leaders, our farmers all minority generational farmers, and our black college certified Panakeia hemp at the historical black FAMU Tallahassee Florida that today I believe has been held back intentionally in Florida. My first wife died at 41 , not because of the cancer but the drugs available killed her and we know with teams globally the impact once policy catches up with global law the impact we will make in cancer as well as the environment. The rural communities where my kids go to school on the Georgia Florida panhandle line have a town in ruins. It is I believe from non psychoactive cannabis all can change. Hemp can capture atmospheric carbon twice as effectively as Forrests with carbon negative bio materials. At my company we do all we can while being unbankable ! It is time policy change and the lack of access and acceleration of non psychoactive cannabis and use of cannabis cover crops in rotation in agriculture in rural communities is a must for food of the future. Hemp also has the potential with non psychoactive products future foods all being held back by current policy that is very questionable at this point. I am a registered Democrat in Florida working in deep red rural America, this is our time hemp cannabis can change America policy and as one species all c Sativa policy is almost against science at this point. As a company we trust the new administration will work to advance public Health and what's best globally for cannabis sativa .

Best Wishes,
David Grand
Bazelet Corp

“Plants With Purpose”

[>https://bazeletcorp.com/<](https://bazeletcorp.com/)

[>http://linkedin.com/in/david-grand-8b92ab1a<](http://linkedin.com/in/david-grand-8b92ab1a)

Cell Phone:

(b)(6)

Co-Founder Bazelet, U.S.A.

“Curiosity driven research into the wonders of nature plants the seeds, sometimes in unpredictable ways, for later innovations”

Disclosure:

Bazelet Americas , LLC is a separate entity and not affiliated with BZLT or any public company.Bazelet Americas, LLC business is to be in Florida MMTC marketplace only and only intended as applicant in low THC federally compliant medical program called MMTC and or is not affiliated with any other Bazelet company globally other than executed third party agreements. No other company shall have claim against Bazelet Americas as this has no direct connection with any entity other than a Low THC Florida application and to date no commercial business other than legal actions.

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Slater, Sandy R. EOP/ONDCP

From: Ed Wood <(b)(6)>
Sent: Thursday, July 8, 2021 12:00 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Application of Equity in U.S. National Drug Control Policy, Ref: 86 FR 35828, Document 2001-14365

As a 2012 recipient of ONDCP's Advocate for Action award, I am disgusted to learn that taxpayer resources are being wasted learning how ONDCP's policies and programs can more effectively advance equity, rather than learning how to meet ONDCP's mission to "reduce substance use disorder and its consequences."

In light of inconsistent and ineffective responses from the Federal Government to the fact that 18 states (plus D.C.) have legalized recreational marijuana in conflict with the Controlled Substances Act, you should be concerned about your mission, not current 'woke' politics.

As Hudson Institute described last week, the "Colorado Experiment" on legalizing recreational marijuana has failed. The black market flourishes. Arrest rates for young blacks and Latinos have risen dramatically. Corruption has spread more widely. Use by youth has increased. Cannabis Use Disorder has worsened so that, "For youth, the number developing CUD, only three years following initiation, rises to over 20 percent."

As if Federal inaction and State illegal actions weren't enough, we now have evidence of Federal complicity in making the situation worse, not better.

The CDC issued guidance in 2017 incorrectly stating, "...it is unclear whether marijuana use actually increases the risk of car crashes."

We supplied an analysis refuting that and other misleading statements in CDC's guidance.

The CDC issued renewed guidance in 2020 that refuted their 2017 guidance.

In spite of a 12/28/2020 written statement to this author by CDC Marijuana and Public Health that the 2017 guidance would be withdrawn, the dangerously misleading 2017 statement is still live on the internet. Check it out.

<https://www.whitehouse.gov/ondcp/>

><https://www.hudson.org/research/17052-the-colorado-experiment-legalized-marijuana-s-impact-in-colorad><

[3] ><https://www.cdc.gov/marijuana/pdf/marijuana-driving-508.pdf><

><http://www.duidvictimvoices.org/cdc-guidance-thc-and-crash-risk/><

<https://www.cdc.gov/transportationsafety/pdf/Drug-Impaired-Driving-Summary-Sheet-LD-508.pdf>

Slater, Sandy R. EOP/ONDCP

From: Marcus Manning <(b)(6)>
Sent: Thursday, July 8, 2021 6:40 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] (b)(6)

In my opinion, it's time to get it right in this country by doing what's right by putting an end to the obvious discrimination in the Afro American communities. Marijuana should be rescheduled and legal at the federal level.

Sent from my iPhone

Slater, Sandy R. EOP/ONDCP

From: Michelle Zara <(b)(6)>
Sent: Thursday, July 8, 2021 11:31 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] White House Invites Comment On How Drug Policies Create 'Systemic Barriers' For 'Underserved Communities'

In reference to the cannabis referendum, the legalization of marijuana will allow for tax income for the states and federal government, as there are more people in favor of declassification and legalization. The numerous positive effects of consuming marijuana are evident, and the drug policies that are in effect are outdated. Currently the prescription use that is FDA approved has many more dangerous side effects and causes health complications including death. The fact that marijuana is illegal is ludicrous and this prohibition needs to end. Conservatives are causing more difficulties and harm not just to the underprivileged, but America as a whole. There are so many benefits economically to the legalization of this plant, and an individual's right to make a choice. More states are embracing this change of attitude, and once the Federal level is approved the rest of the TOO conservative states will come on board...maybe healthcare and mental health issues can be tackled next. The time is now.

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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0016

Comment from Mike, Goldberg

Submitter Information

Name: Mike Goldberg

Address:

PERRYVILLE, MD, 21903

Email: (b)(6)

Phone: (b)(6)

General Comment

Alcohol is FAR more dangerous than cannabis. When are you going to stop your utterly despicable, uber hypocritical jihad against the cannabis using community?

Slater, Sandy R. EOP/ONDCP

From: Mitchell Berger <(b)(6)>
Sent: Thursday, July 8, 2021 8:25 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] RFI comment-Berger
Attachments: ondcpccommentberger1.pdf

Good afternoon, please find attached my comments in response to ONDCP's request for information (<https://www.federalregister.gov/documents/2021/07/07/2021-14365/application-of-equity-in-us-national-drug-control-policy>). Please note that though I am an HHS employee (SAMHSA), these comments represent solely my personal views/opinions and have not been approved or reviewed by others. Thank you for your consideration.

Regards,

Mitchell Berger

Mitchell Berger, (b)(6) Rockville, MD

Executive Office of the President
Office of National Drug Control Policy (ONDCP)
(b)(6)

July 8, 2021

RE: Application of Equity in U.S. National Drug Control Policy, Request for Information (RFI), <https://www.federalregister.gov/documents/2021/07/07/2021-14365/application-of-equity-in-us-national-drug-control-policy>

To whom it may concern: I write to provide two suggestions on ONDCP's RFI published on July 7, 2021. First, I suggest ONDCP work with other federal and non-federal partners to **reinstate the Arrestee Drug Abuse Monitoring survey (ADAM)**, which provided a critical barometer of drug use among persons in the criminal justice system. Second, I urge ONDCP to encourage behavioral health facilities to participate in with others to **participate in local community health improvement planning (generally health department-led) and community health needs assessments (nonprofit hospitals)**.

First, I urge ONDCP to reinstate the ADAM survey which helped measure drug use in arrestees unlikely to be part of other surveys. The Brookings Institute recently (2020) endorsed reinstating the ADAM survey, observing that “[w]ithout the ADAM data, or something similar, it will be extremely difficult to credibly estimate the size of drug-using populations, and thus the total number of people with OUD [opioid use disorder], in the US.”¹ ADAM was administered by the National Institute of Justice/Department of Justice before being scaled back in 2003, was taken over in a revised form by ONDCP in 2007 and then entirely canceled for budget reasons in 2013.² ADAM initially focused on results in 10 geographically diverse counties (35 sites) but was scaled back to five counties (10 sites) when administered by ONDCP.³ ADAM data complemented that of SAMHSA's National Survey on Drug Use and Health (NSDUH),⁴ Treatment Episode Data Set (TEDS)⁵ and other sources. ADAM captured data from arrestees who may have been homeless/transient heavy drug users and therefore less likely to be surveyed as part of TEDS, NSDUH or other studies. Additionally, the ADAM survey “offer[ed] another important piece of information not available in other surveys—a bioassay that detects the recent use of each of ten different drugs—providing the ability to validate self-reports of use.” Specifically, arrestees were asked to provide urine specimens as part of their interview. Revising ADAM would likely cost under \$10 million per year based on past expenses. As the Brookings Institute noted in its report, the survey could be updated to include new questions (e.g., about naloxone). As well, rather than urine specimens, perhaps hair or oral samples could be used as part of a revised survey.⁶

Second, I urge ONDCP to work with the National Association of State Alcohol and Drug Abuse Directors, National Association of State Mental Health Program Directors, National Council for Mental Wellbeing and others to encourage behavioral health agencies, providers and facilities to participate in

¹ Beau Kilmer, Reducing barriers and getting creative10 federal options to increase treatment access for opioid use disorder and reduce fatal overdoses, https://www.brookings.edu/wp-content/uploads/2020/06/3_Kilmer_final.pdf

² <https://obamawhitehouse.archives.gov/ondcp/arrestee-drug-abuse-monitoring-program>; <https://www.thedailybeast.com/govt-abandons-best-survey-for-counting-us-drug-users?ref=scroll>; https://issues.org/p_kleiman/

³ https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/adam_ii_2013_annual_report.pdf

⁴ <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>; Arrestee Substance Use: Comparison of Estimates from the National Survey on Drug Use and Health and the Arrestee Drug Abuse Monitoring Program, August 2014, CBHSQ Review, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-ADAM-2014/NSDUH-DR-ADAM-2014.html>

⁵ <https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set>

⁶ <https://www.samhsa.gov/workplace/drug-testing>

community health improvement and community health needs assessments processes and others to partner with behavioral health stakeholders in these activities. Facilities, providers and state and local behavioral health agencies can participate in community health assessments/community health improvement plan development, encouraged by CDC, the National Association of County and City Health Officials, Association of State and Territorial Health Officials and Public Health Accreditation Board.⁷ These efforts are often led by health departments, Similarly, behavioral health facilities and providers can participate in community health needs assessments required of most nonprofit hospitals.⁸ Members of CDC's and ONDCP's Drug-Free Communities (DFC) program, which also may include many community partners, also can participate in such efforts.⁹ To date, hospitals and communities often do not include substance use or mental health among their priorities. Enhanced effort to connect hospitals, health departments, schools, faith-based entities, workplaces and other partners may be helpful to behavioral health needs are addressed at the community level.¹⁰

Participation in local health planning efforts could help foster emergency preparedness among substance use and mental health facilities and other partners. COVID-19 and past disasters such as hurricanes underscore the need for behavioral health facilities to be prepared with respect to staffing, administering medications, patient tracking and follow up, planning to assist patients with disabilities and facility safety before, during and after emergency events.¹¹ Ideally, behavioral health facilities, which may not be able to be completely self-sufficient in an emergency, can fulfill such goals by partnering with elements of the local public health system including state and local health departments, academic institutions, hospitals and health care providers and others. Conversely, other partners can be better linked to behavioral health agencies and providers to help refer patients and link patients to mental health and substance use treatment as needed. ONDCP can work with the above associations and federal and state partners to encourage behavioral health facilities and DFC coalition members to join these efforts.

⁷ <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment>; <https://phaboard.org/standards-and-measures-for-initial-accreditation/>

⁸ <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>; <https://www.healthycommunities.org/resources/community-health-assessment-toolkit>

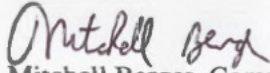
⁹ <https://www.cdc.gov/drugoverdose/drug-free-communities/about.html>

¹⁰ B. Franz et. al. Why don't hospitals prioritize substance abuse in their community benefit programming, *Journal of Public Health Management and Practice*, Jan/Feb. 2019, pp. 62-68; S. Singh et. al. Nonprofit hospitals' response to the opioid epidemic in urban communities: a content analysis of hospitals' community health needs assessments and implementation strategies, *JPHMP*, May/June 2020, pp. 243-251; Kronstadt et. al., Accredited Health Department Partnerships to Improve Health: An Analysis of Community Health Assessments and Improvement Plans, *JPHMP*, May/June 2018, pp. S36-S43.

¹¹ <https://store.samhsa.gov/product/tap-34-disaster-planning-handbook-for-behavioral-health-service-programs/pep21-02-01-001> See e.g., L. Elliott et al., Disaster preparedness among opioid treatment programs: Policy recommendations from state opioid treatment authorities. *International Journal of Disaster Risk Reduction*, Volume 23, August 2017, Pages 152-159; A.R. Griffin, et. al., A Crisis Within a Crisis: The Extended Closure of an Opioid Treatment Program After Hurricane Sandy. *Journal of Drug Issues*, 2018; 48(4), 536–545; H. Matusow et al., Challenges to Opioid Treatment Programs After Hurricane Sandy: Patient and Provider Perspectives on Preparation, Impact, and Recovery. *Substance Use & Misuse*, 53(2), 206–219; J. Roudini et al., Disaster mental health preparedness in the community: A systematic review study, *Health Psychology Open*, January-June 2017: 1–12; E. Storch et. al., Psychiatric Diagnoses and Medications for Hurricane Harvey Sheltered Evacuees, *Community Mental Health Journal*, March 2019; Hurricane Harvey Registry, <https://harveyregistry.rice.edu/>; <https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf>; JW Thompson et. al., An Epidemiologic Study of COVID-19 Patients in a State Psychiatric Hospital: High Penetrance With Early CDC Guidelines, *Psychiatric Services*, Oct. 2020, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000270>; <https://www.madinamerica.com/2020/04/americas-psychiatric-facilities-incubators-covid-19/>; <https://www.asam.org/Quality-Science/covid-19-coronavirus/infection-mitigation-in-residential-treatment-facilities>; <https://www.thenationalcouncil.org/covid-19-guidance-for-behavioral-health-residential-facilities/>

Thank you for your consideration of this comment.

Sincerely,



Mitchell Berger, Comment Submitted 7.8.21: (b)(6)

Note: Please note that I am an employee of HHS/SAMHSA. However, I am making these suggestions in my personal capacity; the views expressed are mine alone, were not reviewed by or discussed with other SAMHSA or HHS staff and should not be imputed to any public or private entity.

Slater, Sandy R. EOP/ONDCP

From: Rich Stevenson <(b)(6)>
Sent: Thursday, July 8, 2021 11:46 PM
To: MBX ONDCP OGC
Cc: (b)(6) (b)(6)
Subject: [EXTERNAL] Public invite for comments on marijuana equity

TO: The White House Office of National Drug Control Policy
Senator Chuck Schumer
Senator Cory Gardner

Good evening!

I am an aspiring minority cannabis business owner and activist here in the state of Missouri. I would love to work with the White House and Biden Administration on solving some of these issues and helping to make a difference here in Missouri and the United States of America.

The number one issue related to this problem is simple: liquid assets barriers.

For instance in Missouri, you have to have \$300,000 to start a cultivation business. No banks can provide loans. Who does this eliminate right from the jump? Minorities. It is a tactic being used in starting all states medical marijuana programs. Then the wealthy business owners, trade associations and their powerful lobbyists draft amendments and push to create legislation that allows them first shot at recreational marijuana businesses. So the system stays rigged.

Furthermore, all of these recreational initiatives have language for "micro businesses" as a band-aid. It's merely throwing a dog a bone. Shut the minorities up by allowing to grow a mere 150 plants or so. Minorities are tired of this type of treatment.

If you want to make a difference as an Administration then the White House should sign an Executive order passing the SAFE Banking Act, abolish all states from setting liquid assets barriers, (which are disparate impact or treatment) and prevent all states from setting rules that cap how many licenses can be awarded. This presents the appearance of corruption and if you simply follow the Missouri Medical Marijuana Program and the outrage it has caused you will see how these types of rules by government agencies can be influenced by the rich, wealthy and politically connected.

The media can do its job too. I have an ongoing lawsuit in Missouri trying to get these rules abolished so there can be minority inclusion. I can't get a story or interview from any media outlet in the state. That's a huge problem. These rules are discrimination as applied. Social equity starts with funding and the ability to be put on an equal platform as the majority. People can protest all we want. As long as these types of things are allowed in commerce and housing, minorities will never catch up. Members of the majority in this industry are aware of that. They keep us as patients to help feed their bottomline and then blame the black market, when the reality of it is legalization kills the black market if it's done right.

I am a prisoner of this failed war on drugs. Having been sent to prison for having less than 250 grams of marijuana, I can now lawfully possess 448 grams in my state. I have a felony on my record. Meanwhile, corporate white businessmen in suits grow billions of pounds of marijuana annually, yet they frowned upon these actions 5 years ago.

Thank you for your time. I would to be of any help to any national panel or testify before any committee on behalf of the patients and aspiring minority business owners in my state and in the United States.

Together we can make a difference. The treatment of minorities in this country as unequal will always continue without executive action. It starts with the leadership of the government and legislators. We have work to do and I'll play my part. I represent myself in court in Missouri. It's a shame that I haven't heard back from the NAACP and ACLU. This is a huge issue with national implications to set the standard of equality in a multi billion dollar industry that is the fastest growing in America.

I won't stop until my voice is heard and I help to make a positive change for equality, social justice and equity. I am a one man wrecking crew. If the average African American household makes \$31k a year how does he/she enter this industry with \$300k in liquid assets? That's the reason why only 1 in 50 Marijuana businesses have minority owners. The Government is allowing open discrimination, instead of keeping State government agencies in check! I have a current complaint with office of Civil Rights in Washington, DC for these very issues.

I simply want a chance. My dreams and goals are shattered from the beginning.

Thank you for your time.

Mr. Stevenson

Slater, Sandy R. EOP/ONDCP

From: John Wanless <(b)(6)>
Sent: Friday, July 9, 2021 9:48 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] How the ONDCP can improve policy

Dear Officials,

Science and widespread experience have shown marijuana is not addictive and is far less harmful than alcohol. - Yet, more than 500,000 innocent Americans are arrested for simple marijuana possession each year and made second-class citizens - for life! They will forever face large obstacles to decent employment, education, travel, housing, government benefits, and will always go into court with one strike against them. They can even have their children taken away!

25 million Americans are now locked away in this very un-American sub-class because of this bogus "criminal" record. That has a horrible effect on the whole country, being a massive waste of human potential.

The fraudulent marijuana prohibition has never accomplished one positive thing. It has only caused vast amounts of crime, corruption, violence, death and the severe diminishing of everyone's freedom.

Thank you for your consideration.

John Wanless

Slater, Sandy R. EOP/ONDCP

From: Mitchell Berger <(b)(6)>
Sent: Friday, July 9, 2021 4:19 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Fw: RFI comment-Berger
Attachments: ondcpccommentberger1.pdf

Good afternoon, please find attached my comments in response to ONDCP's request for information (><https://www.federalregister.gov/documents/2021/07/07/2021-14365/application-of-equity-in-us-national-drug-control-policy><). Please note that though I am an HHS employee (SAMHSA), these comments represent solely my personal views/opinions and have not been approved or reviewed by others. Thank you for your consideration.

Regards,

Mitchell Berger

Mitchell Berger, (b)(6) Rockville, MD

Executive Office of the President
Office of National Drug Control Policy (ONDCP)
OGC@ondcp.eop.gov

July 8, 2021

RE: Application of Equity in U.S. National Drug Control Policy, Request for Information (RFI),
<https://www.federalregister.gov/documents/2021/07/07/2021-14365/application-of-equity-in-us-national-drug-control-policy>

To whom it may concern: I write to provide two suggestions on ONDCP's RFI published on July 7, 2021. First, I suggest ONDCP work with other federal and non-federal partners to **reinstate the Arrestee Drug Abuse Monitoring survey (ADAM)**, which provided a critical barometer of drug use among persons in the criminal justice system. Second, I urge ONDCP to encourage behavioral health facilities to participate in with others to **participate in local community health improvement planning (generally health department-led) and community health needs assessments (nonprofit hospitals)**.

First, I urge ONDCP to reinstate the ADAM survey which helped measure drug use in arrestees unlikely to be part of other surveys. The Brookings Institute recently (2020) endorsed reinstating the ADAM survey, observing that “[w]ithout the ADAM data, or something similar, it will be extremely difficult to credibly estimate the size of drug-using populations, and thus the total number of people with OUD [opioid use disorder], in the US.”¹ ADAM was administered by the National Institute of Justice/Department of Justice before being scaled back in 2003, was taken over in a revised form by ONDCP in 2007 and then entirely canceled for budget reasons in 2013.² ADAM initially focused on results in 10 geographically diverse counties (35 sites) but was scaled back to five counties (10 sites) when administered by ONDCP.³ ADAM data complemented that of SAMHSA's National Survey on Drug Use and Health (NSDUH),⁴ Treatment Episode Data Set (TEDS)⁵ and other sources. ADAM captured data from arrestees who may have been homeless/transient heavy drug users and therefore less likely to be surveyed as part of TEDS, NSDUH or other studies. Additionally, the ADAM survey “offer[ed] another important piece of information not available in other surveys—a bioassay that detects the recent use of each of ten different drugs—providing the ability to validate self-reports of use.” Specifically, arrestees were asked to provide urine specimens as part of their interview. Revising ADAM would likely cost under \$10 million per year based on past expenses. As the Brookings Institute noted in its report, the survey could be updated to include new questions (e.g., about naloxone). As well, rather than urine specimens, perhaps hair or oral samples could be used as part of a revised survey.⁶

Second, I urge ONDCP to work with the National Association of State Alcohol and Drug Abuse Directors, National Association of State Mental Health Program Directors, National Council for Mental Wellbeing and others to encourage behavioral health agencies, providers and facilities to participate in

¹ Beau Kilmer, Reducing barriers and getting creative10 federal options to increase treatment access for opioid use disorder and reduce fatal overdoses, https://www.brookings.edu/wp-content/uploads/2020/06/3_Kilmer_final.pdf

² <https://obamawhitehouse.archives.gov/ondcp/arrestee-drug-abuse-monitoring-program>; <https://www.thedailybeast.com/govt-abandons-best-survey-for-counting-us-drug-users?ref=scroll>; https://issues.org/p_kleiman/

³ https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/adam_ii_2013_annual_report.pdf

⁴ <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>; Arrestee Substance Use: Comparison of Estimates from the National Survey on Drug Use and Health and the Arrestee Drug Abuse Monitoring Program, August 2014, CBHSQ Review, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-ADAM-2014/NSDUH-DR-ADAM-2014.html>

⁵ <https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set>

⁶ <https://www.samhsa.gov/workplace/drug-testing>

community health improvement and community health needs assessments processes and others to partner with behavioral health stakeholders in these activities. Facilities, providers and state and local behavioral health agencies can participate in community health assessments/community health improvement plan development, encouraged by CDC, the National Association of County and City Health Officials, Association of State and Territorial Health Officials and Public Health Accreditation Board.⁷ These efforts are often led by health departments, Similarly, behavioral health facilities and providers can participate in community health needs assessments required of most nonprofit hospitals.⁸ Members of CDC's and ONDCP's Drug-Free Communities (DFC) program, which also may include many community partners, also can participate in such efforts.⁹ To date, hospitals and communities often do not include substance use or mental health among their priorities. Enhanced effort to connect hospitals, health departments, schools, faith-based entities, workplaces and other partners may be helpful to behavioral health needs are addressed at the community level.¹⁰

Participation in local health planning efforts could help foster emergency preparedness among substance use and mental health facilities and other partners. COVID-19 and past disasters such as hurricanes underscore the need for behavioral health facilities to be prepared with respect to staffing, administering medications, patient tracking and follow up, planning to assist patients with disabilities and facility safety before, during and after emergency events.¹¹ Ideally, behavioral health facilities, which may not be able to be completely self-sufficient in an emergency, can fulfill such goals by partnering with elements of the local public health system including state and local health departments, academic institutions, hospitals and health care providers and others. Conversely, other partners can be better linked to behavioral health agencies and providers to help refer patients and link patients to mental health and substance use treatment as needed. ONDCP can work with the above associations and federal and state partners to encourage behavioral health facilities and DFC coalition members to join these efforts.

⁷ <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment>; <https://phaboard.org/standards-and-measures-for-initial-accreditation/>

⁸ <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>; <https://www.healthycommunities.org/resources/community-health-assessment-toolkit>

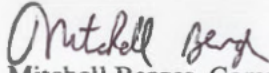
⁹ <https://www.cdc.gov/drugoverdose/drug-free-communities/about.html>

¹⁰ B. Franz et. al. Why don't hospitals prioritize substance abuse in their community benefit programming, *Journal of Public Health Management and Practice*, Jan/Feb. 2019, pp. 62-68; S. Singh et. al. Nonprofit hospitals' response to the opioid epidemic in urban communities: a content analysis of hospitals' community health needs assessments and implementation strategies, *JPHMP*, May/June 2020, pp. 243-251; Kronstadt et. al., Accredited Health Department Partnerships to Improve Health: An Analysis of Community Health Assessments and Improvement Plans, *JPHMP*, May/June 2018, pp. S36-S43.

¹¹ <https://store.samhsa.gov/product/tap-34-disaster-planning-handbook-for-behavioral-health-service-programs/pep21-02-01-001> See e.g., L. Elliott et al., Disaster preparedness among opioid treatment programs: Policy recommendations from state opioid treatment authorities. *International Journal of Disaster Risk Reduction*, Volume 23, August 2017, Pages 152-159; A.R. Griffin, et. al., A Crisis Within a Crisis: The Extended Closure of an Opioid Treatment Program After Hurricane Sandy. *Journal of Drug Issues*, 2018; 48(4), 536–545; H. Matusow et al., Challenges to Opioid Treatment Programs After Hurricane Sandy: Patient and Provider Perspectives on Preparation, Impact, and Recovery. *Substance Use & Misuse*, 53(2), 206–219; J. Roudini et al., Disaster mental health preparedness in the community: A systematic review study, *Health Psychology Open*, January-June 2017: 1–12; E. Storch et. al., Psychiatric Diagnoses and Medications for Hurricane Harvey Sheltered Evacuees, *Community Mental Health Journal*, March 2019; Hurricane Harvey Registry, <https://harveyregistry.rice.edu/>; <https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf>; JW Thompson et. al., An Epidemiologic Study of COVID-19 Patients in a State Psychiatric Hospital: High Penetrance With Early CDC Guidelines, *Psychiatric Services*, Oct. 2020, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000270>; <https://www.madinamerica.com/2020/04/americas-psychiatric-facilities-incubators-covid-19/>; <https://www.asam.org/Quality-Science/covid-19-coronavirus/infection-mitigation-in-residential-treatment-facilities>; <https://www.thenationalcouncil.org/covid-19-guidance-for-behavioral-health-residential-facilities/>

Thank you for your consideration of this comment.

Sincerely,



Mitchell Berger, Comment Submitted 7.8.21: (b)(6)

Note: Please note that I am an employee of HHS/SAMHSA. However, I am making these suggestions in my personal capacity; the views expressed are mine alone, were not reviewed by or discussed with other SAMHSA or HHS staff and should not be imputed to any public or private entity.

Slater, Sandy R. EOP/ONDCP

From: Rich Stevenson <(b)(6)>
Sent: Friday, July 9, 2021 1:25 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Public invite on social equity. (2nd comment)

Good evening!

I am writing for a second time about ways that the White House can make a difference in social equity in the marijuana industry. As I sit back and thought about things that have come to mind in the past and I want to continue to share these thoughts.

As I stated earlier it starts with Congress, but even then the bills introduced thus far are a part of the problem. I have studied this industry for a decade. In one of the bills circulating in Congress, I read that the government will provide States with funding for their marijuana programs if they choose to include social equity provisions. With all due respect President Biden and Mr. Schumer, this sends the wrong message.

The States have a Constitutional duty to treat everyone equally! The rules and laws of each State must comply with Federal laws and the 14th Amendment is clear. All men and women must be treated equally. Liquid assets rules are Unconstitutional. Congress is allowing this instead of banning it! Deeming if unlawful. You are willing to pay millions in tax payer dollars to States to not discriminate against minorities when the United States has a Supremacy Clause over each State?

Why not use that money to create grants for minorities to start these types of businesses? Equity is power. With out money and an equal platform to start on their is no equity. You personally have the opportunity to create generational wealth for 1000's of minorities in one sector of agriculture and commerce that is just forming and taking shape. A huge industry that is to massive and popular to stop. Marijuana itself will not be stopped and legalization is imminent. You have to stay woke in order to see.

If you follow the advice of the last two emails, you will create 1,000s of million dollar minority businesses over time. That's how you begin to change the gap and create generational wealth. An executive signature from the commander in chief, saying states can no longer discriminate against minorities in this industry and anyone harmed by these rules may apply for these businesses. You can do that today. Before full legalization takes shape. You send a clear message. There's a saying that "talk is cheap". We can talk and protest all day. Still doesn't close the gap! I would help draft the rules on an equal platform for this entire country for free, if given the chance. It would be an honor. I'm going to fight for minorities and the youth of America until I take my last breath. I'm just a kid from the Midwest with a dream to help the sick and I'll. The oppressed. The left behind.

I've studied the States of California, Oregon, Washington, Nevada, Colorado, Oregon, Ohio, Michigan, Missouri and Illinois over the last ten years. I know this industry. The war on drugs isn't over until you reschedule Marijuana from schedule 1, expunge past convictions and put an end to discrimination in the legal industry. That's the start.

Thanks again.

Mr. Stevenson

PUBLIC SUBMISSION

As of: 8/6/21 1:33 PM
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Docket: ONDCP-2021-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0017

Comment from Benjamin, Hebblethwaite

Submitter Information

Name: Benjamin Hebblethwaite

Address:

Gainesville, FL, 32605

Email: (b)(6)

Phone: (b)(6)

General Comment

Dear Federal Employees,

U.S. Nation Drug Control Policy is a tool of racism. U.S. National Drug Control Policy results in the disproportionate policing, arrest, and incarceration of Black, Brown and Jewish Americans. According to the American Civil Liberties Union, Black Americans are four times more likely to be arrested for cannabis possession. (See this link: <https://www.aclu.org/gallery/marijuana-arrests-numbers>).

It has also been revealed that President Nixon's motivation to expand the War on Drugs was rooted in racism and politics. Mr. Nixon embraced cannabis prohibition as a tool for harming Jewish and Black Democratic activists. (See this link: <https://www.csdp.org/cms/node/30>).

Cannabis prohibition and drug prohibition are rooted in Nixon's vision of using the War on Drugs as a political and racist tool to harm Black, Brown, and Jewish Americans. Fifty years of disproportionate policing, arrest, and incarceration tragically display the racist and fascist policies of the U.S. Federal Government.

After WWII, U.S. Federal drug policy is one of the central tenants of a U.S. federal neofascism. U.S. Federal Law, elected U.S. officials, U.S. federal government employees, the police force, the courts and the prison system are powerful agents of systematic racist drug policy in this country.

The fact that the U.S. Federal government has maintained this ban for more than 50 years reveals that using the War on Drugs as a tool for racism is one of the gravest catastrophes in our society.

End prohibition on cannabis and releases the cannabis prisoners. Rip out the insidious neofascist culture and policies that permeate the U.S. Federal Government.

How many more innocent lives will be ruined before you ACT?

Ben Hebblethwaite

Slater, Sandy R. EOP/ONDCP

From: Zachary Taylor <(b)(6)>
Sent: Monday, July 12, 2021 3:02 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Drug policy Discussion

Hello,

My name is Zachary Taylor.

As far as I can remember the most important thing as far as I see drug policy is PRESERVE the right for EMPLOYERS, not welfare systems or government circuits to manage drug use.

It's easy — if you cannot afford the drug, you'll innovate.

Or you'll make a legitimate effort to figure out where you went wrong and seek help from..

A TREATMENT CENTER.

If a violent offense occurs, then drugs aside you're in the penal system.

I have never used a hard drug, but I do know if my employer doesn't allow it and I can't afford it without a job — it's not an issue for long.

Employers in Michigan have the right to choose what doctor injured employees go to for work comp injuries, mandate that!

They don't get treatment, after so many strikes they're out!

While maintaining hipaa compliance, an employer is limited to how they can address or redress future employers for this person.

Which would prompt the new employer to not only require PROPER documentation for treatment, but also recurring mandated drug tests. If they can't afford it, maybe they'll go into business for themselves or dodge it by not consuming the drug.

Win fo government for enforcement.

Win for employers who don't have to put up with it.

And if you like it so much, get help or work for yourself.

Thanks for reading!

PUBLIC SUBMISSION

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Tracking No. kr2-ili5-asgy
Submission Type: API

Docket: ONDCP-2021-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0022

Comment from Bennett, Sondeno

Submitter Information

Name: Bennett Sondeno

Address:

Cody, WY, 82414

Email: (b)(6)

Phone: (b)(6)

General Comment

Cannabis MUST be descheduled. It is less harmful/impactful than alcohol or tobacco, so the laws must be brought in line. Right this 100-year wrong NOW while there is an opportunity. Thank you.



National Coalition for Drug Legalization
22970 Newcut Rd
Clarksburg, MD 20871
8 July 2021

Office of the National Drug Control Policy
1600 Pennsylvania Ave NW
Washington DC, 20500

To the Office of the National Drug Control Policy:

This letter is in response to ONDCP request to hear suggestions regarding how future proposed policies, budgets, regulations, grants, or programs might be more effective in advancing equity. The National Coalition for Drug Legalization is a 501c (3) dedicated to advancing the conversation about legalization of all drugs through community service and research. There are three major ways ONDCP can bring about drug laws and policies that are rooted in racial equity, social justice, public health and safety. The following paragraphs will focus on the need for marijuana legalization, research on “illicit” drugs, and the establishment of the National Coalition for Drug Legalization as a Federally Funded Research Center.

First, the United States needs to legalize marijuana. Canada has demonstrated that the world is not going to fall apart by legalizing marijuana. There has been no increase in crime or drug related deaths since the legalization of marijuana. A recent study conducted by the CATO Institute has demonstrated that since the legalization of marijuana by most states in the US, the amount of marijuana smuggled across the border has decreased, forcing drug cartels south of the border to shift their business to other illicit drugs¹. This fact leads us to presume that drug cartels will lose money if the US legalizes all drugs. The ability to protect the drug supply through regulation will change the current illicit drug industry into a consumer driven market where drug users have the choice to purchase drugs from legally sanctioned drug sources.

Second, the United States needs to spend more money researching drugs that are on the schedule. This research does not need to focus on the negative but rather on the positive effects of drugs. Plants such as the coca leaf and entheogens are known to have strong medicinal properties but are currently on the schedule and categorized as “illicit” drugs. Here at the National Coalition for Drug Legalization, we want to explore more ways to develop the therapeutic applications of the coca plant (*Erythroxylum spp*) and bolster equitable, high-value

supply chains led by drug war victims (rural & urban), harnessing bioeconomy science to provide sustainable livelihoods while weakening illicit cocaine economies.

Third, the United States need to establish the National Coalition for Drug Legalization as a Federally Funded Research Development Corporation. Once established, the first order of business is to conduct a drug pilot study, where selected cities across the US are allowed to legalize all drugs. The major goal of this study is to determine if drug legalization will decrease crime and opioid related deaths. The pilot study will help America to reduce the incarceration of so many people of color who are serving sentences for nonviolent drug offenses. The issue of equity and inclusion has never been timelier and we appreciate the opportunity to provide suggestions that will uphold the public trust, protects public health and advances public safety. We request a meeting with ONDCP to discuss the interest of a drug pilot study as referenced above. Thank you for your time and we look forward to hearing from you.

Very Respectfully,

Veronica Wright
Founder, National Coalition for Drug Legalization
<https://www.nationalcoalitionfordruglegalization.org>

(b)(6)

(b)(6)

PUBLIC SUBMISSION

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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0018

Comment from Jordan, Amass

Submitter Information

Name: Jordan Amass

Address: United States,

General Comment

Hello my name is jordan scott amass and i am a 22 year old bill paying, tax paying, community servicing, hard working young man. I am also on my way to prison because of a plant..... Let that soak in morally for just a second. Imagine your own child about a plant. Now, the fact that in my state being maryland 15,000 people are arrested that cost 30,000 dollars plus a piece to keep incarcerated totals 450 million dollars spent about a plant is preposterous. If you look at states who have fully legalised youll see that the business offering canna products, the rec dispensaries, the general communities are thriving. The plant brings financial, medicinal, and spiritual benefit to everyone that it blesses. I cant even begin to imagine where i would be without it and the answer is pribably dead truly. I wish that this medicine wouldnt be as scrutinized as it is. The plant deserves full legalization for so many reasons but a large one being people like myself are losing their very lives and futures over something they had such pure intentions for. Non violent, humans that are not rapists, murderers, thieves, burglars, etc have to sit with those previously mentioned. I hope that the people can safely improve their quality of living soon and that you all will realise the importance of safe access to true medicines. I also hope you have a wonderful day and thank you for reading.

Slater, Sandy R. EOP/ONDCP

From: T <(b)(6)>
Sent: Tuesday, July 20, 2021 5:30 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Cannabis Rules & Regulations

There need to be reparations going directly to the Black community in the form of direct payments and coming from businesses that are currently profiting off of cannabis as many Black Americans sit in or have sat in jail/prison because of cannabis-related charges. Even still today LAPD is proportionately pulling over Black Americans for the alleged smell of cannabis per the officer's original reasoning for pulling the said black drivers over, only to find out that many a times no weed was found in the vehicle! The pretend "war on drugs" created by the American Govt has destroyed & disrupted the lives of many Black Americans! Black Americans make up over 30% of the unhoused population in LA County even though they are only 8% of the total population in LA County!
#FakeEminentDomain

When it comes to addressing these systematic issues of Cannabis, I encourage the following;

1. Direct community investments in Black communities, support programs for youth crime & gang prevention.
2. Invest in community services by offering funding for housing & social service needs within Black / Brown communities.
3. Invest in direct cash payments to Black/Brown community members.
4. Make licensing easy/free for potential cannabis owners from the black/brown community.
6. When we talk about systematic issues please remember that they are generational, offer support to descendants of those affected by systematic abuse, those are still living within the conditions created by the systematic abuse.
5. Support small growers and require cities to respect voter mandate in regards to cannabis (Antelope Valley San Bernadino, etc. LA County Sheriff and the LA County Board of Supervisors violation.)
6. Push to legalize cannabis on a federal level; Push to support online e-commerce-to-delivery businesses.
7. Push for sales tax to be permanently used for affordable housing needs and direct community investments in the youth, eradicating poverty.

--

Best,
Tieira

www.HTWWS.org

Slater, Sandy R. EOP/ONDCP

From: Lynne Hall <(b)(6)>
Sent: Thursday, July 22, 2021 11:58 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] For FDA on CDC 2016 guidelines on opioid MME

As a disabled American Indian living in a rural area, I thank you for taking comments.

The entire Guidelines should be thrown out.

As most people know the first sign that something is wrong is pain. Most doctor's will take a person seriously and give them something to help them, while ordering test and blood work.

Doctor's are not stupid! After such test a treatment plan is developed but did they give the doctor a chance? Did they wait to see what the doctor would do? No!

No, one script and it's jail. Set up and their patients out of luck! GOOD JOB!

So much easier to pick up a phone book than to do a proper investigation.

My dead doctor had told me the truth. If you come in here for pain and I try to help you I'd go to jail, but if you go to street and get some marijuana you'll only get a slap on the wrist! The last thing he said was he didn't want to see me back in a chair, but that's what happened.

He had treated me for 30 plus years and had to stop. He had sent me for test regularly every 3 months all those years and we had a honest relationship. But I was sentenced to pain management, where for 2 years no one even read my file. I ha ARD which they bill as Acute respiratory distress not Adhensions Related disorder. And on the last visit my blood pressure was dangerously high. I was told it was Pain related but there was nothing they could do, because the doctor was at the beach at this new office. And to go to the emergency room. At a pain management clinic, that took over 9 months to see the doctor who signed my scripts!

You have allowed 490 pill mills to exist. I know for a fact 2 of my wealthy friends never got tapered and receive over the 90 MME. The rest of us got cut from Dr Durtett of the pain and brain Palmetto pain clinic in Aiken SC.

So not equal treatment. Only care for the rich.

Message we want the poor to die or suffer. SO CDC SUCCESS.

ALSO DO NOT GET SICK AS A CHILD. YOU WILL BE SCREWED AS AN ADULT

Don't join the service unless you hope to die, because you will die in pain if you get hurt beyond repair.

Why not set up Assisted Suicide if you aren't going to treat people as individuals?

Do not think for a minute that this isn't discussed around every family dinner table.

No one trust the CDC! My 3 grandsons will never play sports. People are aware of what you have let happen.

American is Nazi Germany now. The CDC has made law. Not how we were taught

Here in SC we know Graham doesn't care, but will help you get disability and let you become bedridden. Lose your job, lose any quality of life. He only wants donations from those poor sick people. And what Thrump wants. I can forward his emails.

We can't wait for this injustice to be fixed in a year. Doctor's are choosing to retire. People are dying by choice or accident because you have allowed this to go on for far to long.

Stop it now!

Thank you for the opportunity to comment.

Lynne Hall

Legacy pain patient since age 11.

Sent from my iPhone

Slater, Sandy R. EOP/ONDCP

From: Andrew Klein <(b)(6)>
Sent: Tuesday, July 27, 2021 4:41 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Comments on ONDCP and equity

The failure of the nation's jails to provide robust drug and alcohol withdrawal management and treatment continues to be an increasing cause of jail deaths. According to the latest Bureau of Justice Statistics report on jail fatalities (*Mortality in Local Jails, 2000-2018-Statistical Tables, April 2021*), the mortality rate from drug and alcohol intoxication has more than quadrupled since 2000. In fact deaths were up 19% over the last two years alone and are undoubtedly still rising as the opioid epidemic continues unabated. The failure to address these rising jail deaths also underscores the continuing racial inequality in the nation's response to the drug epidemic as the jail population is disproportionately non-White. As of the latest BJS report, the jail rate for Blacks in 2018 was 592 per 100,000, for Indigenous Americans and Native Alaskans it was 401 per 100,000, compared to 187 for Whites. (Z. Zheng, Jail Inmates in 2018 Bulletin, March 2020, NCJ 253044.) The majority of the more than ten million Americans who cycle through local jails each year suffer from alcohol and substance use disorders. It is estimate that up to 65% suffer from a substance use disorder (see, e.g., Criminal Justice Drug Facts, NIDA website (><https://www.drugabuse.gov/publications/drugfacts/criminal-justice#ref><)). As a result, jails have become the primary *de facto* drug detoxification facilities for the nation. Yet, according to the U.S. Department of Justice, as of 2009, only 2% of jailed individuals withdrawing from substances were provided specific withdrawal treatment (J. Bronson, et. al. Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Bureau of Justice Statistics, 2017). The figure has increased since then, but still represents only a small fraction of the nation's more than 3,100 jails. The vast majority of jails do not, for example, provide access to standard medications for opioid and alcohol use disorders. Repeatedly across the nation, incarcerated individuals have had to sue in federal court to be able to access these medications even when they have current, valid prescriptions.

Last January, the U.S. Department of Justice Civil Rights Division and the U.S. Attorney's Office for the District of New Jersey released its investigation report on the Cumberland County Jail in Bridgeton, New Jersey after six inmates had died by suicide withdrawing from opioids. It concluded that "Opioid Withdrawal, Left Untreated, Has Serious Medical Consequences for Inmates Including Increased Risk of Suicide." Further, the failure of the jail to provide withdrawal treatment represented a violation of the detainees constitutional rights.

Unless and until incarcerated persons, including those detained in the nation's jails awaiting trial, have equal access to safe withdrawal management and treatment as provided others in the community, there can be no racial equity in this nation's response to the drug crisis. While the Bureau of Justice Assistance and the Substance Abuse and Mental Health Services Administration provide grants to promote drug treatment in select jails and prisons, and federal court rulings and Justice Department investigations such as the one completed in New Jersey address individual jails, there is no national coordinated leadership to ensure that the disproportionate Black population in jails receive life-saving withdrawal management, much less equal access to drug treatment. Most of the nation's jails operate independently without oversight. Most are severely under resourced medically. Without the national leadership that should be provided by ONDCP to ensure jails provide safe and appropriate drug withdrawal management and treatment, the nation's drug control policy will continue to be racially unequal.

It should also go without saying, that if this nation is to confront its drug problem, continuing to largely ignore the largest, most concentrated population of those with substance use disorders, is a losing national drug control strategy, representing the largest missed opportunity available to reach out to millions of persons in desperate need of treatment every year.

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Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0012

Anonymous Comment

Submitter Information

Name: Anonymous Anonymous

Email: (b)(6)

General Comment

I am a chronic pain patient on long term opiate therapy. I can't find a new doctor willing to see my as my PCP just because of the CDC guidelines. Long term opiate therapy is the only solution that has given me any quality of life yet every month I go through such anxiety is this the month I loose access or start getting force tapered only because of the CDC guidelines. They have caused millions of patients to loose access to the only medication that was helping them have any semblance of quality of life.

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Document: ONDCP-2021-0001-DRAFT-0003

Comment from Ashley, Shukait

Submitter Information

Name: Ashley Shukait

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Belleville, MI, 48111

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General Comment

The COVID-19 pandemic exacerbates existing inequities in our community, disproportionately impacting Black, Indigenous, Latinx and low income communities and further for those who identify as LGBTQIA+. The realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequities affect both people's vulnerability to and capacity for effectively dealing with drug-related harms.

Persons who use substances deserve the dignity, compassion, and respect that we offer to all other individuals. The COVID-19 pandemic and its public health responses have unintentionally resulted in increased overdose deaths, creating a storm of syndemics. Direct action to ensure multi-level approaches with evidence-based practices, pragmatism, and compassion are critical to addressing the harms caused by the criminalization of substance use and racialized policies for health equity and social justice.

When the federal government and affiliating agencies focus on criminalization of substance use, no matter how it is framed, forced treatment is still punitive and does not support trauma-informed or healing environments. Harm reduction works, but yet many interventions are not possible because of federal policies and the disconnect between state and local municipalities.

Harm reduction implements best-practices and utilizes a health-centered response to drug use that assesses improvement by many measures – not simply by people's drug use levels, but also by their personal health, employment status, social relationships and general wellbeing. While multiple federal and state governmental agencies such as CDC and SAMHSA are starting to

recognize syringe service programs as comprehensive services that address health issues of HIV, viral hepatitis, overdose, skin and soft tissue infections and substance use management utilizing a harm reduction trauma-healing philosophy, it is NOT enough.

The stigma of substance use, leads to discriminatory practices in health care, public health and social services. The criminalization of substance use, keeps programs from implementing the vary practices that the CDC is currently funding. For example, Syringe Service Programs have historically been under-funded and criminalized. What maybe allowed per state laws, may not be allowed in local municipalities. When paraphernalia is illegal, individuals are forced to reuse equipment, such as syringes, increasing the risks of HIV/HCV, infective endocarditis, and death. This also leads to discarding of syringes in places that cause the very complaint against syringe service programs, when in reality, it is due to the fear of arrests. When substances are criminalized, it is not solely using that substance causing the overdose risks, it is because they had to use alone, often times behind a locked door with no support for accessing the help and services that could of provided the compassion and support they needed to prevent the loss of life.

There are over 30 years of documented evidence to support harm reduction services, including overdose prevention centers/safe consumption sites/harm reduction centers. There is 20 years of evidence, now acknowledged by the CDC that the drug poisonings are due to illicitly manufactured fentanyl, adulterants, and usually involve multiple substances.

At what point do those in charge of a country say enough is enough, what we have done for 50 years isn't working and care about the disproportionate impacts on it's most historically oppressed communities? At what point do we listen to those who are most impacted, as they are closest to the solution? If we cannot have an honest conversation, admit to the wrongs and develop changes that are led by science and best-practice, then we are not only setting future generations up for failure.

Here is a blog I did for Harvard, related to Health equity and reproductive justice.

<http://info.primarycare.hms.harvard.edu/blog/transforming-perinatal-care>

I have attached two bibliographies of documented evidence of harm reduction and some quick fact sheets from The National Harm Reduction Coalition.

Please, include harm reductionist, people who use drugs, and those impacted directly by the criminalization of substance use to all aspects of programs, policies, and decision making of the ONDCP.

Thank you,

Ashley Shukait, MPH, CHES

Attachments

72221 Bibliography

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FOUNDATIONS OF HARM REDUCTION

HARM REDUCTION IS:

- Incorporating a spectrum of strategies including safer techniques, managed use, and abstinence
- A framework for understanding structural inequalities (poverty, racism, homophobia, etc.)
- Meeting people “where they’re at” but not leaving them there

WE USE **PEOPLE FIRST** LANGUAGE:

- A person is a person first, and a behavior is something that can change - terms like “drug addict” or “user” imply someone is “something” instead of describing a behavior
- Stigma is a barrier to care and we want people to feel comfortable when accessing our services
- People are more than their drug use and harm reduction focuses on the whole person

Health & dignity

Establishes quality of individual and community life and wellbeing as the criteria for successful interventions and policies

Participant centered Services

Calls for non-judgmental, noncoercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm

Participant Involvement

Ensures participants and communities impacted have a real voice in the creation of programs and policies designed to serve them

Participant Autonomy

Affirms participants as the primary agents of change, and seeks to empower participants to share information and support each other in strategies which meet their actual conditions of harm

Sociocultural Factors

Recognizes that the realities of various social inequalities affect both people’s vulnerability to and capacity for effectively dealing with potential harm

Pragmatism & Realism





Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use or other risk behaviors

WHY HARM REDUCTION WORKS

- Provides a space for people to be open about their drug use and sexual behavior so it’s not hidden, perpetuating feelings of isolation
- Values people and their expertise so they feel empowered to determine and voice their own hierarchy of need and next steps are clear between provider and participants
- It is rooted in evidence-based practices that have shown decreases in health and social harms
- Keeps individuals engaged in care if they relapse and at any stage in their drug use

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FOR MORE RESOURCES, VISIT [HARMREDUCTION.ORG](https://harmreduction.org)

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**NATIONAL
HARM REDUCTION
COALITION**

HARM REDUCTION INTERVENTIONS

(H)arm (R)eduction:

A philosophical and political movement focused on shifting power and resources to people most vulnerable to structural violence



(h)arm (r)eduction:

The approach and fundamental beliefs in how to provide the services



risk reduction:

Tools and services to reduce potential harm



The “risk itself (e.g. related to drug use or sex work) that you’re discussing

The “mindset” that someone brings to the situation, including thoughts, mood, and expectations



The physical and social environments of where the person is, and their perception of how that can promote/reduce risk

RISK

- What issue is being presented?
- What other possible sources of harm might be connected to the main issue?
- What drug is being used? What is the risk of overdose?

SET

- How are they feeling? Confident? Angry? Anxious?
- Are they physically in pain or hurt? Do they need to get well?
- Can they engage with you fully? Are their basic needs being met?

SETTING

- What is the physical environment where the potential harm is occurring? In a home? At work? On the street?
- Who is around them? Police, bystanders, other participants? How does the person present to these people? How will they react?

Case Study : Jessica

Jessica has been using heroin on and off for the past 10 years. Jessica stopped using for a few months while she was with her ex, but they recently broke up. She is feeling depressed and anxious and is looking to use again. She buys a bag and heads to the syringe exchange for some new points and heads to her encampment in a rush.

RESPECT TO CONNECT: UNDOING STIGMA

WHAT IS STIGMA?

Stigma is a social process linked to power and control which leads to creating stereotypes and assigning labels to those that are considered deviate from the norm or behave “badly” -- stigma creates the social conditions that makes people who use drugs believe they are not deserving of being treated with dignity & respect, perpetuating feelings of fear and isolation

WHAT DOES LIBERATION LOOK LIKE?

- Liberation is the act of setting someone free from imprisonment, slavery, or oppression
- In the context of drug use & sex work, liberation is about freedom from thoughts or behavior -- “the way it’s supposed to be” -- and how we are conditioned to perpetuate harms to others

WHAT DOES STIGMA LOOK LIKE?

- Stigma limits a person’s ability to access services they need because they feel unworthy of receiving or requesting services
- Stigma creates barriers while receiving services by people feeling unwelcome or judged by program staff that offers services

TREE OF LIBERATION

Leaves: Actions

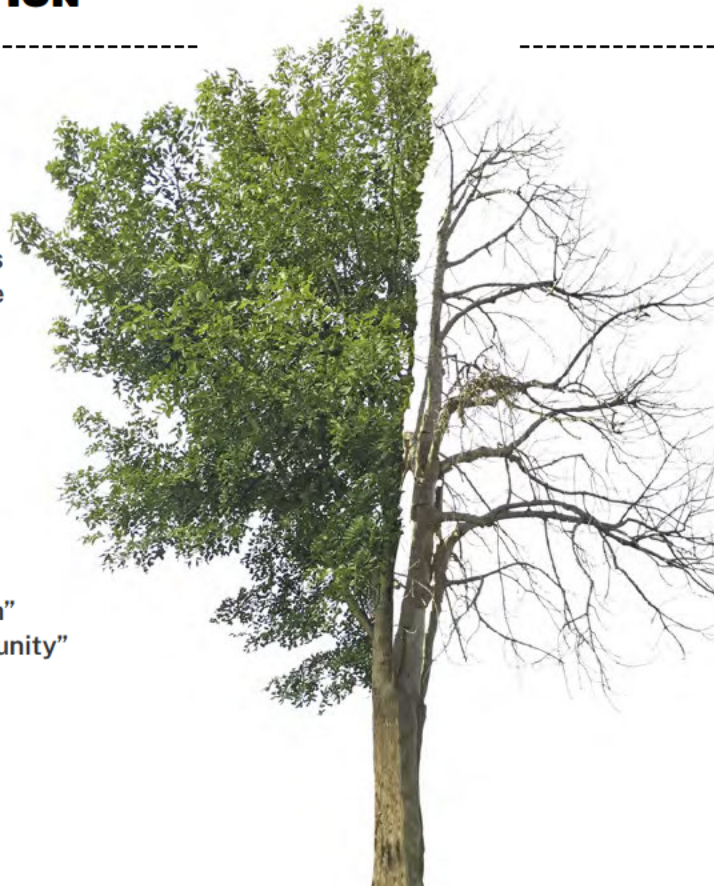
- Create plans together based on their goals
- Ask clarifying questions to understand the whole story & needs
- Share resources & education for their friends to have

Trunk: Beliefs

“They can do _____”
“They’re telling me the truth”
“They care about the community”

Roots: Perceptions

Capable
Trustworthy
Caring



TREE OF STIGMA

Leaves: Actions

- Ignore the story & project your own agenda
- Require mandatory XYZ because “they won’t do it otherwise”
- Only talk about the “disease” & not about what they have control over

Trunk: Beliefs

“They’re probably lying”
“They don’t have the willpower”
“They can’t help themselves”

Roots: Perceptions

Not trustworthy
Lazy
Sick

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FOR MORE RESOURCES, VISIT [HARMREDUCTION.ORG](https://harmreduction.org)

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**NATIONAL
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HOW WE STIGMATIZE PEOPLE

Pathologizing drug use & patronizing people who use drugs

Implying that people who use drugs are diseased, don't have control over themselves, or can't be trusted

Blaming people who use drugs & imposing our own moral judgements

Telling people that use drugs that they don't care about themselves or their community

Criminalizing people who use drugs

Asking someone who may look like they use drugs if they have ever been incarcerated during an employment interview & being immediately disqualified

Creating fear around people who use drugs which serves to isolate them

Believing people that people who use drugs are morally corrupt, untrustworthy, dangerous to children & the community

HOW YOU CAN BRING IT TO YOUR WORK



Actively include people who use drugs & experience marginalization for their expertise when developing new programming or evaluating current one



Ensure services are grounded in an understanding of how people's health, priorities, & experiences are shaped by the criminalization of drug use



Emphasize building relationships & trust with people who use drugs as important outcomes



Ensure all services are provided in a culture of respect & safety within workplace



Consider how past histories of trauma, violence, layers of disadvantage & stigma may affect a person's ability to engage with providers



Review documents & materials to ensure we are using people first language/non-stigmatizing language & change them if necessary

SAFE(R) DRUG USE

WAYS PEOPLE USE DRUGS

Smoking

Using a pipe, stem, or bong. Make sure everyone has their own pipe or mouthpiece. If you are smoking crack, use a filter.

Snorting

Crush powder as fine as possible & make sure everyone has their own straw. Alternate nostrils between hits.

Swallowing

Pills, crushed in thin paper, or a drink. Mix your own drink so you know how strong it is. Can take up to an hour to kick in so wait a while before consuming more.

Booty Bumping

Use a turkey baster or syringe without a needle. Avoid sharing equipment and get vaccinated for Hep A.

Injecting

Use your own sterile syringes & gear. If you need to reuse syringes, wash with cold water, bleach, & then water again.

BENEFITS OF INJECTING DRUGS

- Very efficient way to use - drugs are absorbed directly into the bloodstream. This can lead to a more intense & longer high.
- Can be more economically efficient - folks may need less drugs compared to smoking or snorting, which saves money.

RISKS OF INJECTING DRUGS

- Criminalization of injection paraphernalia.
- If sharing equipment, HIV/Hep C transmission.
- Higher rates of overdose & overdose related death for people injecting drugs compared to smoking or snorting.
- Skin and soft tissue infections, such as abscess and other bacterial infections - some can be fatal.

SAFER INJECTION TIPS

#1 | Prepare Yourself

- Find a safe, clean, well-lit area
- Clean hands or fingertips with soap & water or an alcohol pad
- Wipe injection area with alcohol pad in one direction

#2 | Prepare Solution

- Using your own clean cooker or spoon, mix drugs with sterile water; heat (add Vitamin C if necessary)
- Add a filter (piece of cotton ball or pellet, AVOID cigarette filters) using clean fingertips
- Insert tip of syringe into filter and pull up solution

#3 | Find A Vein

- Body heat can help veins be more accessible - find a warm place or bundle up!
- Use a tourniquet a few inches above the injection site to help the vein plump up (avoid using shoestrings or leather belts)
- Insert the needle bevel up into the vein.

#4 | Register Your Shot

- Before injecting, pull back slightly on the syringe to check for dark red blood (this means you hit a vein).
- If the blood is bright red, frothy, & pushes back the plunger, you hit an artery, take the syringe out immediately and seek medical advice!
- After registering, release tourniquet before injecting.

#5 | Do A Test Shot

- Inject a little bit of drug solution to "taste" and test strength & effect before injecting more from that syringe
- This can help prevent overdose.

#6 | Inject & Tidy Up

- Once you finish injecting, dispose of used syringe in a sharps container.

There are many reasons why people cannot adopt all these steps. If you can use as many of these as possible regularly, it will dramatically reduce harm. Even using just one reduces harm - celebrate small steps/any positive change!

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FOR MORE RESOURCES, VISIT [HARMREDUCTION.ORG](https://harmreduction.org)

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SKIN & SOFT TISSUE INFECTIONS (SSTI)

What are SSTI's?

- Skin and soft tissue infections (or SSTIs) are bacterial infections such as abscesses, cotton fever, and endocarditis.
- For people who inject drugs, they can be caused by improperly cleaned skin, a missed shot, non-sterile injection equipment, or contaminated drugs.
- It's critical to provide both the equipment & safer injection education to promote the safest possible injection every time.

Signs of an SSTI

- Bad odor or smell
- Affected area getting bigger
- Redness around edges
- Swelling
- Tenderness
- Thick pus
- Fever/chills
- Pain or loss of feeling

When someone presents with a wound that is causing them pain or other distress our first recommendation is ALWAYS they see a medical professional for diagnosis & treatment. Even if you are 99.9% sure something is wrong only a medical professional can give a diagnosis.

HOW TO MANAGE SSTI'S

- Symptoms might not always appear at the injection site.
- If you miss a shot, apply ICE or frozen item (peas, snow, cold drink) on the same day & elevate. If swelling occurs the next day, apply HEAT regularly using a cloth soaked in hot water, in a sink of warm water, or using a hand warmer.
- Avoid injection at or below the affected area.
- Do not squeeze or poke an abscess. This can introduce more bacteria to the wound.
- If things don't improve after 3 days, or if you are experiencing chills, fever, extreme fatigue or pain on the abscess, SEEK MEDICAL ATTENTION. This may be a blood infection which could be deadly.

HOW TO AVOID SSTI'S

- Clean skin prior to injection, including injection site & fingertips.
- Use sterile equipment including syringes, cookers, & cottons.
- Use safe injection techniques (see front) to avoid missed shots & vein injury.
- Cover injection site with a band aid to prevent bacteria from entering.

PROVIDER TIPS

Ask & Listen:

Your participants are the experts! They can tell you what they know, what they need, what's working, & what's not.

Research:

There are plenty of resources out there to help you.

Provide Options:

Cater to a range of ways that people take their drugs by offering a variety of safer use/sex options.

Celebrate Small Steps:

Celebrate small steps: Affirm any positive change!

RESOURCES

National Harm Reduction Coalition:
harmreduction.org

Exchange Supplies:
exchangesupplies.org

Safety Works:
1800safety2.com

Injecting Advice:
injectingadvice.com

Tips:
harmreduction.tips

SEX WORK & HARM REDUCTION

WHAT IS SEX WORK?

Provision of sexual services or performances by one person (Sex Worker) for which a second person (Client or Observer) provides money or other markers of economic value.

These markers of economic value may include:

- money
- food
- shelter
- drugs
- and more

SEX WORK IS AN UMBRELLA TERM INCLUSIVE OF

- Trade sex
- Porn performance
- Dancing
- Phone
- Web cam/internet
- Survival-based
- Street-based
- BDSM
- Magazine
- Film/Video
- Out Calls / In Calls
- & more

SEX WORK CAN BE LICIT OR ILLICIT



In situations of illicit sex work, risk is involved for all three parties.

SEX WORK INVOLVES A

- Worker
- Consumer
- Often times, Manager

WHAT IS SESTA/FOSTA?

What is it?

- Stop Enabling Sex Traffickers Act / Fight Online Sex Trafficking Act
- Bipartisan bill passed by House & Senate March 2018, signed April 2018.

How does it work?





- Makes third party sites responsible for posting ads for sex workers – legally liable for trafficking.
- Since its passage, Craigslist personals, Backpage, and other sites have been pulled down.

What's the impact?

- Makes it more difficult for sex workers to find & screen clients.
- Pushes people out into the street again – putting sex workers of color, of trans identity, and/or of undocumented status further at risk.
- Creates more competition & more risk for sex workers who are 100% street-based (& often survival-based).
- Puts people MORE at risk of being trafficked.

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WHY DO PEOPLE ENGAGE IN SEX WORK?

Choice

- Julia chooses to work as a dominatrix because the work is profitable & she enjoys it.
- Julia chooses to do sex work.

Circumstance

- Mark is marginally housed, & engages in a relationship with Peter to have a place to sleep.
- His sex work is circumstantial.

Coercion

- Leah's partner coerces her into trading sex with their supplier in exchange for drugs even though she doesn't want to.
- This is a human rights violation & not the same as consensual sex work.

SEX WORK IS WORK

Everyone who engages in sex work has personal, unique reasons for doing so.

Sex work is one of the few trades in which someone without any formal education can provide for themselves at an equal level to someone with an advanced degree.

However, sex workers who hold marginalized identities are uniquely vulnerable to racism, transphobia, xenophobia, classism, & other forms of structural violence.

HARM REDUCTION INTERVENTIONS

Drop-in center

Community organizing & Policy change

Intracommunity skill sharing

Street outreach

Don't assume! Don't try to 'save' anyone from sex work Bad date sheet

Safer drug use & overdose prevention materials

Medical & health services

Safer sex materials & education

Bad date sheet

Offer anonymous testing services

Offer hand sanitizer, antiseptic wipes, mouthwash, makeup remover towelettes

RESOURCES

St. James Infirmary:
stjamesinfirmary.org

SWOP Bay Area:
facebook.com/swopbay

SWOP Behind Bars:
swopbehindbars.org

BaySWAN:
bayswan.org

Sex Workers Project:
sexworkersproject.org

Slater, Sandy R. EOP/ONDCP

From: Andrew Klein <(b)(6)>
Sent: Thursday, July 29, 2021 8:10 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] racial equity

An addendum to my comments sent 7/27.

Research confirms that current national drug control policy is failing to reach Black Americans.

Donohue, J.M., Jarlenski, M.P, Kim, J.Y., Tang, L., Ahrens, K., Allen, L., Austin, A., Barnes, A.J., Burns, M., Chang, C.H., Clark, S., Cole, E., Crane, D., Cunningham, P., Idala, D., Junker, S., Lanier, P., Mauk, R., McDuffie, M.J., Mohamoud, S., Pauly, N., Sheets, L., Talbert, J., Zivin, K., Gordon, A.J., Kennedy, S. (2021). Use of Medications for Treatment of Opioid Use Disorder Among US Medicaid Enrollees in 11 States, 2014-2018. Journal of American Medical Association. 326(2), 154-164. Doi: 10.1001/jama.2021.7374

A cross-sectional study examined how opioid use disorder (OUD) treatment among Medicaid enrollees changed from 2014 to 2018. Administrative codes were analyzed from inpatient stays, outpatient facilities and offices from 1,024,301 Medicaid enrollees from 11 states (Delaware, Kentucky, Maryland, Maine, Michigan, North Carolina, Ohio, Pennsylvania, Virginia, West Virginia, and Wisconsin) diagnosed with OUD. A majority of Medicaid enrollees in this study were women (51.2%), 21 to 34 years old (41.7%), non-Hispanic White (76.1%), and had another substance use disorder (50.6%).

Findings:

Although medication for OUD increased from 47.8% in 2014 to 57.1% in 2018, non-Hispanic Black enrollees had the lowest rates of OUD medication and were less likely to retain treatment.

Across 11 U.S. states there was an increase in the use of opioid use disorder medications among Medicaid enrollees from 2014 to 2018 from 47.8% to 57.1%. Non-Hispanic black enrollees, however, were found to be the least likely to use opioid medication and retain treatment.

Andrew Klein

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Slater, Sandy R. EOP/ONDCP

From: Hcdavis <(b)(6)>
Sent: Friday, July 30, 2021 4:10 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Comment

ONDCP comment

I am a disabled attorney in Delaware. Henry Clay Davis, (b)(6)

You can start by preventing DEA from practicing medicine without a license and committing malpractice while doing so.

That way you would have less inappropriate interference with actual doctors treating disabled people. People in pain that never ends, allergic people without access to a full a month supply of the most commonly used decongestant prior to it being made OTC as safe enough but the DEA hamhandedly limiting access to less than 20 days supply in an effort (a futile one judging from reports) to limit manufacture of methamphetamine, encouraging medical experimentation on pain patients in the VA & in the general populace & other drug war fueled atrocities. (Alternative medication practices for anesthesia and pain control after surgery is now replete with cocktails of various sorts to avoid using ordinary opiates but not studied for efficacy or safety. That used to be illegal experimentation on humans but now seems commonplace.)

Lack of access to multiple specific use strains of cannabis because DEA insists on control of production of a beneficial weed harms everyone. It made cannabis into a demon drug with no medical use, or even subject to more study, for racist motives and hysteria building the budgets of enforcement. It reflects a fever pitch associated with failed Prohibition practices. It is also a gathering of effective power by federal enforcement rather than scientific evaluation of the plant, thus preventing its use the same as the prior obviously racist motives.

You might also curb the suicide of veterans over untreated pain from war injuries caused by offering them yoga classes and massages instead of the cheap 5,500 year old medically acceptable remedy that is readily available but forbidden to them. (Opiates)

People of color are likewise treated as "drug seekers" merely for seeking effective pain control. While regularly DEA agents appear in public to boast about "fighting" the drug war, they lock up effective pain treatment when there is no effective alternative offered or available anywhere. Further they pontificate about prohibition policies that have been proven to be counterproductive by a national experiment with alcohol "control" and military style enforcement. While regularly you have to discipline, fire, and incarcerate Agents of the very agency that does this idiotic "enforcement" for corrupt dealing with the cartels that are actually causing the OD crisis to spin out of control with cheap smuggled fentanyl. When are you people going to get a clue?

We just had a pandemic where we essentially exhausted the opiate supply given how much was needed to intubate patients and manage their pain while on and off a ventilator. The DEA simply ignored that and has scheduled further reduction in the national supply despite having previously cut the 25% safety margin of previous years which was the cause of short supply in the pandemic.

Stupid, myopic, harm inducing policies and practices with little to recommend them except racism, stigma, and a failure to learn from the Prohibition effort that utterly failed despite nation wide efforts & amendment of the constitution.

Shooting yourself in the foot is stupid, but the feet getting hit are also the disabled, people of color and the poor. Shame is a paltry weapon to use when the money is on the other side and you listen to opioid hysteria propaganda from PROP and shatterproof, but it's the only weapon we have left.

END THE DRUG WAR. You lost. Start really implementing harm prevention instead of equine feces prohibition based policies. Do it across the board and quickly and you will see a massive declines in street drug ODs, people in constant pain dying, and veteran suicide. Illicit fentanyl and polypharmaceutical drug use for other than medical reasons are the overwhelming cause of the real epidemic in drug use in the USA — the epidemic of overdose and people harmed by the boneheaded policies of multiple agencies that leads to suicide. While you are at it, make cannabis legal to possess, grow, & sell, subject to reasonable regulation by almost anyone but the DEA.

Respectfully submitted, Henry C. Davis.

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Comment from Ingrid, Walker

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General Comment

Dear Executive Office of the President,

I am a drug researcher whose work examines why our drug policies do not serve us a country and people. My research of the last 5 years has specifically focused on working with other drug researchers to identify what it is that we do not know or research, the impacts of those gaps, and exploring ways to fill those knowledge gaps. An article I co-authored with Dr. Jules Netherland ("Developing a Transformative Drug Policy Research Agenda in the United States") that lays out the concerns and recommendations of researchers and the primary gaps in our knowledge base. This series of studies was aimed at improving drug policy. Among the major issues identified was the lack of participation of people who use drugs in the development of primary drug research.

That project led to a survey (just completed - we are still reviewing the data) of drug researchers about the reasons that they struggle to include people who use drugs in their research. A top reason has to do with the funding stream and the ways in which the National Institute of Drug Abuse (and other funders) privilege certain kinds of research over others. One of the recommendations of the researchers, cited in our article about developing a better research base, is to provide funding for ethnographic research and studies that examine social structural determinants for substance use disorder and other kinds of substance use.

It's important to note that while more than 85% of people who use drugs do not suffer chaotic use

("addiction" or "abuse"), the vast majority of our research is focused on that important minority. By not researching the entire spectrum of drug use, we reinforce misguided notions about drugs and their users and perpetuate harmful policies.

I urge you to look at the recommendations in the attached article, which speak to the concerns you've raised about equity and the inclusion of people who use drugs in research and policy-making.

Developing a Transformative Drug Policy Research Agenda in the United States:
<https://journals.sagepub.com/doi/10.1177/0091450918811178>.

Sincerely,

Dr. Ingrid Walker
University of Washington, Tacoma

Attachments

TransformativeDrugResearchAgenda_Walker_Netherland

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Ingrid Walker¹ and Julie Netherland²

Abstract

Despite its strengths, drug policy scholarship in the United States has deficiencies and systemic biases that contribute to misinformation about drugs and people who use drugs. Factors ranging from funders' biases to an overemphasis on abstinence-only outcomes limit the scope and focus of drug policy research. These deficiencies and the highly politicized nature of drug policy reform have led U.S. decision-makers to largely reproduce the uninformed thinking that epitomizes failed drug policies. In an effort to address some of these limitations, we designed Unbounded Knowledge: Envisioning a New Future for Drug Policy Research, a project to engage researchers in thinking about how U.S. drug policy research should be transformed. The project involved a diverse group of multidisciplinary drug researchers and clinicians in a focused collaboration to identify what drug research should be—but is not—studying in the U.S. It consisted of: (1) a preliminary series of interviews with researchers, (2) identification of common research constraints and factors that would transform the direction of drug policy research in the U.S., and (3) a daylong workshop to craft an aspirational research agenda. Participants were broadly in consensus that significant changes are needed to create different ways to conduct drug policy research and new opportunities within the research environment. They also generated specific ideas for research that could better shape U.S. drug policies in ways that move beyond the dominant focus on criminalization and medicalization. This article offers recommendations generated by the project for improving drug policy research in the U.S.

Keywords

drug policy, research methods, research funding, harm reduction, United States

Introduction

Drug policy in the United States has been influenced by multiple forces, including medicalization, harm reduction, and decriminalization, but among them, prohibition remains dominant. Researchers in

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the U.S. have produced a breadth of high-quality work in this context, and yet the narrow prohibitionist framework of American drug policy continues to influence and constrain the research it helps fund and produce. Some U.S. scholars note that drug policy research can manifest assumptions, deficiencies, and systemic biases that contribute to misinformation about drugs and people who use drugs (Brownstein, 2016; G. Hunt, Milhet, & Bergeron, 2011; Kilmer, Caulkins, Pacula, & Reuter, 2012; Kleinman, Caulkins, Hawken, & Kilmer, 2012; National Research Council, 2001; Netherland, 2016). In a recent example, in 2015, Nancy Campbell and David Herzberg hosted a U.S. symposium calling for the incorporation of gender analysis into critical drug scholarship (Campbell & Herzberg, 2017). Yet, such critical analyses remain a subset of U.S. drug research. As a result, conversations about drug use in the public sphere, including those among policymakers, media, researchers, and the general public, reveal a wide variety of thinking about who uses drugs, why, and with what outcomes. Many researchers in the U.S. struggle with the prohibitionist model's constraints and conditions, particularly its reductionist perceptions of drugs and people who use drugs through the lenses of criminalization and the medicalization of addiction (Alexander, 2011; Clark, 2011; Conrad & Schneider, 1980; Garriott, 2013; Granfield & Reinarman, 2014; Hansen, 2017; G. Hunt & Barker, 2001; G. P. Hunt, Evans, & Kares, 2007; Netherland, 2012; Raikhel & Garriott, 2013; Reinarman, 2005). Historically, much of this misunderstanding has been driven by racism, classism, and stigma about people who use illegal drugs and has resulted in punitive and largely ineffectual policies (Mauer, 1999; McKim, 2017; Sales & Murphy, 2007). While elsewhere in the world there may be a "quiet revolution" happening within drug policy research (Brownstein, 2016), in the U.S., the community of critical drug researchers is relatively small, and drug policy research remains largely bound by the ideologies of criminalization and medicalization (Netherland, 2012).

These deeply entrenched ideological forces affect drug policy, in that "the fundamental inconsistencies of drug prohibition continue to be accommodated in policy reform" (Taylor, Buchanan, & Ayres, 2016, p. 453). We argue that the same can be said of the vast majority of drug policy and addiction research in the U.S.: Because it accommodates and functions within the prohibitionist framework, it has limited effectiveness in producing new ideas or in helping propel forward needed changes. Indeed, Lancaster (2016) has pointed out that the "evidence" produced by researchers does not sit outside of the policy process but that policy processes and evidence are interrelated, each helping to enact the other. What we mean by "addiction" or "drugs" is constantly in flux, reflecting contemporary understandings and sociopolitical debates far more than any truths inherent in those concepts (Fraser, Moore, & Keane, 2014; Keane, 2002; Netherland, 2012). Often, U.S. research on drug policy and addiction reinforces the assumptions of the policy and cultural framework in which it is situated resulting, for example, in an overemphasis on abstinence-only or prohibition-related outcomes with a focus on pathology, loss of control, and the harms associated with "problematic use" (Frank & Nagel, 2017; Heather, 2017; G. Hunt & Barker, 2001). At the same time, this frame and related drug policy research ignore the vast majority of drug use that is recreational and functional, while taking for granted the arbitrary lines drawn between legal and illegal substances. In the U.S., the ways in which prohibition has constituted a cultural understanding of drugs and users continue to produce problems with particular meanings, "problems" that reinforce assumptions about drugs and users rather than open new solutions at the state and federal levels (Bacchi, 2012). This understanding of drug policy as one site in which "the politics and materiality of drugs are made" (Fraser & Moore, 2011, p. 500) reflects the indeterminacy of "drugs" and "users," even as it acknowledges the dominance of prohibitionist knowledge production.

Additionally, how research informs policy poses particularly challenging systemic issues in the U.S. (Brownstein, 2013; Daniels & Thistlewaite, 2016; Gstrein, 2018; Stein & Daniels, 2017). Almost two decades ago, the U.S. National Research Council's (NRC) comprehensive report argued that the nation's data and research programs were "strikingly inadequate to support the full range of policy decisions that the nation must make" (NRC, 2001, p. 1). Little has changed to improve the "woeful lack

of investment in programs of data collection and empirical research” about drug use to assess and inform drug policy (NRC, 2001, pp. 1, 7). Despite recognized limitations in methods, common data sets like the National Survey on Drug Use and Health continue to be the standard in U.S. drug policy research (Barratt et al., 2017; Walker, 2017). Beyond the kinds of evidence that are produced, the dissemination of research suffers from a lack of communication among the disparate organizations, disciplines, and individuals involved in drug policy research—much of it is shared with small, focused audiences (Campbell & Herzberg, 2017; Kleinman et al., 2012; Peretti-Watel, 2011; Ritter, 2009; Taylor, 2016). Consequently, the use of research in policy-making is selective and tends to reinforce flawed understandings of both legal and illegal drugs and the people who use them (Du Rose, 2015; Hammersley, 2011; Moore, 2008; Ritter, 2009; Sturgeon-Adams, 2013; C. H. Weiss, 1983). This self-reinforcing dynamic extends to public discourse in the U.S., where the stigma, misinformation, and myths about drugs and people who use drugs persist, repeated even by reputable media outlets (Linnemann and Wall, 2013; Reeves & Campbell, 1994; Reinerman & Levine, 1989; Swalve & DeFoster, 2016; Walker, 2017). The highly politicized nature of drug policy reform, fed by a knowledge-deficit about drugs and the people who use them, has led U.S. decision-makers to largely reproduce the uninformed thinking that epitomizes failed drug policies.

What has been missing in the U.S. is a research agenda that attempts to address the systemic, fundamental fallacies of the prohibitionist framework. Gstrein (2018), in a scoping review of social construction and ideation research in drug policy, defines drug policy as “government policy that addresses issues arising from the use of illicit drugs, with a particular focus on health outcomes” (Gstrein, 2018, p. 76). We use “drug policy research” here to refer to this domain but also include research that concerns addiction, treatment, harm reduction interventions, drug supply and markets, and drug-related criminal justice research. Despite the emergence of research contesting reductionist notions of drugs and people who use them—more broadly outside of the U.S. but also as a minority voice within U.S. research (see, e.g., Bourgois & Schonberg, 2009; Campbell, 2002, 2007; Campbell & Herzberg, 2017; Granfield & Reinerman, 2014; G. Hunt et al., 2011; Moore, 2008; Netherland, 2012; Raikhel & Garriott, 2013; Reinerman, 2005)—dominant drug policy discourse in the U.S. continues to impede complex understanding of drug-related issues, perpetuating a research culture that confirms normative assumptions that drugs are a threat and precludes alternative knowledges and more holistic research programs. To make more effective interventions in the widespread effects of prohibitionist thinking, Taylor (2016) calls for a “collective action by critical scholars to contest these damaging processes,” for scholars to move forward with innovative research agendas and for scholars to “go public” even when they risk being “othered” and devalued (p. 101).

To focus on addressing these issues as well as answering the call for innovative research in the U.S., we initiated a project entitled, UnBounded Knowledge (UBK): Envisioning a New Future for Drug Policy Research. As a collaboration between a cultural studies scholar and a social scientist with a background in public health research, UBK brought concerns from those fields about the social construction of drugs and users to bear on the question of how U.S. drug policy research could be influenced to challenge (and think beyond) the cultural bounds of drug criminalization and medicalization. We also wanted to consider ways to approach related constraints within the U.S. research context, such as the lack of centralized data repositories, the absence of nationalized health care and attendant records, and the current inability to link administrative data systems at the level of individuals. The project included a diverse group of multidisciplinary drug researchers in a focused collaboration to identify what drug research in the U.S. should be (but is not) studying absent these constraints. UBK engaged this group of researchers through interviews and a structured, collaborative conversation to articulate ways to move past specific research barriers to create more interdisciplinary studies in areas that were identified as opportunities for and most critically in need of change. Through this project, we identified several key areas that would begin to move U.S. research beyond the current constraints, including new ways of doing drug policy research and specific research projects that

would help shift U.S. policy in new directions. In this article, we report on the project, particularly its emphasis on how to better inform research gaps in the U.S. through a collaborative, interdisciplinary approach.

U.S. Research Environment

Drug policy research in the U.S. has been shaped not only by the cultural context of stigma and biases about people who use drugs but also by systemic issues that have reinforced the prohibition model, such as how drug research is designed and funded, how academic incentives and organization shape research, and a variety of methodological limitations within drug research practices. Critical drug scholars, largely outside the U.S., have focused on the ways in which the roles of stakeholders, ideas, politics, and public discourse co-construct drug policy and its conception of drugs and users (Fraser & Moore, 2011; Gstrein, 2018; Lancaster, Ritter, & Diprose, 2018; MacGregor, 2013; Race, 2017; Smith, 2015; Thompson & Coveney, 2018). Such scholarship theorizes working more fluidly with the conceptual framework of evidence-based policy (EBP), pursuing ontological and epistemological questions about what and who constitute knowledge and evidence, and proposing “a post-evidence based approach to policy analysis” (Gstrein, 2018, p. 83). With drug policy research evolving in these theoretical directions elsewhere, we might ask how the U.S. drug policy research community remains somewhat entrenched in the EBP model and seems challenged to address its policy environment.

Two documents, produced 16 years apart, help illustrate some of the ways in which drug policy research in the U.S. has trouble identifying, much less critiquing, the prohibitionist framework that frames and helps produce it. The 2001 NRC report for the Office of National Drug Control Policy (ONDCP) laid out a series of recommendations for improving drug policy research in the U.S. While the report covers an astonishing amount of terrain, its primary conclusions were to invest in infrastructure and data systems to better assess illegal drug consumption and the effectiveness of enforcement policies aimed at drug users. Written in service of the ONDCP at a time when billions of dollars had already been spent on punitive drug policies resulting in the mass criminalization of hundreds of thousands of Americans, the authors call for better and more diverse evidence to support or challenge the effectiveness of those policies. However, they fail to challenge the fundamental drug war framework by, for instance, interrogating the arbitrary divisions between illicit and legal substances or calling for research into the underlying motivations or root causes of drug use. Even their nod to a reduction of the demand for drugs is focused on evaluating the effectiveness of sanctions to reduce demand. While the report recognizes limitations inherent in the ONDCP’s criminalization policy, such as the desirability of having better data about drug consumption, the NRC review is restricted in its ability to question some of the fundamental fallacies and assumptions undergirding it (NRC, 2001, pp. 3, 6, 11). This is not surprising at a time when the ONDCP’s budget tripled, escalating funding for the war on drugs and antidrug media campaigns (ONDCP H11225, 1998).

In 2018, more than 15 years later, the key funders of drug research in the U.S., the National Institutes of Health (NIH; Courtwright, 2010; Malizia & Ferro, 2014), received an additional \$500 million USD from Congress to address the opioid overdose crisis. In the research plan for the Helping to End Addiction Long-Term initiative, the NIH writes that it intends to focus on medications for treatment, overdose prevention, and reversal; neonatal abstinence syndrome; nonaddictive medications and alternative treatments to pain; and optimizing treatments for opioid use disorder with a focus on the expansion of medication-assisted therapies (Collins, Koroshetz, & Volkow, 2018). While all laudable goals, this research plan, like the one proposed by the NRC, likely does little to disrupt a policy framework that remains rooted in a narrow individualistic approach overly focused on the end point of addiction, one that does little to account for (much less intervene in) the social determinants of drug use, or employ additional harm reduction interventions proven effective internationally, such as safer consumption spaces or heroin-assisted treatment.

This challenge to establish a more expansive and critical research agenda in the U.S. is perhaps not surprising given that, in the U.S., drug research funding often comes with particular ideological purse strings. In addition to the federal mandate to sustain drug prohibition, the funding of drug policy research is tied not just to the drug war but to its twin logic, a medicalized understanding of drug use as addiction. The vast majority, up to 80%, of drug policy research is funded by the National Institute on Drug Abuse (NIDA; Malizia & Ferro, 2014), whose mission and scope are narrow: “to lead the Nation in bringing the power of science to bear on drug abuse and addiction” (Volkow, 2011). NIDA’s emphasis on addiction neuroscience has become a primary area in U.S. drug research (Campbell, 2007, 2010; Hall et al., 2015; Reinerman, 2005). Sociologist Scott Vrecko (2010) describes NIDA as largely responsible for making “the neuroscientists’ laboratory . . . an obligatory passage point for the production of truths about addiction” (p. 58). NIDA’s overemphasis on the brain de-emphasizes other systemic factors influencing drug use, such as poverty, racism, and the social environment (Hansen & Netherland, *in press*). A review of their 2016–2020 strategic plan reveals that NIDA generally does not intend to fund projects that examine harm reduction interventions, the therapeutic potential of drugs such as cannabis, or the harm associated with current drug policies grounded in abstinence, the threat of punishment, or its collateral consequences (NIDA, n.d.). For example, the words “harm reduction” appear nowhere in the 60-page strategic plan. Rather, NIDA spent 43% (\$438.1 million) of its budget on basic and clinical neuroscience; 25% (\$252 million) on epidemiology, services and, prevention research; and split 13% (\$131.9 million) between medications development and research into how specialists in infectious diseases common among people who use drugs can help screen and provide interventions for addiction. The remaining 19% (\$193.7 million) went to intramural research, support for a clinical trial network, and administrative support (Koch, 2015).

Some have argued that the NIH’s extramural funding system, including NIDA, creates another problem: It favors more experienced researchers over younger ones and more conservative projects over more innovative ones. According to an essay by four scientists, including Harold Varmus, MD, Nobel Prize co-recipient and once director of the NIH, “The system now favors those who can guarantee results rather than those with potentially path-breaking ideas that, by definition, cannot promise success” (Alberts, Kirschner, Tilghman, & Varmus, 2014, p. 5774).

In addition to issues of focus and funding, the field of U.S. drug policy research faces a number of methodological limitations, in part, stemming from the policy context that shapes it. For example, there is a considerable focus on the most extreme drug use (addiction) and its treatment to the exclusion of other drug use and natural recovery (Decorte, 2011; Granfield & Cloud, 1999; O’Malley & Valverde, 2004; Sobell, Ellingstad, & Sobell, 2000). The lack of a broad view of drug use means U.S. research consistently forgoes understanding the vast majority of people who use drugs, those who are self-regulating, and their motivations and concerns (Askew & Salinas, 2018; Duff, 2004; Fraser, 2008; Kiepek & Beagan, 2018; Race, 2009, 2017; Walker, 2017). Also, in the U.S. policy context, there is often a failure to adequately include and involve those directly impacted by drug use or drug policies in research design, collection, and interpretation of data based, in part, on stigma and assumptions about the inability of people to use drugs to engage meaningfully in such activities produced (Jürgens, 2005; Lancaster et al., 2018; Osborn & Small, 2006).

Taken together, all of these issues present a significant problem: They outline the context of what we in the U.S. can and do collectively “know” about drugs, the impact of our drug policies, and how to best respond to both ongoing and emerging drug-related problems. A significant challenge in the U.S. research environment is the self-fulfilling hold that the prohibitionist model has on many aspects of the drug policy landscape, from policy and funding to public health and public opinion. For example, in the midst of the current opioid overdose crisis, despite the emergence of interest in harm reduction strategies, the U.S. policy response to illegal drug use continues to be driven by prohibitionist and medicalized contexts. The federal government has doubled down on criminalization through mandates such as the U.S. Department of Justice’s (2018b) memos to “combat this deadly [opioid] epidemic” by

urging federal prosecutors to “consider every lawful tool at their disposal,” including “seeking capital punishment for certain drug-related crimes”. This followed a memo in which the U.S. Department of Justice (2018a) urged prosecutors to pursue marijuana violations to the fullest extent of the law. Further, because public drug discourse in the U.S. cannot seem to escape medicalization’s logic of illegal drug use as harmful and drug addiction as requiring abstinence as a solution, harm reduction is a nonstarter at the federal level. Instead, the focus is on reducing supply and addiction treatment (President’s Commission on Combatting Drug Addiction and the Opiate Crisis, 2017). While a handful of the states hit hardest by the opiate crisis are attempting to implement needle exchange programs and open safe consumption sites, such harm reduction measures struggle to win public support at the local level precisely because they are not seen, as Keane (2003) argues in other contexts, as value-neutral in the moralized arena of drug debate.

UBK Project

The UBK project was designed as a deliberate attempt to generate fresh thinking about the future of U.S. drug policy research in ways that would address the confines of the prohibitionist and addiction-focused medicine frames that have dominated the field. While the premise of the project is founded in the scholarship that demonstrates particular gaps and biases in U.S. drug policy research landscape, we in no way mean to suggest that there is no excellent research being done in the U.S. and abroad that provides counterexamples and critiques to the U.S. prohibitionist framework. Nor did we construct this as a formal, disciplinary research study. Rather, the project was an attempt to be broadly generative in developing applied projects that would address the interstices and absences in current U.S. drug policy research. We acknowledge that UBK was informed by a certain political sensibility and that the project was intentionally framed to invite researchers to partner in a different kind of intervention or problem-solving. If “evidence” is not fixed, but constituted in part by specific performances and practices (Lancaster, 2016), our hope was to invite and explore less dominant or conventional performances and practices. In particular, there are few opportunities in the U.S. for truly interdisciplinary drug research (Dunbar, Kushner, & Vrecko, 2010; Kushner, 2006) and, thus, the knowledge generated is frequently bound by disciplinary siloes as much as by the prohibitionist context in which we work.

UBK was conceived of and implemented by a university-based researcher and the Drug Policy Alliance (DPA, 2018), an advocacy organization whose mission is “to advance those policies and attitudes that best reduce the harms of both drug use and drug prohibition, and to promote the sovereignty of individuals over their minds and bodies.” In this sense, UBK was a deliberate attempt to collectively envision a research agenda that could imagine and work in a context beyond the frame of prohibition and to encourage participants to think expansively and in a multiplicity of ways about potential research that would improve U.S. drug policy. We thought a multi- and interdisciplinary collaboration across what are often epistemic or disciplinary boundaries would illuminate new ways to address long-standing, systemic issues in drug policy research in the U.S. Our hope was to model a new way of working for U.S. drug researchers.

The project consisted of three distinct parts: (1) a preliminary series of interviews with researchers and drug policy-related professionals, (2) the identification of common research constraints and a set of factors that would transform the direction of drug policy research, and (3) a daylong workshop to craft an aspirational research agenda built on this foundation. The project’s goals were to illuminate the problems in the current drug policy research landscape from a multidisciplinary perspective, imagine what drug policy research could and should look like, and develop a core of multidisciplinary researchers who might take this conversation back out into a variety of research contexts. Our ultimate objective was to start a dialogue within the drug research and research funding communities in order to begin to shift the kinds of research that are funded and conducted. Over the summer and fall of 2017, we interviewed more than 30 professionals, mostly from the field of research, whose work informs or

reflects drug policy. Participants were selected to include individuals from a wide array of disciplines, stages of career, and settings. We sought individuals whose work is characterized by fresh thinking and applied solutions and whom we believed would welcome stepping outside the dominant U.S. research paradigm as well as collaborating freely across disciplines and areas of expertise. We selected participants in consultation with a committee of researchers from harm reduction, sociology, social work, drug policy, and gender studies. The participant group was crafted with special attention to perspectives that are often not well represented in U.S. drug policy—such as the perspectives of people who use drugs—eventually creating a group of researchers, researcher/clinicians, and a journalist working at the intersection of science and drug policy. In designing the project, we had in mind methods akin to that used by Nutt et al. (2010), who convened a group of experts to help establish a framework for determining drug harms. Consensus methods have long been used in health and health services research, particularly for controversial topics. Our project also draws on the nominal group process in which participants are first asked to answer questions individually and then brought together for a structured group discussion (Fink, Kosecoff, Chassin, & Brook, 1984; J. Jones & Hunter, 1995).

To gather individual answers, we conducted 30 one-on-one interviews by phone and a follow-up e-mail. We asked participants to reflect on what factors currently constrain drug research in the U.S. and, as a result, what researchers currently do not know but should seek to learn. Using a semi-structured guide, the two authors of this manuscript conducted the interviews, which lasted between 45 and 60 minutes. The interview guide consisted of five questions about limitations and gaps in the current research environment, focusing on gaps in the research, methodological issues, funding problems, and sources of bias in the research. For most of the interviews, a second staff person sat in on the interview and took notes. The interviews were not recorded or transcribed but were well represented in extensive notes, which were then analyzed by the interviewers, along with the broader project team, to identify the key themes.

Researchers have debated the advantages of tape recording interviews (see, e.g., Cachia & Millward, 2011; Halcomb & Davidson, 2006; R. S. Weiss, 1995). We opted not to tape or transcribe our interviews due to the specific nature of this project. First, our request to participants to identify a significant set of constraints on research asked them to, potentially, be critical of the very systems in which they work (editorial boards, federal grant fund sources, etc.) and so we kept comments anonymous to increase their comfort and candor. Second, because we were asking participants to identify a systemic set of factors—the barriers they faced, the gaps they saw, and the methodological issues they observed—our interest was in capturing major themes and ideas rather than analyzing transcripts for a detailed textual or discourse analysis. Note-taking more than adequately captured these responses. Participants' responses provided a rich body of material from which to better understand various individual and shared factors that limit drug policy research. These data were developed into a "summary of constraints" and represent a significant set of problems that U.S. researchers commonly identified as limiting their work. This summary document was then sent to all participants, so that they had the opportunity to review the summary we prepared to ensure that the summary accurately reflected their views, correct any misinformation, and/or add additional information.

Following the interviews, we shared the summary of constraints with participants and then asked them to propose three key changes that would improve and transform U.S. drug research and policy. From that set of factors, we devised a summary of improvements to the research environment. The two documents, outlining constraints and potential improvements, became the foundation for a daylong workshop on what kinds of research are most needed and, specifically, how to design and manifest a more effective research agenda. Our goals for the meeting were to (1) work with the group collaboratively to create specific, actionable strategies for resolving research barriers, (2) articulate an aspirational list of research projects, and (3) highlight areas for immediate action.

In December 2017, 25 researchers met in Washington, DC, for the third phase of this project. This group included most of the original interviewees (some were not able to attend) as well as additional

participants selected to create a multidimensional, representational, and interdisciplinary group that included one perspective external to the U.S. attendees represented all points in their careers, from graduate students to emeritus professors and included a variety of perspectives involving quantitative and qualitative research, public health and health-care practice, journalism, and policy-making. In addition, the participants' areas of expertise in research and practice focused on a wide range of topics from various methodologies and represented the fields of anthropology, clinical psychology, criminology, cultural studies, epidemiology, geography, history, law, methodology/statistics, media studies, medicine, public health, public policy, psychiatry, and sociology. Participants worked in various small groups (both random and self-selected by topic) in addition to working together as a whole. Through a two-part framework, we first asked participants to collectively build on the identified constraints to clarify what factors would most transform those limitations. Then, in four smaller groups, participants collaborated to create a list of projects that would form an aspirational research agenda. Finally, from the latter list, participants self-selected into different topic groups briefly developed a multidimensional, ideal research project to disrupt current barriers in drug policy research.

The information generated from the meeting was recorded in extensive notes as well as through the use of a graphic recording service, which translated conversations into images and text on large sheets of paper as the meeting took place. Participants were invited to review and correct notes and the graphic recording on-site as well as to comment on a summary of the proceedings provided to them shortly after the meeting.

Moving Forward: Unbinding Knowledge

Participants in UBK generated a body of ideas about how to address current research constraints to move U.S. drug policy forward. Most notably, the meeting highlighted the importance of working in interdisciplinary research clusters to shape research design and outcomes across academic, organizational, public health, and health-care practice domains. Perhaps the strongest finding from the project was the desire and need for more discussion of drug policy research across disciplines, with several attendees noting how their own thinking and work had been deepened by just one day of being exposed to other perspectives. The group came up with dozens of concrete suggestions that, while they may not be new in a global context, have simply not been centered in the U.S. drug research environment: from developing rapid response grants to deal with emerging drug-related crises, to studying polydrug use or changing the outcomes measures used to assess drug treatment and other intervention studies. Some of these recommendations may appear to be in tension with one another. For example, there was a strong emphasis on the need to look at the effects of structural forces but also a recommendation for more research on how individuals themselves manage drug use effectively. Such variations reflect a recognition of coexisting tensions between structural factors and the role of individual agency in drug use. There is a need for drug research that can inform policies at multiple levels, from individual interventions to policy change, with a recognition of the reciprocal relationship between micro and macro level forces. In a study that broadly explored needed areas for research, the recommendations focused on gaps that, when informed with data, may produce different policy opportunities. Participants acknowledged that, even as they push for visionary and sweeping change, incremental steps are needed to get there.

We focus first on "Different Ways to Research," recommendations that outline strategies to surmount systemic boundaries and limitations in the U.S. research environment, changes that would also disrupt current research paradigms to generate more innovative projects. Next, we discuss "Research That Would Change Drug Policy," topics primarily related to the group's efforts to work beyond the individualist, prohibitionist, and addiction-focused frames in U.S. drug policy research. Specifically, these recommendations call for broader levels of analysis and deepening research on substance use in ways that challenge the narrow, but dominant, view of drugs as inherently dangerous. As a whole, this

research outline has the potential to interrogate some of the primary myths and underlying fallacies of the prohibitionist frame that Taylor, Buchanan, and Ayres (2016) identify, such as the belief that substances are currently categorized according to some scientific rationale, drugs inherently cause crime and social problems, continued drug use inevitably leads to addiction, and drug use has no place in a civil society. Based on the constraints generated from our interviews, we would add the fallacy that drug problems are fundamentally caused by individual behavior and choices as well as the failure to widely study harm reduction interventions, self-regulated drug use, and policy-level interventions.

Different Ways to Research

The strongest consensus to emerge from the meeting was the need for new ways of working in U.S. drug policy research. At the top of that list was the desire for interdisciplinary forums, such as the one created by the project itself. Participants agreed that many significant barriers to actionable and effective drug policy research are structural, including the mandate to work within a discipline (Campbell & Herzberg, 2017; Dunbar et al., 2010; Kushner, 2006, 2010). Further, the structure of academic and for-profit funding, research, and publication distances researchers from the immediacy and impact of policy on people who use drugs and their needs (Stein & Daniels, 2017). Putting a diverse group of people from 15 different disciplines and all stages of career in a room together necessarily complicated issues in productive ways. The impetus for UBK was a recognition that drug policy problems in the U.S. are complex and multifactorial and as such, require deep thinking from multiple perspectives in conversation with one another. Inviting participants to problem-solve across disciplinary and professional domains led to a critically robust and collaborative discussion of research issues and potential solutions, including their immediate impact on people who use drugs and those who work with them. Specific recommendations for improving the ways of doing drug policy research in the U.S. include the following:

Build interdisciplinary partnerships (especially between qualitative and quantitative researchers). Academic and professional silos, as well as the diverse and sometimes conflicting policy contexts of 50+ state and federal arenas, limit our ability to understand and contextualize the research we conduct. Multi- and interdisciplinary research is urgently needed. Many of the projects designed by the UBK participants required interdisciplinary teams working together in multistage studies. Creating pathways for those collaborations and partnerships is a critical first step. Identifying the most suitable venues for this kind of work is a key second step. Research engaged across disciplines and organizations would lead to more nuanced ways of tackling both long-term and immediate needs (see also Bourgois, 1999, 2002; Rhodes, Stimson, Moore, & Bourgois, 2010).

Redesign the research environment. The research process in the U.S.—from its structure, funding, design, and publication—needs to be modified. Structures of funding, research incentives, and career demands in academic and for-profit settings foreclose on the issues researchers might prefer to study, including topics that they believe would contribute to better drug policy. Participants underscored the need for publication outlets that serve policy-oriented outcomes, such as journals and other platforms that invite multi- and interdisciplinary scholarship. Specifically, participants identified a need to challenge the structure and incentives within academia to promote more innovative research as well as scholars' role in communicating to the media, the public, and policymakers—ideas that appear to be gaining more currency in academia (Badgett, 2016; Daniels & Thistlewaite, 2016; Stein & Daniels, 2017). These include strategies to teach and reward public scholarship and media work, develop forums for interdisciplinary work, and transform the peer review process to make it more constructive, rapid, and interdisciplinary. They also recommended creating new publication outlets, such as additional policy-oriented journals, journals for interdisciplinary and qualitative work, and accessible platforms for

public-facing scholarship about drug use and drug policy. These kinds of strategies would help push past existing barriers, open up more space for critical drug studies, and encourage the development of innovative research and policies.

Incorporate different types of expertise. Too much drug research employs assumptions and thinking shaped by criminalization and stigma by researchers with little experience with drugs and/or exposure to people who use drugs. Research should involve stakeholders as investigators (people who use drugs, community members, etc.) across the spectrum from research design and data collection to analysis and dissemination of findings (Lancaster et al., 2018). Among the potential benefits of such inclusion are to identify areas for research unseen by people who do not use drugs, disabuse the research community of such mischaracterizations, and lift the silence on talking freely about illegal drug use practices—especially with regard to pleasure—and as a matter of social justice.

Diversify funding resources and objectives. Not surprisingly, participants had a number of recommendations related to funding. These included more funding for innovative and exploratory work, access to rapid response grants, support for collaboration across disciplines (also across setting, research experience, or point in career), and backing for ethnographic and qualitative research as well as for modeling and cost effectiveness research. In addition, participants noted the need to fund younger or less-represented scholars—particularly women, people of color, and those impacted directly by the war on drugs—who often bring a much-needed fresh perspective.

Work to reschedule drugs, such as cannabis and psychedelics, to promote research on their therapeutic uses.

Current drug schedules in the U.S. are problematic for a variety of reasons but particularly because of the lack of research underlying their categorization of drugs. Research is needed to address both the therapeutic uses and potential harms of substances impeded by these misguided categorizations. A strategy to make Schedule 1 drugs more accessible for research is essential to improve the knowledge base about scheduled drugs (see also Doblin, 2000).

Alter the metrics for intervention studies. In regard to intervention studies, the group recommended focusing on outcomes beyond reductions in or cessation of drug use and recidivism, such as quality of life, housing status, employment, family reunification, and client satisfaction and preferences.

Research That Would Change Drug Policy

In addition to changes in how drug researchers work and how the drug research environment is structured, participants broadly agreed on content areas that require greater focus. Participants chafed against the current emphasis in U.S. drug policy research on narrow, individualistic approaches that fail to contextualize drug use, its harm, and the harms and benefits of the interventions we employ to address it and how that focus contributes to a policy discourse that roots the solution to drug problems in addressing individual pathology through either criminalization or medicalization. Similarly, they commented on the relatively few studies that assess policy-level interventions or studies looking at international issues, such as how U.S. policy impacts other countries and global drug policy, and discussed the ways in which this gap may contribute to the failure of policymakers, the media, and the wider public to fully consider the implications of the U.S. drug policy abroad. Overall, they called for a broadening of perspective and scope, one that would necessitate the kinds of interdisciplinary approaches described above. Recommendations for specific, much-needed areas of drug policy research in the U.S. are as follows:

Structural issues: Expanding the levels of analysis. As noted above, the majority of research on drugs in the U.S. focuses on the level of individual drug use. These studies are critically important to understanding who uses drugs and why, but they are insufficient for providing policymakers and the public the information needed to respond effectively to drug problems. While the term “problematic use” can itself be problematic, we are using it here to acknowledge that drug use happens on a spectrum ranging from experiences that can enhance one’s functioning to those which can create substantive problems (albeit often exacerbated by social circumstances). Participants urged more research on the structural and social conditions (i.e., racism, network impoverishment, and other forms of oppression) that contribute to problematic drug use and/or support abstinence or functional drug use. Social determinants of drug use have received some attention internationally (see, e.g., Spooner & Hetherington, 2005) and in the U.S. (see, e.g., Galea, Ahern, & Vlahov, 2003; Galea & Vlahov, 2002). Although difficult to measure and study (NRC, 2001), in part, because of the complex interplay of factors, tackling some of the challenges of doing so could help us get to the root causes of problematic drug use, encouraging policymakers to intervene further upstream. For example, how do access to housing, education, employment, social cohesion, incarceration, or community institutions impact drug use? Researchers in Canada, for instance, found that injection drug users with unstable housing were more likely to end up in emergency departments and called for stable housing as a potential policy solution (Palepu et al., 1999). Why do certain subpopulations in a particular region struggle more with resolving substance use issues? For example, Gossop, Marsden, Stewart, and Treacy (2000), looking at routes of administration among people seeking drug treatment in England, found significant regional variations that had implications for how policymakers and providers approached prevention and treatment as well as for health officials’ distribution of services, such as vaccination hepatitis B. Through interdisciplinary partnerships, between qualitative and quantitative researchers, participants projected ways to move from broad structural issues to subpopulations about which we know very little.

To provide a more concrete example from the UBK meeting itself, one of the smaller UBK working groups focused on the lack of research that examines how community- and structural-level factors impact drug markets and drug use. They were interested in understanding how and why certain drugs enter a community and whether or not there are community-level factors that deter the introduction of drugs and/or their use once introduced. Why, for example, do some communities have high opioid overdose rates, while others do not? Focusing on fentanyl, they suggested comparing two jurisdictions with different overdose rates and examining a range of factors to better understand what factors impact the market for and use of fentanyl. For instance, they would use mixed methods (qualitative and quantitative) to examine the role of law enforcement, social services, housing and employment opportunities, and other factors. Working with historians, they would try to better understand the drug markets, how new drugs are introduced to the community, and what political and community forces might be at play. This research could lend insight into what kinds of policy and community factors might impede or mitigate the introduction and spread of drugs within communities as well as harmful drug use.

Just as we need to know more about the structural factors impacting sales and use, so too we need to know more about the effectiveness of policy interventions at the macro level. While some studies are emerging about marijuana legalization (see, e.g., Bachhuber et al., 2014; Cerdá et al., 2012; Pacula, Powell, Heaton, & Sevigny, 2015), and there are a small number of studies about supply-side policies used to address the opioid overdose problem in the U.S. (see, e.g., Baehren et al., 2010; Buchmueller & Carey, 2017), participants encouraged more research and evaluation of policy interventions as they unfold, including studies of “natural experiments.” Policy changes and practices beyond cannabis legalization—such as Good Samaritan Laws, naloxone access, drug induced homicide prosecutions, drug checking, expanded access to treatment—are being rapidly implemented, but studies of these interventions and their effectiveness are scarce (see, e.g., Bardwell & Kerr, 2018).

Deepening and broadening understandings of substance use. Perhaps nothing has shaped U.S. drug research more profoundly than the pervasive belief that illicit drugs are inherently harmful and addictive. The pathologizing of drugs and the people who use them influences our assumptions about motivations for drug use, the kinds of questions we ask, whom we study, and the outcomes we measure. Moreover, these kinds of logics and discourse undergird the neoliberal project of governing pleasure as well as the demonization and criminalization of those who use “demon drugs” (O’Malley & Valverde, 2004; Race, 2009; Reinerman & Levine, 1997; Walker, 2017). The intense focus on the harms of drugs in the U.S. has meant we know relatively little about their therapeutic and recreational uses or about the vast majority of people who stop using drugs on their own (Granfield & Cloud, 1999; Sobell et al., 2000). There were three areas identified for more focused research on substance use: self-regulating drug use, the positive motivations for and outcomes of drug use, and better understanding of polydrug use.

Participants noted we have much to learn from the vast majority of people who use drugs functionally. In addition to structural factors, what is it about self-regulating drug use that might become part of drug use education and harm reduction strategies? The potential benefits of studying normative drug use and self-regulating drug use are enormous. They can lend insight into why and how most people who use drugs can control their use and how many of those who cannot control use quit on their own (natural or spontaneous recovery). Research topics would include what kind of calculations or incentives motivate people to regulate or stop use, what resiliency or assets do people have or need to moderate drug use, and what motivates their use in the first place. By focusing on “problematic” drug use, we have learned much about the problem but not much about preventing it or what might be the most effective solutions. This area of research has great promise to lead us to new ways of approaching more severe and consequential drug use as well as better understanding a broader spectrum of drug use.

One of the major artifacts of prohibition is that we have little research about why people use drugs, the net benefit of drug use, and the outcomes sought by people who use drugs. Research that addresses pleasure, life management, drug use for spiritual and health benefits, and so on, would begin to fill in a cultural picture of the motivations for most drug use and allow policymakers to make more nuanced decisions about how and why they intervene in the consumption of drugs.

While most people who use drugs do not use a single drug at a time, drug policy research in the U.S. often isolates substance use by drug. People who use drugs may combine alcohol, opiates, stimulants, and benzodiazepines—and often they are not even aware that some of these will interact with other drugs. Indeed, some of the overdose deaths in the current opioid overdose crisis are the result of polysubstance use—mixing opioids with a deadly combination of alcohol and/or benzodiazepines (Jan et al., 2014; C. M. Jones & McAnich, 2015; Park, Saitz, Ganoczy, Ilgen, & Bohnert, 2015). The opiate overdose crisis is just one example of a critical cultural and policy need for a better understanding of polysubstance use. With the proliferation of novel psychoactive substances ranging from spice to fentanyl, research on the short- and long-term health effects of using drugs in combination is urgently needed. Additionally, more studies that collect ethnographic data about what drugs are actually being used together, why, and in which contexts are needed.

Conclusion

The participants in UBK were emphatic that a better future for drug policy research in the U.S. requires researchers who can work collaboratively across boundaries of discipline and profession to answer the field’s most challenging and urgent questions. In a setting that itself attempted to model such collaboration, they articulated significant structural changes to drug policy research and conceptualized projects that would meet crucial informational needs. Given the opportunity to work across disciplinary and organizational domains, participants were highly motivated to join forces to change the conversation and transform research and policy in the U.S. With an understanding that the dominance of prohibitionist logic permeates drug policy research, the participants wanted to commit to projects

that would make the problems inherent in that framework more visible while providing better data to address immediate needs. Collectively, they endorsed improvements to research contexts to, in turn, build a better knowledge base.

We have highlighted just a few of the recommendations generated by the UBK project, and even the full spectrum of ideas that came out of the meeting are just a gesture toward what U.S. drug policy research could become. We recognize that this was a select group that does not represent the drug policy research community in the U.S. and that the discussion would have been even richer had we been able to bring more international researchers to the table. Nonetheless, what the project demonstrated is both some of the problems with how U.S. research is currently conducted and the potential to reimagine drug policy research by bringing people together across disciplines and supporting them in thinking beyond the bounds that normally constrain them.

While we understand that changing such pervasive systemic and institutional factors will not happen as a result of one project, we also recognize that the conversation needs to begin somewhere. We share these findings in the hopes of furthering the dialogue about how to improve drug research in the U.S.—by addressing both long-term challenges and offering ideas that may be addressed sooner as low-hanging fruit. In fact, the group generated several suggestions for advancing this agenda. These included using the findings to engage research funders—both public and private—in conversations about supporting more visionary projects; fostering conversations within academia, the media, and among policymakers about improving the field; instituting a recognition award to incentivize innovative, interdisciplinary projects; creating a virtual network of interdisciplinary critical drug scholars; training researchers to engage more directly with policy and funding change efforts; and developing additional forums for interdisciplinary work. Many of these suggestions are being taken up by the DPA's Office of Academic Engagement, which convened the UBK group. In addition, some participants plan to move ahead on the collaborations they conceptualized at the meeting—even absent of additional funding and support.

It remains to be seen whether or not a small project like this can begin to shift entrenched systems and beliefs in the U.S. that structure how drug policy research is funded and conducted. The prohibitionist frame and the pull to individualize the problem of addiction are strong in the U.S. and are being bolstered in some ways by the current political climate—including federal leadership that is dismissive of research in general. Nonetheless, there are also signs of tremendous opportunity, including a new interest in more progressive responses to the opioid overdose problem, driven in part by the racial politics of the problem (Netherland & Hansen, 2016, 2017), as well as what appears to be a resurgence of interest in scholar-activism and the publicly engaged researcher (Badgett, 2016; Daniels & Thistlewaite, 2016; Stein & Daniels, 2017). If the enthusiasm and commitment of the UBK participants is any indication, there seems to be a motivated cadre of critical drug scholars in the U.S. ready to work in new ways and to shape a new research landscape—one that can do more to critically interrogate the dominant and destructive ideologies that drive much of the U.S. drug policy.

The challenge remains to make the cultural changes that will help bridge disciplinary and organizational silos and support collaborative cross-disciplinary work to better inform and bring more rationality to U.S. drug policy. To that end, the project drove home the need for spaces and funding to support interdisciplinary research networks and concrete projects, especially because so many of the policy problems that need to be solved are multifaceted. Many of the most urgent and compelling questions in drug policy can only be answered through interdisciplinary approaches, and yet there are too few forums or incentives for researchers to engage in this way. The group recognized that to help solve some of the country's most vexing drug policy problems, we need collaborations that are not supported by current research structures, funding, and outlets. In the spirit of the project, we invite a conversation about how and where such interventions might already be taking place and where they might be welcome.

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Ingrid Walker is an associate professor of American studies at the University of Washington, Tacoma, where she researches and teaches about the politics of contemporary culture in the United States, particularly critical drug studies. Her book, *High: Drugs, Desire, and a Nation of Users*, addresses the social construction of drugs in the U.S. Her TEDx Talk, “Drugs and Desire,” explores the stigmas surrounding psychoactive drugs, from caffeine to hallucinogens. Her writing has appeared in the *Journal of Popular Culture*, *NANO*, publications of the Alcohol and Drug History Association, and the edited volumes *Conspiracy Nation* and *The Gangster Film Reader*.

Julie Netherland is the director of the Office of Academic Engagement for the Drug Policy Alliance. In that role, she advances drug policy reform by supporting scholars in doing advocacy, convening experts from a range of disciplines to inform the field, and strengthening DPA’s use of research and scholarship in developing and advancing its policy positions. She previously served as the deputy state director of DPA’s New York Policy Office, where she was instrumental in passing two laws to legalize the use of medical marijuana in New York and advancing a number of harm reduction and public health approaches to drug policy. She is the editor of *Critical Perspectives on Addiction* (Emerald Press, 2012). More recently, her work with Helena Hansen, MD, PhD, on the racialization of the opioid epidemic has appeared in the *American Journal of Public Health*, *BioSocieties*, and *Culture, Psychiatry and Medicine*.

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Comment from Kimberly, Smith

Submitter Information

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General Comment

Hello,

My name is Kimberly. I'm an RN and chronic pain patient. I would like to say that when access is denied for safe pharmaceutical opioids for chronic pain, incurable painful conditions, cancer, surgery, life surgical complications it gives patients with nothing but inhumane, cruel, and unethical pain and suffering. When people are denied the pain care they need to function and having a better quality of life it puts them at risk of looking for unsafe illegal illicit drugs that so many are overdosing on and dying. 93,000 recently, I believe or no hope leading to patient suicide. It doesn't take a genius to know this. For example. A veteran who served our country goes to the VA because he suffers severe back pain. He is denied the opioid medications that provide relief, gets denied because of opioid hysteria created by the CDC, which has become weaponized against our physicians. Walks out to the VA parking lot and blows his brains out. This veteran is only 1 of the numerous suicides caused by the CDC 2016 guidelines which were written in secret, in silence, illegally without any input from ACTUAL EXPERTS, of which Andrew Kolodny, Roger Chou are not. Pain specialists and chronic pain patients were let out of the CDC guidelines. Andrew Kolodny, Roger Chou, Shatterproof are profiting off the pain and suffering of the pain community and both have conflicts of interest. These are hate groups. Chronic pain patients are paying the price for other people's grief of loved ones who have overdosed and died from ILLEGAL ILLICIT UNSAFE STREET DRUGS, the data the CDC pushed was inaccurate. The pharmaceutical companies shouldn't be being sued because we have an illegal drug problem in the United States. That was all about money. Those who would need access to the drugs for addiction aren't able to access the opioids for treatment, so where is all these Billions of dollars going? Andrew Kolodny made \$500,000 testifying against Johnson and Johnson. What makes this man an EXPERT? The CDC 2016 guidelines need to be abolished, the DEA needs to get out of the doctors office. The DEA officers pretend to have a painful condition, and if a physician writes that script, their going to prison, losing Everything they ever worked for. Doctors should be able to practice medicine to the best of their knowledge without fear of prosecution. The doctor-patient relationship now has been destroyed along with America's healthcare. I could go on and on. The patient monitoring, having to take urinalysis testing. We are

under attack, being surveillance. Now Medicare and Medicaid have joined in to be a dictator in what and what dose a person can and can't have for pain. Less than 90 morphine equivalent. Pain care is no longer individualized and one size fits all does not work. There's nothing left but to abolish the CDC'S 2016 guidelines and let the FDA do their own job.

Thank you for your time,

Kimberly Smith, RN, chronic pain patient

Slater, Sandy R. EOP/ONDCP

From: Aaron Pluff <(b)(6)>
Sent: Monday, August 2, 2021 5:29 PM
To: MBX ONDCP OGC
Subject: [WARNING: UNSCANNABLE EXTRACTION FAILED][EXTERNAL] Written comments may be submitted by members of the general public

THE
[UNITED STATES](#)
MUST END THE PROHIBITION OF
[MEDICAL CANNABIS.](#)

Written comments may be submitted by members of the general public and stakeholder organizations by email to (b)(6)

ONDCP encourages and will accept public comments on or before August 6, 2021.

The Office of National Drug Control Policy (ONDCP) is seeking comments from the public on whether and to what extent ONDCP's policy development process, drug budget review and certification processes of the 18 National Drug Control Program Agencies, and Grant Administration Programs perpetuate systemic barriers to opportunities for underserved communities and individuals from those communities. ONDCP is also seeking comments from the public regarding how its future proposed policies, budgets, regulations, grants, or programs might be more effective in advancing equity.

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The Veterans Action Council (VAC), 2021

Executive Summary

[The Veterans Action Council](#) (VAC) is an all volunteer group of Veterans, and venerated professionals in our respective fields. We came together to promote and coordinate efforts on issues concerning Veteran access to alternative treatments and therapies, thereby promoting the physical health and mental well-being of Veterans and their families. We are submitting this “*Green Paper*” to the White House Office of National Drug Control Policy (ONDCP), in response to their request for input from the public regarding their policies, and how they negatively impact segments of our society.

Our *Green Paper* outlines significant concerns within the medical cannabis community, and what we feel are some potential remedies. First and foremost, we are concerned that Veterans are not included in the equity breakdown of Executive Order 13985. We respectfully request that you include our council in your taskforce assembling the next national drug control strategy. As Veterans of the United States (U.S.) Armed Forces, we call on the ONDCP and the Veterans Health Administration (VHA) to fully recognize cannabis as a viable treatment option for U.S. Veterans. Leaders are increasingly aware of the devastation to former military members and their families caused by inappropriate prescription of [opiates](#), [SSRIs](#), [benzodiazepines](#) and [other pharmaceuticals](#). Multiple attempts have been made to resolve the inability of Veterans to incorporate cannabis into their official treatment plans. Every attempt made to address our

concerns has been sabotaged at the federal level. The VHA must take action on this issue. Federal leadership in the executive and legislative branches of our government must understand the enormity of this situation.

The fact is, [Veterans are self-medicating with cannabis and other substances](#). Veterans report turning to cannabis after pharmaceutical options provided by the VHA -- some of which include warnings of suicidal ideation -- exacerbate their symptoms. We have an opportunity to expand the conversation into areas such as [MST](#), [TBI](#), [CTE](#), and [other issues Veterans face](#) beyond post traumatic stress (PTS). [Veterans farming cannabis should be supported by the Department of Agriculture](#), with programs sponsored by the VHA. Veterans are being forced, sometimes into criminal behavior, to heal themselves using alternative substances not currently recognized by the VHA. The experienced cultivators and medical healthcare and research providers in our network are capable of providing reliable information regarding the benefits of using [“real world” cannabis](#), as opposed to the currently [mandated NIDA](#) product. These professionals can break down the many data points of cannabis being used by Veterans across the country.

Finally, given the VHA is a federal program, operating in all fifty states, [Veterans receiving care from the VHA are federal patients who require equal medical treatment](#), regardless of state laws. The current situation is untenable and an expansion of existing federal policy is in order. Service members are losing their benefits before entering into Veteran status, and they are experiencing undiagnosed issues stemming from their service. This leaves Veterans with debilitating health concerns that often result in them fending for themselves. We are urging our representatives to protect the health and safety of Veterans by de-scheduling cannabis and re-opening the federal Compassionate Investigational New Drug Program (IND) through the VHA. This will ensure cannabis and [other adjunct treatments](#) are available options for Veterans' healthcare in all 50 States and Territories of the U.S.

Key issues within the Veteran community regarding medical cannabis laws.

- To date, [36 states and 4 territories](#) of the United States have legalized the use of medical cannabis.

Citizens across our country have acknowledged the therapeutic potential of cannabis, as witnessed by their voter initiatives, and state legislation addressing the disparity between law and reality. Even still, not all state medical programs are created equal. In one state, a Veteran may have access to a wide array of cannabis products, whereas in others the options are significantly limited in product and methods of administration. What's more, due to "local control" ordinances in "legal" counties, Veterans can still be denied access to their medication despite their compliance with state laws.

- [The Patient/Doctor Relationship](#).

VHA Directive 1315, as of December 8, 2017 is in effect and addresses State-approved marijuana programs. Tens of thousands of Veterans have voluntarily self-identified as cannabis users after recommendations are received outside of the VHA, and the requirements of their State or Territory of residence are met. The directive outlines the responsibility of the VHA Medical Facility Director to ensure cannabis use reported to clinical staff is charted in a separate section of the Veteran's electronic health record. Further in the directive it is noted that *if* the provider discusses medical cannabis, "relevant information" must be documented in the progress notes.

Since the inception of state run cannabis programs there has been a disconnect between VHA healthcare providers and their patients. Veterans require the unobstructed ability to engage in open and honest dialogue with their VHA Primary Care Teams about their use of cannabis; where they can then develop proper treatment plans, documenting their experiences, and utilizing the healthcare system designed for them. The Veterans Action Council is requesting the VHA provide to this organization the results of evaluating patients using cannabis therapeutically for the last decade, preferably in an Executive Summary format with all data relevant to this treatment appreciated.

- Added burden to Veterans and their families.

Veterans are being forced to pay out of pocket to access state medical cannabis programs across the country. The cost of these programs vary from state-to-state for credentials that have to be renewed on an annual or bi-annual basis. The cost of cannabis itself varies greatly from store to store, county to county, and state to state. It is not cheap, especially for Veterans on fixed incomes choosing between their bills or cannabis. Recommendations for cannabis from our VHA primary care physicians should be the agreed upon treatment plan, rather than going to a state authorized entity. These

recommendations can be converted into vouchers to be filled at local dispensaries, [as the Canadian medical cannabis program demonstrates](#).

- [Criminal or Patient?](#) That depends on [which state Veterans call their home](#).

Veterans will violate the law to heal themselves, and the authorities have no trouble enforcing those laws. Idaho for instance, possession of *any* amount of cannabis is a crime -- [punishable by up to one year in jail, and/or a \\$1,000 maximum fine](#). Veterans are being victimized by the criminal justice system, simply for attempting to find relief. [Our Heroes deserve treatment options that transcend state lines](#). No matter what state a Veteran may call their home, despite being a qualified cannabis patient under a state program, all possession or use of cannabis on VHA property is federally restricted. This means that a Veteran can be charged with a federal crime for medicating themselves at their VHA hospital, nursing home, Fisher House, or federal housing.

- [Cannabis Use Disorder \(CUD\)](#).

CUD has become a staple of VHA medical records for Veterans choosing to have honest discussions with their primary care teams regarding their cannabis use. Under a diagnosis of PTS, substance abuse is an attributed factor in the further diagnosis of CUD. Through word of mouth Veterans have come to learn that cannabis helps alleviate a majority of symptoms attributed to PTS. They end up with a CUD diagnosis with no contributing factors other than their use of cannabis and a diagnosis of PTS, along with an [unwarranted stigma](#) to overcome. To see the blatant bias at play, one need only to look at the [budget request from the Department of Veterans Affairs to the ONDCP for FY 2022](#). The VHA would rather spend a billion dollars on substance use disorder, than research the medical utility of cannabis. Any funding provided to the VHA from the ONDCP should contain provisions mandating research into the efficacy of cannabis when used to treat PTS, TBI, chronic pain, etc.

- [Proliferation of opioid prescriptions](#) since the start of the Global War On Terror (G.W.O.T.).

Within the VHA, pharmaceutical narcotics are being prescribed in staggering numbers, [putting Veterans at the forefront of the opioid epidemic that has swept the country](#). Many individuals are entering military service in top physical and mental health, only to be thrust into an overwhelmed system relying too heavily on a pharmaceutical approach to healthcare. The VHA has recently taken minor steps to include a more holistic approach to Veteran healthcare, but has continually denied the inclusion of cannabis regardless of the science. Studies show [opioid use/abuse is reduced in states that have legalized medical cannabis](#), and it is time for VHA primary care teams to act upon this information. █

- [Suicide rate increase](#) since the start of the G.W.O.T.

In addition to being inundated with pharmaceutical narcotics, the Veteran community is struggling with alcohol. For individuals who have lost their identities, careers, professions, and oftentimes spouses, children, and friends, these potentially destructive substances are too easy to abuse. We have lost more troops to suicide [than to combat](#), many more. Death is an ever-present reality in combat environments. Through training, repetition, teamwork and accountability, the warfighter hardens themselves against this fact. To protect what they love, they knowingly enter into the fight. Nobody was ready for the suicide epidemic. There was no preparation, and it is getting worse. Over the years leaders have stated “nothing is off the table” when it comes to curbing the suicide rate within the military community, it is time for them to prove it. The status quo further aggravates hardships for America’s Veterans.

- [Veterans learning about their medicine is empowering](#), therapeutic, and is the reason you are reading this.

All across the country there are programs geared toward Veterans interested in agriculture. Cannabis farming should be no different. There are many benefits to farming, gardening, and generally getting out in nature on a regular basis. The routine of planting, tending to a crop, harvesting, and preparing for the next season is a structure that fits right in line with the military mentality. [Farming](#) brings with it a sense of hope, opportunity, and accomplishment. Bringing in any successful crop is an achievement. It keeps the mind and body occupied, focused, and engaged in a productive manner. Self-sustainability is a key component to a happy, healthy lifestyle.

Veterans should have the opportunity to learn more about cannabis, or other medicinal herbs if they are at all interested. Cannabis Centers of Excellence at specified VHA healthcare facilities designed to teach Veterans about their medication, how to grow it, and to supply regional VHA facilities are called for. Top performing VHA facilities, along with consideration of state cannabis laws should be identified as the initial qualifications for implementation of this proof of concept. Cannabis cultivation facilities do not have to be on the VHA campus, but can utilize land grant university space, and/or vacant Department of Defense property, in partnership with various community programs. This scenario fosters further community engagement.

- The NIDA/University of Mississippi [monopoly must be busted up](#).

[Research into the medicinal properties of cannabis needs to be fast-tracked](#). Over-reliance on research conducted by the National Institute on Drug Abuse has hindered our overall understanding of the cannabis plant; its safety, efficacy, and potential medical utility. Monopolizing patents, obstructing objective research, and working to subvert patient's access to the healing properties of cannabis, are all federal themes played out time and again. This is not hyperbole. It is documented in myriad court cases spanning decades, [leading right into the present moment](#).

- [Research from allied nations sponsored by the NIH](#) needs to be acknowledged, and acted upon.

Since the early 1960's, the National Institutes of Health have been providing scientists in the state of Israel with grants to research the cannabis plant, its compounds, and potential for medicinal use. United States taxpayers have paid for research which has led to the state of Israel becoming the world leader in cannabis science. Additionally, due to compulsory service requirements for their citizens, barring medical or other disqualifications, the majority of Israeli citizens are Veterans.

Scientific breakthroughs have led to cannabis being introduced as a viable treatment for use within the Israeli healthcare system. Tens of thousands of Israeli Veterans use cannabis on a regular basis which is supplied to them by their government. It is time for the United States to treat her Veterans with the same respect and compassion.

- [Research investigating what Veterans are using in real-world scenarios](#) is required.

Because of federal obstruction, Veterans are forced to conduct their own research. "For Purpose" organizations like the [Helmand Valley Growers Company](#) -- a Veteran owned entity -- are [working toward identifying answers](#) to questions being ignored by the United States government. Veterans want to participate in objective cannabis research programs. [This research will further assist in understanding medical cannabis](#), and how to best introduce it into treatment regimens.

The Veterans Action Council is including the following document "*Marijuana as Medicine*" from 1993, for comparison regarding cannabis policy then, and now. The news articles, political discussion, controversy, injustice, and misery of it all are outrageously similar. **Emphasis has been added where we feel the information is particularly striking.** When you read about states taking individual action -- **pressure campaigns led by sick, disabled, and dying patients** -- remember that now, in 2021, we are looking at over a dozen states with *recreational* cannabis laws. The movement founded by Mr. and Mrs. Randall for access to *medical* cannabis is to this day being ignored by our federal government, and so called representatives..

The *Green Paper* is a testament to the Truth announced so long ago, and a proclamation that we will no longer accept the prohibition of cannabis. Decades spent attempting to get through to our elected officials that we know the truth

about cannabis, engaging in constant struggle with out of control federal agencies, have [left us with a significant gap in our healthcare and knowledge base](#).

In the two decades since the G.W.O.T. began, that gap has consumed over one hundred thousand Veteran lives, if we are just accounting for those who have committed suicide.

The time to act on this was yesterday.

Marijuana As Medicine

Initial Steps

Recommendations for the Clinton Administration

Robert C. Randall & Alice O'Leary

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Dedication

Carl E. Randall & James C. O'Leary

Who gave us good minds,
The courage to use them,
And who taught us to tell the Truth.

Acknowledgement

Funded by:
Richard J. Dennis
Chicago, Illinois.

Preface

“The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefit of this substance in light of the evidence in this record.”

In the Matter of Marijuana Rescheduling
Francis L. Young, Chief Administrative Law Judge
Drug Enforcement Administration (DEA)
September 6, 1988

Judge Young's decision followed two years of court-ordered public hearings. The record, In the Matter of Marijuana Rescheduling, constitutes the most complete review of marijuana's therapeutic properties in the 20th century.

Purpose

Marijuana's medical value is incontrovertible. This simple fact was true 5,000 years ago. It's true today.

Marijuana's therapeutic value is not at issue. What is at issue are irrationally prohibitory federal policies which prevent marijuana's legal, medical availability. This is not an insignificant problem. Today, many thousands of seriously ill Americans must break the law to meet their urgent medical needs. Governmental attempts to criminalize the sick for securing needed medical care are intolerable in a civilized, democratic society.

Much has been written about marijuana's medical use. Those seeking detailed factual information on the plant's long medical history, complex chemistry, therapeutic actions or current legal status can easily find such information elsewhere.

This publication speaks to the present moment -- our national government is in transition, the medical prohibition of marijuana is in crisis, and people are suffering. One year ago, in March 1992, the Bush Administration killed the nation's fourteen year old marijuana-as-medicine program, slamming the door on seriously ill Americans who dared to petition their government for legal access to medically needed marijuana. Today, seriously ill Americans are dying, going blind, and being crippled by this cruel policy.

On January 20, 1993, President Bill Clinton inherits the problem of medical marijuana. **This publication is designed to provide interested parties with an overview of the problem and a review of those events which led the Bush Administration to kill the nation's Compassionate IND program.** It also explores the political dynamics of medical marijuana. The American people strongly favor marijuana's medical availability and they will no longer tolerate bureaucratic efforts to legally prevent such use.

Finally, this publication outlines pragmatic actions President Clinton can take to resolve this problem. These recommendations are not designed to satisfy drug warriors, left or right. Instead, they are crafted to meet the legitimate treatment needs of those who are currently ill, while encouraging aggressive research and exploring legally appropriate ways to make marijuana medically available for therapeutic use in the treatment of life-and sense-threatening diseases.

Ending the five decades of irrational federal policy is not a simple undertaking. But failure to confront the bureaucracy and rationally resolve this problem will condemn many seriously ill Americans to unnecessary suffering and many others to unwarranted criminality.

Of all the problems facing the new administration, resolving the question of marijuana's medical availability is easy. All it takes is courage, compassion and common-sense.

Robert C. Randall & Alice O'Leary
January 1993

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The Great White Drug* Let The Market Decide*

What Can President Clinton Do?

Presidents Come & Go* On The Other Hand*

Beyond Cultural Warfare*

Recommended Actions

Restore Compassion* Encourage Research* Explore Options*

Conclusion

Appendix

Executive Summary

Among the problems President Clinton will inherit from the Bush Administration is the matter of marijuana's legal availability for legitimate medical purposes.

This document outlines the existing situation, provides critical background information, and recommends the pragmatic steps the Clinton Administration can take to resolve the problem of marijuana's legal availability for medical use.

Marijuana has NO political complexion. This is NOT a liberal issue with well defined conservative opposition. Indeed, conservatives believe doctors, not bureaucrats, should be in charge of medical care. The bipartisan character of public support is so broad that political efforts to characterize the following recommendations as liberal or radical will lack credibility and further isolate such critics from the emerging social mainstream.

The following actions are recommended to the Clinton Administration:

- I. Immediately and fully restore the FDA's Compassionate IND program for medical marijuana,
- II. Encourage aggressive medical research by rescheduling marijuana from Schedule I to Schedule II of the Controlled Substances Act, and
- III. Appoint a Presidential Task Force to fully explore appropriate ways to make marijuana available for therapeutic applications.

These moderate initial actions -- restore, encourage, explore -- enjoy broad public support. The American people know marijuana has legitimate medical uses, and they deeply resent bureaucratic efforts to block marijuana's medical availability.

By adopting the above recommendations President Clinton will be credited for taking decisive action to ease human suffering by ending decades of ideologically institutionalized gridlock. The hallmarks of the recommended actions are courage, compassion and common-sense. A broad coalition of groups will support these moderate moves and individuals - including many seriously ill Americans - will publicly offer their testimony of thanks and congratulations.

“If we think we are going to accomplish much by subterfuge, somehow hiding the fact that marijuana ... may be of benefit for some purpose, I would disagree. I think sooner or later the public will find out, and it will become one more reason not to trust the Federal Government on anything it says....”

Rep. Stephen L. Neal
Chairman, Task Force on Marihuana,
Select Committee on Narcotics Abuse and Control Hearings, May 20, 1980.

WHY PRESIDENT CLINTON MUST RESOLVE THIS PROBLEM

The Clinton Administration should resolve this problem because:

1. Seriously ill Americans are suffering as a result of irrationally prohibitory federal policies,
2. The American people reject the medical prohibition and view bureaucratic efforts to block marijuana's medical use as a regulatory fraud, and
3. By failing to act President Clinton will inherit, and be forced to defend, the Bush Administration's extremely unpopular War on Drugs approach to marijuana's medical use.

The Problem

People are suffering.

Marijuana has unique therapeutic properties in the treatment of several life-and sense-threatening diseases including glaucoma, cancer, AIDS, and neurologic disorders resulting in muscle spasm and chronic pain.

Federal law, however, forbids marijuana's medical use. Licensed physicians who routinely prescribe far more dangerous drugs are legally forbidden to provide people who are dying, going blind or being crippled with licit, therapeutic access to marijuana.

This stark conflict between urgent medical needs and prohibitory federal policies has created a perverse situation in which physicians must send desperately ill Americans into the streets -- and criminality -- to meet their legitimate medical needs.

Modern studies have reconfirmed marijuana's historically recognized therapeutic value. This document only concerns itself with marijuana's medical use in the treatment of several life- and sense-threatening disorders.

Glaucoma: Glaucoma is the leading cause of blindness in the United States. In the 1970's researchers discovered marijuana significantly lowers the elevated eye pressures associated with glaucoma. Between 2 and 4 million Americans are afflicted with glaucoma and nearly 10,000 are blinded by the disease each year. This statistic indicates that standard treatments and surgery are often ineffective. It is clear that, for some glaucoma patients, the addition of marijuana can make a critically important difference in prolonging sight.

Cancer: One million Americans are diagnosed with cancer each year. Many suffer from intractable nausea and vomiting caused by highly toxic anti-cancer drugs. The debilitating effect of chemotherapeutic agents cause many patients to discontinue potentially life-saving treatment. Medical studies consistently show marijuana is one of the safest, most effective anti-nausea drugs known to man. In the mid-1970s cancer patients began smoking marijuana to control nausea and vomiting, and stimulate appetite. Subsequent studies found marijuana helps up to 90% of these patients control nausea and vomiting.

AIDS: HIV-positive (HIV+) people smoke marijuana for many of the same reasons as cancer patients. Marijuana effectively reduces the intense nausea, vomiting and rapid weight loss caused by advanced HIV-infection and the highly toxic drugs used to treat AIDS. While it has only recently come to public attention the medical use of marijuana, even though illegal, is already widespread among HIV+ people. AIDS is now the nation's most rapidly increasing cause of death. More than 242,000 Americans have AIDS and more than 1 million Americans are now infected by the deadly virus.

Muscle Spasm: More than a million Americans suffer from neurologic conditions like multiple sclerosis (MS), muscular dystrophy, spinal injury and arthritis which cause severe muscle spasms and chronic pain. These conditions are not well treated with conventional medications. Marijuana's illegality makes it impossible to accurately estimate how widespread marijuana's medical use is among neurologically-impaired Americans. It is clear marijuana's medical use among paralyzed Americans is now widespread. As one neurologist testified during the recent DEA hearings, **"You cannot walk down a neurology ward in a V.A. hospital without smelling marijuana."**

Marijuana does not cure any of these conditions. But rationally employed, under medical supervision, marijuana can prolong sight in glaucoma, ease nausea and vomiting caused by anti-cancer and AIDS therapies while helping patients maintain body weight, reduce the crippling spasms common to neurologic disorders like multiple sclerosis, muscular dystrophy and paralysis, and ease chronic pain.

Political Analysis

The Medical Prohibition Has No Public Support.

It is difficult to find any other question which unites so many of the American people in opposition to an existing federal policy.

Federal laws which prohibit marijuana's therapeutic availability are not politically, socially or legally tenable. Federal agencies enforcing the medical prohibition long ago lost the public debate for hearts and minds.

While few people would identify medical marijuana as a "front-burner" issue, there are emblematic aspects to the problem which can directly affect public perceptions of an administration's candor, honesty and compassion.

All available evidence suggests the medical prohibition of marijuana has no support among the American people. Indeed, public repudiation of the medical prohibition is now nearly universal. Despite two decades of bureaucratic disinformation the American people view the medical prohibition as an irrational outgrowth of misdirected War on Drugs zealotry.

Public rejection of the medical prohibition is evident in political actions, available polling data, and recent election returns.

Political Actions

In 1978, a young cancer patient, Lynn Pierson, brought marijuana's medical value to the attention of the New Mexico Legislature. After public hearings in which cancer and glaucoma patients and their physicians strongly endorsed marijuana's medical availability, the legislature overwhelmingly enacted the nation's first law recognizing marijuana's medical value.

Patients in other states quickly followed Lynn Pierson's lead and petitioned their legislatures for similar laws. The result was an explosion of state legislation which has continued into this decade.

On December 31, 1991, Massachusetts Governor William Weld signed the nation's thirty-fifth state law recognizing marijuana's medical value. In every instance these state laws gained broad bipartisan support and were enacted by tremendous legislative margins.

State efforts to end the medical prohibition failed, however, because of entrenched opposition from federal drug agencies. This bureaucratic opposition had very real human consequences. In New Mexico nine patients, including Lynn Pierson, **died "while waiting for promised supplies of federal marijuana which never arrived."**

Despite bureaucratic hostility, six states finally managed to satisfy federal regulatory demands to establish programs of patients' access to medical marijuana.

Angered by federal efforts to destroy the intent of their marijuana-as-medicine statutes, the legislatures of New Mexico, Michigan and New Hampshire enacted Resolutions to the U.S. Congress condemning federal efforts to block marijuana's medical use. The Michigan Resolution bluntly states:

"Federal agencies have failed to meet this good faith effort, and have instead, through regulatory ploys and obscure bureaucratic devices, **resisted and obstructed** the intent of the Michigan legislature."

- 1) Many of these state legislative actions were authored by conservatives. **The first four states to recognize marijuana's medical value -- New Mexico, Florida, Illinois, and Louisiana -- could hardly be characterized as "liberal."**
- 2) State laws recognizing marijuana's medical value consistently received exceptionally broad bipartisan support. A cumulative 87% of the state legislators voting on this question voted in favor of making marijuana medically available.
- 3) These legislative actions were endorsed by the major media in these states and received broad public support. Physicians, nurses, and patients appeared at legislative hearings to express their support for marijuana's medical availability.
- 4) Opposition to such legislation was muted, ill-organized and often dismissed as hysterical.
- 5) Finally, **the profoundly bipartisan nature of these political actions indicates medical marijuana is not a politically or culturally sensitive issue.** Significantly, no legislator who sponsored or supported marijuana-as-medicine legislation ever lost an election because of such support.

97th Congress
2D Session H.R. 4498

To provide for the therapeutic use of marihuana in situations involving life-threatening or sense threatening illnesses and to provide adequate supplies of marihuana for such use.

IN THE HOUSE OF REPRESENTATIVES

September 16, 1981

Mr. McKinney (for himself, Mr. Gingrich, Mr. Fish, and Mrs. Fenwick) introduced the following bill; which was referred to the Committee on Energy and Commerce

March 3, 1982

Additional sponsors:

Mr. Kastenmeier, Mr. Forsythe, Mr. Ottinger, Mr. Beilenson, Mr. O'Brien, Mr. Fazio, Mr. Neal, Mr. Edgar, Mr. Minish, Mr. Whitehurst, Mr. Jeffords, Mr. Frenzel, Mr. DeNardis, Mr. Miller of California, Mr. Stokes, Mr. Porter, Mr. Stark, Mr. Applegate, Mr. Ginn, Mr. D'Amours, Mr. Lehman, Mr. Bonoir of Michigan, Mr. Morrison, Mr. Erdahl, Mr. Synar, Mr. Dannemeyer, Mr. Addabbo, Mr. Beville, Mr. Marlenee, Mr. Zeferetti, Mr. Guarini, Mr. Harkin, Mr. Richmond, Mr. Rahall, Mr. McGrath, Mr. Seiberling, Mr. Dellums, Mr. Weiss, Mr. Siljander, Mr. LaFalce, Mrs. Collins of Illinois, Mr. Bingham, Mr. Gibbons, Mr. Chappell, Mr. Frank, Mr. Oberstar, Mr. Rinaldo, Mr. Daniel B. Crane, Mr. Garcia, Mr. Pritchard, Mr. Molinari, Mr. Mineta, Mr. Derwinski, Mr. Gradison, Mr. Ford of Tennessee, Mr. Hughes, Mr. James K. Coyne, Mrs. Snowe, Mr. Simon, Mr. McCollum, Mr. Conyers, Mr. Brown of California, Mrs. Martin of Illinois, Mr. Marks, Mr. Green, and **Mr. Pickle**.

Federal Legislation

This same pattern of bipartisan political support was also evident in federal legislative efforts. In September 1981, four Republican Congressmen - Stewart McKinney (CT), Millicent Fenwick (NJ), Hamilton Fish (NY) and Newt Gingrich (GA) - introduced a federal marijuana-as-medicine bill. This legislation, re-introduced in 1983 and 1985, received broad bipartisan support in the House, attracting more than 110 co-sponsors. It is difficult to find another legislative matter which could unite far-right conservatives Gingrich, Fish, William Dannemeyer and Mickey Edwards with moderates McKinney, Fenwick and William B. Hughes, and liberals Richard Gephardt and Barney Frank.

Despite the wide-range of political support for meaningful federal legislation, Representative Henry Waxman (CA) failed to hold public hearings on this Republican sponsored marijuana-as-medicine measure.

In early 1987, Representative McKinney became the first Member of Congress to die of AIDS. No federal marijuana-as-medicine bill has been introduced in Congress since his untimely death.

Opinion Samplings

Polling data of public attitudes on this question mirrors the actions of the state legislatures and consistently indicate a vast majority of the American people believe marijuana has medical value and should be legally available, by prescription.

There is a generalized public anger over increasingly intrusive bureaucratic controls on the delivery of medical care. A recent poll conducted by The Wirthlin Group found 80% of Americans believe patients should have a legal right to use promising, but not yet approved, therapies for terminal illnesses such as AIDS or cancer.

Even in non-fatal diseases, 78-84% of the American people felt control over the choice of medical treatment should be decided by patients and their physicians, not remote bureaucrats or policemen.

This deep-seated public concern over who controls basic medical decisions is starkly evident in the polling data available on the question of marijuana's medical availability.

Polls & Surveys

[The first reliable polling information on this question](#) appeared in the late 1970's from surveys conducted in Pennsylvania and Nebraska. Both polls disclosed more than 80% of those randomly questioned favored marijuana's prescriptive medical availability. A very sizable majority of all those questioned -- whether segmented by age, party identification, religion, education or income -- supported marijuana's medical use. Both polls, conducted by different polling organizations, found opposition to marijuana's medical use was limited to a scant 12% of the population.

A telephone poll conducted by the Detroit Free Press on October 13, 1978, revealed 85.4% of those calling favored prescriptive access to marijuana.

In Washington, the State Medical Association conducted a poll in which 80% of the doctors favored the controlled medical availability of marijuana.

A more recent polling of physicians was conducted in 1991 by Harvard University's J.F.K. School of Public Policy. More than 2,000 career specialists were surveyed about their attitudes towards marijuana's medical utility. An astonishing 89% of those physicians with an opinion said marijuana is an effective antiemetic treatment.

Unscientific radio-talk show and newspaper samplings of public opinion consistently register a similarly high range -- 75-85% -- of public support for medical marijuana.

For example, a December 22, 1992 radio-talk poll conducted by Roanoke, Virginia station *WFIR* is typical. The station reports that 96% of the listeners who phoned the station vote-line endorsed marijuana's medical availability.

The most recent scientific poll on this question was conducted for the Drug Policy Foundation. In response to the one question relating to marijuana's medical use 69% of those questioned favored prescriptive access to marijuana for the treatment of glaucoma.

Public Elections

While polls provide a "snapshot" of social attitudes, [there is no more powerful, exacting or legitimate expression of the electorate's mind than that afforded by an election.](#)

There have been two recent public elections on the question of marijuana's medical availability.

In November 1991, "liberal" San Francisco became the first political jurisdiction in the United States to put this question on the ballot. An astonishing 79.5% of the electorate rejected the federal prohibition to vote in favor of marijuana's medical availability.

In November 1992, the voters in "conservative" Santa Cruz County, south of San Francisco, voted to end the medical prohibition by an equally astonishing 77.1%.

Significantly, Proposition P in San Francisco and Measure A in Santa Cruz County won by larger electoral margins than any national candidate on the 1992 ballot or any previous voter initiatives in California history.

A Remarkable Consensus

There is no other issue which unites so many of the American people in opposition to an existing federal policy.

The American people know marijuana has medical value, and they are clearly fed-up with bureaucratic efforts to block marijuana's therapeutic availability. As noted above:

- 87% of the legislators in thirty-five states voted to end the medical prohibition.
- 82% of the American people, when polled, reject the medical prohibition.
- 79.5% and 77.1% of the voters in two public elections voted to end the medical prohibition.

The scale of the electoral victories in California reflects the bipartisan consensus so evident in the state legislatures, in the range of co-sponsors attracted to Representative McKinney's federal marijuana-as-medicine bill, and in the available polling data.

The most remarkable aspect of this vast public consensus is its constancy over time, and its reach beyond mere party or ideological identifications. In the purest political terms the net difference between multi-ethnic urban liberal voters in San Francisco and predominately white, conservative voters in Santa Cruz County rejected the medical prohibition to vote in favor of a more rational and humane policy directed at meeting legitimate medical needs.

INHERITING BAD POLICY

Current Federal Policy

Richard Nixon was president when marijuana was made a Schedule I drug under the federal Controlled Substances Act. As such marijuana is defined in law as a drug "with no accepted medical use in treatment in the U.S."

For twenty-two years FDA, by erecting regulatory barriers to cogent scientific and medical evaluations, has assisted DEA in maintaining the medical prohibition. For example, FDA officially classifies marijuana, a natural plant with an ancient medical heritage, as a New Drug.

Gerald Ford was president when a federal court ruled a glaucoma patient's use of marijuana was not criminal, but an act of "medical necessity." In part, federal Judge James Washington ruled, "**It is unlikely that [marijuana's] slight, speculative and undemonstrable harm could be considered more important than defendant's right to sight.**" Concurrent with the court's verdict, this man also became the first American to secure legal, medical access to FDA-approved supplies of pre-rolled marijuana cigarettes.

Jimmy Carter was president when FDA, in the wake of a lawsuit by this glaucoma patient, created the Compassionate IND system for medical marijuana.

Demands for Change

For twenty years the medical prohibition has been under sustained scientific, medical, legal, social and political challenge. In the course of this protracted debate the courts, a majority of the state legislatures, the press and the American people have rejected the medical prohibition.

Eroding societal support for the medical prohibition reached its zenith in 1988 when DEA's chief administrative law Judge Francis L. Young condemned the federal prohibition as "unreasonable, arbitrary and capricious." After two years of court-ordered public hearings, Judge Young ruled DEA should immediately reschedule marijuana to Schedule II, and recommended marijuana be made prescriptively available for the medical treatment of persons afflicted by life-or sense-threatening disorders.

Anticipating the bureaucratic response, Judge Young noted:

"There are those who, in all sincerity, argue that the transfer of marijuana to Schedule II will 'send a signal' that marijuana is 'OK' generally for recreational use. This argument is not specious... **The fear of sending such a signal cannot be permitted to override the legitimate need ... of countless sufferers for the relief marijuana can provide when prescribed by a physician....**"

Medical Prohibition Under Pressure

Judge Young's historic verdict fractured the bureaucratic facade of unqualified resistance and greatly accelerated patient demands for access to care. These demands took on even greater urgency in the early 1990s when **FDA was compelled to expand the nation's Compassionate IND program for medical marijuana to include HIV+ people and Americans afflicted by neurologic disorders like paralysis, multiple sclerosis, and muscular dystrophy.**

Federal drug agencies were whipsawed by these accelerating demands for care. **DEA steadfastly maintained marijuana has no medical value even as FDA authorized marijuana's compassionate medical use for the treatment of an expanding number of life-and sense-threatening diseases.** By April 1991, this profound contradiction in federal policy brought the medical prohibition into crisis.

The Collapse of Compassion

This crisis in policy reached critical mass in April 1991, when the U.S. Court of Appeals rejected DEA's standards for scheduling marijuana. In so ruling the Court focused on the central contradiction in federal policy: **how could DEA argue marijuana is medically useless if FDA routinely authorized marijuana's therapeutic availability in compassionate programs of medical care?**

Bush Blunders

The Bush Administration foolishly sharpened public awareness of this long unresolved problem in June 1991, when PHS Chief James O. Mason abruptly and arbitrarily terminated the nation's fourteen year old Compassionate IND program for medical marijuana.

Confronted by a rising tide of demands for licit access to medical marijuana, alarmed by DEA's rapidly eroding legal position, and under escalating bureaucratic pressure to "do something," the Bush Administration panicked. **PHS Chief Mason initially cited the "surge in new applications" as his reason for terminating the long-standing program.**

"It is more than being cruel. It's uncivilized."

Ron Shaw

Chronic pain patient

Florida Today, March 4th, 1992

"They're giving me a death sentence."

Tim Braun

AIDS patient

AP, March 12, 1992

"Why won't they believe us?"

John Skidmore

AIDS patient

CNN, March 13, 1992

Mason's announcement caught policy-makers in the White House off-guard. It also triggered intense, universally negative editorial reaction. People with glaucoma, AIDS and other serious illnesses besieged the White House, Congress and the bureaucracy. This fierce, sustained public reaction stunned the Bush White House.

For the next nine months, while desperately ill Americans suffered, the Bush Administration was torn by protracted inter-bureaucratic debate.

Events in the real world only deepened the Bush Administration's confusion.

- October 8, 1991: The Florida Supreme Court ruled marijuana can be a drug of "medical necessity" in the treatment of AIDS.
- November 6, 1991: Nearly 80% of the voters in San Francisco rejected the medical prohibition. By some estimates, more than 65% of the city's conservative voters favored marijuana's medical availability.
- December 1, 1991: The popular CBS News magazine program *Sixty Minutes* highlights the question of marijuana's medical availability in a segment titled "Smoking to Live."
- February 1992: The National Association of People With AIDS (NAPWA) endorsed marijuana's medical availability in AIDS care and called on the White House to maintain the Compassionate IND program.
- February 1992: **The nation's ten legal marijuana smokers blasted the Bush Administration for "turning the promise of compassionate care into a cruel bureaucratic con game played against desperately ill Americans."** The patients accused PHS Chief James O. Mason of "medical terrorism."

Administration officials, traumatized by these external events, wandered through indecisive policy debates marked by months of private meetings attended only by bureaucrats and political appointees. **The obvious chaos solidified public impressions that federal drug policy was being driven by ideology and not by concern for the needs of seriously ill Americans.**

What the Press Says . . .

Let Sick People Have Medicinal Marijuana

"Sick people should not have to become outlaws to relieve their suffering."

USA Today,
November 24, 1992

Kinder, Gentler Marijuana Policy

"When the medical history and testimony of patients . . . Are juxtaposed against the policy dictates of the Bush Administration and the impact they have on individuals, the meanness of the federal bureaucracy is inescapable. [We] can and must be more humane."

The Boston Globe,
June 5, 1992

The Drug War Claims More Innocent Victims

"The Public Health Service's message to [patients who medically need marijuana] is: Drop dead. The bureaucrats . . . don't deny that marijuana helps. But if some people with AIDS will die sooner rather than later because they can't get pot, the people at PHS are bravely resolved to accept that sacrifice . . . Plenty of Americans can see the difference between legalizing marijuana for recreation and legalizing for medical treatment. Why can't the drug warriors in Washington?"

Stephen Chapman,
The Chicago Tribune March 12, 1992

Medical Use of Marijuana; Let Doctors Decide

“[T]he Public Health Service recommendations evidence a prejudice against study of this natural drug’s medical effectiveness. Such prejudice is especially unfortunate because of marijuana’s low toxicity, far lower than aspirin... Such hypocrisy is not harmless; it can turn medically needy citizens into criminals.”

The Star Tribune,
Minneapolis, Minnesota
March 23, 1992

War on Drugs Heaps Suffering on Sufferers

“It’s a shameful decision.... [T]o ban the use of marijuana as a medicine has nothing whatsoever to do with the physical effects of the drug on its users; the decision is based solely on the political effects of the drug on Bush’s ill-advised war on drugs.”

The News Herald,
Panama City, Florida
March 13, 1992

Why Not Let Suffering People Use Pot?

“It’s obvious that the government hasn’t made or sponsored the studies necessary to find out for sure whether marijuana can be beneficial Why in the world not, given the accumulation of reports from patients who say pot has helped them when nothing else has? It’s inexcusable that the necessary answers aren’t available to sick and suffering people who need them.”

From the *Chicago Tribune*,
as published in “Other Voices,”
The Tampa Tribune
March 25, 1992

The Last Smoke

“Some sick people who would benefit from marijuana will be deterred by the ban; others, desperate, will smoke it anyway. So far, 35 states have endorsed medical marijuana. In San Francisco police have agreed to turn a blind eye to it. Unless the government does something similar, smoking marijuana to relieve intolerable discomfort will remain, incredibly, a crime.

The Economist,
March 28, 1992

The Government’s Tunnel Vision Denies Pot’s Useful Potential

“It seems the Public Health Services and corollary agencies such as the National Institutes of Health are doing everything in their power to deny the obvious -- that marijuana deserves consideration as a prescription drug. This tunnel vision brought on by a single-minded drug war and election year politics is not only unscientific, it’s cynical and cruel.”

The Mining Journal,

Marquette Michigan
March 29, 1992

In a futile attempt to escape this public censure the White House Office of National Drug Control Policy actually joined the chorus of outrage. In January 1992, **White House officials called PHS Chief Mason's actions "unconscionable" and bluntly told PHS "people are suffering" because of bureaucratic delays in the delivery of FDA-promised supplies of medical marijuana.** The White House promptly leaked this scathing letter.

Bush Blunders II

It was too late. In March 1992, War on Drugs hardliners in the bureaucracy won. Bush killed FDA's Compassionate IND program for medical marijuana. **FDA dumped hundreds of Compassionate IND applications into the trash and scores of patients were arbitrarily denied promised access to medical care.** Only a handful of patients - those already receiving medical marijuana -- were spared.

Editorial and news reaction to the March 1992 announcement was even harsher and more sustained than in June - September 1991. PHS efforts to justify the policy shift were subjected to outright ridicule. To make matters worse, high officials in PHS, FDA, NIDA and the White House - in off-the-record comments - routinely told reporters they strongly opposed the Bush Administration's decision to terminate the Compassionate IND program for medical marijuana.

The most scathing comments, however, came from the seriously ill. One Minneapolis AIDS patient, Tim Braun, captured the public mood when he told the *Associated Press*, "I think it's a decision ... made by some bozos that don't get their fat duffs out of the office and ask the doctors who work with patients like this, talk to the patients who are using it, talk to the families and the friends that see the difference."

Braun received the FDA approval for marijuana therapy in December 1990. For nearly eighteen months, while bureaucrats bickered, Tim Braun waited for his FDA-promised marijuana. Often he could not obtain enough marijuana off the streets to meet his needs. During these times Braun always lost weight. At one point he lost 60 pounds.

When an *AP* reporter told Tim Braun about the PHS decision to kill the Compassionate IND program Tim prophetically said, **"They're giving me a death sentence."** Tim Braun, 44, died two months later without ever receiving the compassionate care his government had promised to provide.

Critics charge **Bush killed the program in a craven attempt to appease War on Drugs hardliners and homophobic elements of the religious right.**

Destroying the nation's marijuana-as-medicine program may have appealed to a few cultural zealots in Bush's narrow base, but **"killing compassion"** fueled the already wide-spread public perception Bush was **"out of touch," "uncaring,"** and **"too ideological"** to remain in office.

Aftermath

Bush's politically maladroit move to kill the Compassionate IND program has galvanized patients, physicians and drug reform advocates. As a result, the incoming administration faces an active, aggressive and broad-based coalition ready to amplify deep-seated public demands for an end to the medical prohibition.

By far the most legitimate and powerful voices in this emerging coalition belong to seriously ill Americans who command media attention. A review of media from June 1991 through June 1992 underscores just how decisively **a few well-spoken patients "won" the public debate** against George Bush. Significantly, editorial and press reaction to Bush's medical prohibition was universally negative, often hostile.

“Essentially, we’re victims but they’re making us criminals”

Ladd Huffman

MS patient

Des Moines Sunday Register, March 22, 1992

“Closing our eyes to what’s happening is not helping; it is the real blindness.”

Elvy Musikka

Glaucoma Patient

Oregon Daily Courier, October 1992

SYNTHETIC SOLUTIONS

Rather than respond to public and political demands for marijuana’s medical availability, federal drug agencies are instead promoting bureaucratically sanctioned alternatives which are synthetic, expensive and often ineffective. It is ironic that after decades of pretending marijuana is medically useless, federal drug agencies are now aggressively pushing synthetic Marinol, the so-called “pot pill,” by arguing it is as safe and effective as marijuana.

Patients familiar with the synthetic “pot pill” have strongly condemned the bureaucrats for “pushing” an inferior substitute. One AIDS patient recently told a reporter,

“I tried [Marinol]. I went through five pills before I was able to keep one down... When I did manage to keep one down it took a long while to take effect, and only worked about half a day. Two or three tokes on a joint helps me immediately.”

Let'em Eat THC

Delta-9-Tetrahydrocannabinol (THC) is the most powerful *psycho*-active chemical in marijuana. Synthetic THC was developed for drug abuse research on rats and other animal subjects. **The synthetic “pot pill” was never intended for human use in a routine of medical care.** In the early 1980s, however, federal agencies were overwhelmed by demands for legal access to government supplies of marijuana cigarettes for use in legislatively authorized, state programs of patient care. **FDA and DEA, unable to meet these state requests for natural marijuana, began promoting synthetic THC pills as a therapeutic substitute for marijuana.**

In September 1980, federal agencies released THC through the National Cancer Institute’s Group C Treatment Program. Then federal agencies frantically searched for a private-sector pharmaceutical company to sponsor a New Drug Application (NDA) for the federally-developed THC pill. In exchange, federal agencies promised the company exclusive control over the medical market for synthetic THC.

This promotion of synthetic THC was not designed to meet legitimate human needs. **It had only one objective: to maintain the medical prohibition against marijuana.**

The public was told “Pot Pill Approved.” Federal drug agencies assisted in a disinformation campaign by saying marijuana was no longer medically needed because the modern, synthetic “pot pill” had arrived. **Federal agencies knew this was a lie.**

What Patients Say . . .

“Overall I was very disappointed with Marinol. Never did it seem to relieve my nausea It didn’t help my appetite, much less ease my headaches. Compared with marijuana, Marinol is a joke.”

Jim Barnes
Michigan AIDS patient

“While synthetic THC helped to control my spasms, I noticed that the drug appeared to become less effective with repeated use. I also noticed that, unlike marijuana, THC had a powerful mind altering effect...”

David Bransetter
Missouri quadriplegic

“The difference was like night and day. When I used marijuana it was much more helpful.”

Ron Jochim
Maryland cancer patient

“I’ve been taking Marinol for more than a year. But it’s very hard to regulate. It doesn’t stimulate my appetite. Marijuana stimulates my appetite [and] is a lot easier to control than the Marinol pill.”

Daniel Parsons
New Hampshire AIDS patient

“We expected [Marinol] would work as well as marijuana. We were wrong.”

John J. Dunsmore, Jr.
Colorado father of cancer patient

“There was a really big difference between how I feel after smoking marijuana and how I feel after Marinol. Marijuana makes me feel relaxed. I can think clearly.”

Barbra Jenks
Florida AIDS patient

“Based on our findings in New Mexico, marijuana has distinct therapeutic advantages over synthetic THC.”

Katy Brazis, R.N.
New Mexico oncologic nurse

“Marinol is ok sometimes. And sometimes Marinol fails to work and I feel nauseated. Marijuana always works.”

Rocky Lane
California AIDS patient

“If Sheila has marijuana to smoke she doesn’t get real sick.”

Rosalie Pluskis
Wisconsin mother of cancer patient

Marinol Isn’t Marijuana

The problem with this synthetic strategy was most quickly evident to patients. Marinol isn’t marijuana. The synthetic solution failed because Marinol is only marginally effective.

The difference between marijuana and THC was apparent from the outset. Cancer patients quickly discovered smoking marijuana is far more effective than swallowing oral THC pills. During the DEA hearings before Judge Young, one researcher, Norman Zinberg, M.D., testified that during his 1974 research nearly **half the patients quit his legal, THC-based study in order to obtain illegal, but more effective, marijuana.**

Zinberg’s observations were amplified in an internal National Cancer Institute (NCI) memo from mid-1978. **Synthetic THC is described as “erratic,” “unpredictable,” and finally dismissed as “unfit” for human use.** Marijuana cigarettes, by contrast, are described as “reliable” and “highly predictable.” After reviewing the available evidence the cancer specialists at NCI concluded, **“All in all the [marijuana] cigarette may be the best means of delivering the drug.”**

After reviewing the available evidence DEA Judge Francis L. Young concluded Marinol is not an adequate substitute for marijuana.

Some will argue these are “old” conclusions. Yet as recently as 1992, Dr. Robert Gorter, a primary researcher of synthetic Marinol’s use in AIDS therapy, echoed Zinberg’s testimony:

“Again and again patients have testified that they prefer marijuana above dronabinol [Marinol] for its appetite stimulating effect. Therefore, it is hoped that marijuana will stay an option for the medical treatment of [wasting syndrome] in AIDS patients.”

Why is inhaled marijuana superior to synthetic THC?

Speed of delivery: When inhaled, marijuana reduces nausea and vomiting in five to ten minutes. Marinol, when ingested, takes 1 to 4 hours to start working. This gives patients plenty of time to throw up the pill.

Control of Dose: Marijuana, when inhaled, **works so quickly patients can exercise very fine control over their dose.** Once relief is achieved they simply stop smoking. Inversely, a patient exercises NO control over an oral dose; once the pill is swallowed all further control is lost. Moreover, because oral THC takes so long to work, and works so erratically and unpredictably, patients may take a second oral dose. **Little wonder adverse psychological effects are far more common among people employing oral Marinol than among those smoking marijuana.**

Chemical Composition: Marijuana, like all naturally occurring substances, is chemically complex. **Marijuana has more than 400 chemical ingredients.** Little is known about which chemical ingredients -- or what combination of ingredients -- are responsible for the plant's multiple therapeutic actions.

Federal agencies did not approve Marinol because of evidence indicating delta-9-THC is marijuana's most *therapeutically*-active ingredient. Delta-9-THC was synthesized to facilitate drug abuse research on marijuana's psychoactive effects. **Trapped by their legal fixation on psychoactive effects, federal agencies simply assumed, despite ample evidence to the contrary, that what gets you "high" makes you well.**

The irony, of course, is that to avoid making marijuana medically available, **federal agencies are now aggressively promoting a synthetic alternative which contains pure THC which is profoundly more psycho-active than marijuana in its natural form.**

Pills are medically familiar. Smoking is not. Opponents of marijuana's medical use often argue inhalation is not compatible with modern medical practice. In the name of science such opponents would deprive those who are now ill of care while researchers endeavor to create a perfect "marijuana-like pill."

Advocates of marijuana's medical availability do not contend marijuana is "perfect" or object to research into synthetic alternatives. Such research must continue and, in some cases, begin. But **it is medically unethical to use an elusive search for pharmaceutical perfection as an excuse to deprive millions of currently ill Americans of therapeutic access to an effective, albeit imperfect, treatment.** This is particularly true when one considers the long and distinguished history of marijuana's medical use.

To put it simply; how can the government criminalize seriously ill citizens who choose to medically use a God-given plant?

The Great White Drug

When bureaucratic attempts to push synthetic Marinol as a substitute for marijuana fail, federal drug agencies fall back on another old standard: there are "new" drugs which make marijuana medically unnecessary.

In the early 1980s, for example, federal agencies promoted Torecan (Reglan) as an antiemetic substitute for marijuana. Health care workers like Torecan because patients are well-controlled. Indeed, Torecan **renders patients nearly comatose.** Many still vomit, but **they are not conscious enough to care.**

Michigan tested the Torecan alternative in their state authorized marijuana program. Researchers allowed patients to begin on Torecan or marijuana. Patients could, at any time, elect to switch to the alternative drug. Significantly, **90% of the patients who started on marijuana stayed on marijuana.** Even more significantly, 90% of the patients who received Torecan elected to switch to marijuana.

The most recent "new" drug receiving bureaucratic praise as a marijuana alternative is Zofran which **costs \$600 per dose and requires hospitalization at a cost of \$500 - \$1,500 per day.** Zofran is said to be effective 75% of the time in helping patients vomit six times or less per chemotherapy treatment.

By contrast, **marijuana costs a penny per dose, patients can safely use it at home, and marijuana helps 90% of cancer patients unable to obtain relief using prescriptive antiemetic agents.**

There is a final important difference. Zofran is not an appetite stimulant. Marijuana is. **A patient employing marijuana at home can sit down to eat dinner with the family.** This is not a matter of insignificant benefit.

As Kenny Jenks, Chairman of the *Marijuana/AIDS Research Service* (MARS) has noted, “To the unintentionally anorexic the munchies can be a life-saver.”

Let The Market Decide.

No one is advocating that all patients with marijuana-responsive disorders be forced to use marijuana. **Ultimately the decision to employ any medication is a profoundly personal decision which is best left to the patient and physician.** In a more rational world natural marijuana and synthetic Marinol would both be medically available and patients and physicians would determine which drug was most appropriate for a particular treatment need. The market would decide.

For nearly two decades, federal agencies have used the medical prohibition to prevent such a market-based determination. They have compounded this error by granting an exclusive monopoly to the manufacturer of Marinol. In doing so FDA has ensured that the American people will be forced to pay exorbitant prices to obtain a demonstrably inferior synthetic substitute developed and researched almost exclusively at tax-payers' expense.

**Surely if physicians
can be trusted to prescribe morphine,
they can be trusted
to employ marijuana in a safe,
medically appropriate
manner.**

INITIAL STEPS

WHAT CAN PRESIDENT CLINTON DO?

One thing is certain, inaction is not an option. The Clinton Administration will be publicly compelled, early on, to take steps to resolve this problem. Fierce bureaucratic resistance is likely.

Presidents Come & Go

Federal drug agencies will conspire to enmesh President Clinton in a foolhardy defense of their publicly unpopular medical prohibition.

The bureaucrats will use pending legal actions against DEA to draw the new administration into the issue on their side. It is also possible federal agencies could initiate actions designed to embarrass the new administration.

These bureaucratic pressures can be considerable. The nine months of policy chaos triggered by PHS Chief Mason's impromptu attempt to kill the Compassionate IND program in June 1991 was **an outgrowth of the deeper struggle between ideologues in the bureaucracy and political realists** in the Bush White House.

By January 1992, White House realists, alarmed by the corrosive political effects of the medical prohibition, publicly called bureaucratic efforts to kill the Compassionate IND program "unconscionable." Yet, in March 1992, War on Drugs ideologues won. The program was terminated. **FDA dumped hundreds of Compassionate IND applications into the trash and scores of patients were arbitrarily denied promised access to medical care.** Only a handful of patients - those already receiving medical marijuana - were spared.

In the end the bureaucrats got their (nearly) absolute prohibition. But at what price? President Bush was subjected to months of negative news stories and scathing editorial comment which reinforced the already widespread public apprehension that **zealots had taken over his administration** - as indeed they had.

Bureaucratic resistance to marijuana's medical use is deeply ingrained. **Entrenched and terrified of change, federal drug bureaucrats do not have to live with the political consequences of their publicly discredited prohibition.** Politicians, as Mr. Bush recently learned, are not so easily forgiven.

On The Other Hand

If President Clinton fails to decisively address this problem, seriously ill Americans, backed by an articulate, broad-based coalition of drug law reform, legal, libertarian, medical and patient-advocacy groups will focus this same powerfully corrosive media energy on the incoming administration.

Seriously ill Americans who medically need marijuana are increasingly well-organized and have ample access to national media. Events from June, 1991 through June, 1992 suggest the tremendous influence such patients can exercise. A review of the media during this period shows just how decisively these patients thrashed Bush and the bureaucrats who sought to block marijuana's medical availability.

If President Clinton takes no action **these demands for reform will intensify.** Some elements within this broad coalition may cynically exploit seriously ill Americans in a misguided attempt to promote reforms which have **nothing to do with marijuana's medical availability.** The notion that ending the medical prohibition will automatically lead to the backyard cultivation of marijuana may appeal to romantics in "the movement." But **such antic aspirations do not seriously address the legitimate treatment needs of the ill.**

The American people -- in particular those who are seriously ill -- will not be well served by a Punch 'n Judy culture clash between ultra-prohibitionists on the far right and utopian reformers on the far left. The Clinton Administration cannot meet the needs of seriously ill Americans by responding to pressure from “ideologues” and “activists” operating on the political margin; left or right.

Beyond Cultural Warfare

By advancing a decisive, yet moderate plan to resolve the problem of marijuana’s medical availability the Clinton Administration can:

- Avoid public identification with extremely unpopular Bush policy,
- Seize the initiative in crafting a credible solution, and
- **Effectively demonstrate a willingness to cut through the decades of ideological crap and bureaucratic stonewalling to deliver the kind of “change” the American people expect.**

The nation is ready to resolve this problem as two recent editorialists illustrate.

On January 4, 1993, the *Albany Times Union*, noted “**We are somewhat incredulous... that the federal law of the land still bars marijuana for any medical use...**” In keeping with public opinion, the editors in Albany conclude, “**There’s no good reason to forbid such use.**”

The following day, a continent away, the *Oakland Tribune* echoed the comments of the *Albany Times Union* when it observed that the medical prohibition is “wrong-headed because it **denies reality.**” The *Tribune* noted that morphine and cocaine, “highly addictive drugs, are available for doctors to prescribe. Their use is successfully controlled through extra-stringent prescriptions.”

The paper concluded with a **call for “clear-headed and compassionate policy that allows the medical use of marijuana.”**

The recommendations outlined in this document will not satisfy libertarians and those on the left who advocate sweeping changes in the U.S. drug law. Nor will these recommendations appeal to the ultra-prohibitionists in the bureaucracy and on the right. In short, the recommendations advanced here are not designed to satisfy those with a merely political agenda.

These recommendations instead appeal to the broad American middle. They focus on three simple objectives: 1) meeting the legitimate treatment needs of those who are currently ill, 2) increasing marijuana’s availability for research, and 3) exploring pragmatic ways to resolve the regulatory problems created by five decades of irrational federal policy.

The American people know marijuana has important medical benefits. What is now needed is a rational plan to make marijuana legally available, under medical supervision, to those with legitimate medical needs.

RECOMMENDED ACTIONS

Step I - Restore the Compassionate IND program for medical marijuana

It is imperative the government meet the legitimate medical needs of currently ill Americans by restoring the Compassionate IND program for medical marijuana.

This is the minimum action the Clinton Administration should take.

The Compassionate IND program, created in 1978 during the Carter Administration, was arbitrarily terminated by the Bush Administration in March, 1992.

President Clinton should reverse PHS Chief Mason's publicly unpopular and arbitrary action by fully restoring the nation's Compassionate IND program for medical marijuana.

Prior to March 1992, FDA had authorized marijuana's compassionate, therapeutic availability to persons afflicted by glaucoma, cancer, AIDS, multiple sclerosis, muscular dystrophy, paralysis and chronic pain.

Of the highest priority: all persons who received FDA-approval under the Compassionate IND program prior to March, 1992 should receive the licit treatment access to marijuana they were promised. **FDA should be firmly instructed to handle all future Compassionate IND applications for marijuana in a timely, legally appropriate manner.**

IMPLEMENTATION

Step I can be implemented by Executive Order of the President. Restoration of the nation's marijuana-as-medicine program can also be accomplished by the Commissioner of FDA, the Chief of Public Health Service, the Assistant Secretary for Health or the Secretary, Health and Human Resources.

FDA and DEA will seek to block restoration of this program. At some point they will simply assert there is not enough "legal" marijuana in federal stockpiles to meet the anticipated needs of Compassionate IND applicants. The most obvious response, of course, is to instruct the bureaucrats to **grow more marijuana.**

In addition to meeting the legitimate treatment needs of those who are currently ill, **a properly administered Compassionate, single patient IND program could quickly provide a wealth of information on the full range of marijuana's therapeutic actions.** Treatment and research would advance hand-in-hand.

Step II - Encourage aggressive medical research by rescheduling marijuana from Schedule I to Schedule II of the CSA

The medical prohibition is rooted in ideological, not medical concerns. This ideological view is most evident in DEA's discredited definition of marijuana as a medically useless Schedule I drug. **This irrational classification is not legally tenable.**

[DEA has used marijuana's highly restrictive Schedule I status to impede legitimate research efforts and intimidate physicians seeking Compassionate IND approval.](#)

DEA's Schedule I classification of marijuana has already been declared "unreasonable, arbitrary and capricious" by the agency's chief administrative law judge, and the U.S. Court of Appeals (D.C. Circuit). This matter is still being litigated in the pending case of ACT v DEA.

If President Clinton fails to alter the DEA's misclassification of marijuana his DEA Administrator and his Attorney General will soon have to appear before the U.S. Court of Appeals to defend DEA's publicly unpopular medical prohibition.

Altering marijuana's classification to Schedule II would dramatically reduce regulatory barriers to cogent medical research while maintaining strict security requirements and severe criminal penalties for misuse of the drug.

For example, most physicians have a DEA registration to prescribe Schedule II substances. Placing marijuana on Schedule II would eliminate the need for physicians to seek special, Control I clearance from the DEA. It would also reduce often duplicative state reporting requirements. Many states require physicians engaged in Schedule I research to register with the state health and/or law enforcement agencies. No such special registration and reporting requirements exist for physicians engaged in the routine prescriptive use of Schedule II substances. **Surely, if physicians can be trusted to prescribe morphine (Schedule II), they can be trusted to employ marijuana in a safe, medically appropriate manner.**

Placing marijuana on Schedule II - **as many states have already done** - effectively removes DEA from direct involvement with physicians engaged in FDA-authorized studies. Rescheduling would in no way diminish FDA control over marijuana's therapeutic availability.

IMPLEMENTATION

Step II can be accomplished by Executive Order of the President, by action of the Attorney General or the DEA Administrator. Since DEA's chief administrative law judge has already issued a detailed ruling recommending marijuana's immediate reclassification to Schedule II no additional hearings on this matter are required.

Step III - Appoint a Presidential Task Force to Explore Marijuana's Legal Availability for Medical Applications

Steps I and II are designed to address the urgent medical needs of the currently ill and permit physicians to aggressively explore marijuana's therapeutic uses. But steps I and II do not resolve the primary problem.

The medical prohibition of marijuana has been in place for more than five decades. In this time federal agencies have evolved rococo regulatory controls which have transformed the medical prohibition into a Gordian knot of Catch-22 provisions and contradictory bureaucratic demands. **This awkward regulatory structure is designed to thwart rational study and reform.** The Clinton Administration must cut through this Gordian knot of regulatory nonsense.

On the surface making marijuana legally available for medical purposes seems simple. As a natural substance, however, marijuana is not a "new drug." Nor does it have a private pharmaceutical sponsor. Creating a rational system of prescriptive medical access encompasses complex regulatory and legal issues. There are also concrete concerns of appropriate governmental control over, and involvement in, programs of research, cultivation, manufacturing and distribution. These questions require careful, public consideration.

A Presidential Task Force should be created to isolate and evaluate such questions. **This Task Force should not be chartered to "decide" if marijuana is therapeutically useful. Patients and physicians, courts and legislatures, researchers and history have already resolved this question.** Marijuana clearly has medical value. **The Task Force should be charged with determining how the nation can best acknowledge this fact in order to address the legitimate treatment needs of seriously ill Americans.**

This Task Force, in short, should provide President Clinton and his Administration with a cogent, humane plan for ending the medical prohibition by **creating a rational system of prescriptive access to marijuana.**

This Presidential Task Force should be chaired by the Surgeon General. But **this effort will lack credibility if the bureaucrats who created this problem are put in charge of defining a solution.** Public participation is critical to a successful outcome. **Members of this Task Force should be drawn from patients affected by the prohibition, researchers and physicians from various medical specialties, state and/or federal legislators familiar with health-related issues, representatives from disease-specific advocacy groups, experts in drug policy and law enforcement.**

Such a Task Force will require a small budget and staff, and should have the power to call on federal officials and others to testify and provide guidance. Since people are suffering **the Task Force should move with dispatch and issue recommendations on needed regulatory and/or legislative actions** by late 1993.

CONCLUSION

Seriously ill Americans are suffering because of federal policies which prohibit marijuana's prescriptive medical use. To maintain this irrational prohibition, federal drug agencies have ignored the will of the people and the needs of seriously ill Americans, retarded research, obstructed the intent of state legislatures and refused to abide by administrative and judicial rulings.

In March 1992, President Bush, under pressure from War on Drugs ideologues in the bureaucracy, arbitrarily terminated the nation's long-standing marijuana-as-medicine program. People are dying, going blind, and being crippled by this cynical policy.

Based on polling data, election returns and the actions of their elected political representatives, **the American people do not support the medical prohibition.** Indeed, it is difficult to find any other question which unites so many of

the American people in opposition to an existing federal policy. **A vast majority of Americans view the medical prohibition as a regulatory fraud;** an irrational outgrowth of War on Drugs zealotry.

President Clinton has two options. He can commit his political credibility to a foolhardy defense of the medical prohibition or he can move to end that prohibition.

By taking moderate steps to meet the medical needs of seriously ill Americans, President Clinton can win broad public and political support for a rational system of prescriptive access to marijuana. Failure to resolve this problem will leave the new President exposed to attacks from ultra-prohibitionists on the right and utopian reformers on the left. These attacks will have a very corrosive effect on President Clinton's evolving relationship with the American people.

Federal drug agencies will, of course, strongly resist efforts to end the medical prohibition. It is likely these agencies will agitate their clients in politics, law enforcement and the pharmaceutical sector to oppose such action. It is less likely, but possible, that medical marijuana could be exploited by some as a cultural "wedge" issue. However, **there is precious little political profit to be gained opposing compassion.** All available data indicate such arguments have very limited public appeal. Moreover, true conservatives are strongly opposed to bureaucratic interference in personal medical decisions. Conservatives supported state legislation recognizing marijuana's medical value. In Congress many conservatives sponsored a federal marijuana-as-medicine measure.

The American people know marijuana has medical value, they are fed-up with bureaucratic efforts to block marijuana's medical use, and they are weary of being victimized by those on the political margins - left and right - who advocate the cult of cultural warfare.

The American people did not elect President Clinton merely hoping for change. They voted for Mr. Clinton to **initiate change.** We hope the pragmatic and moderate recommendations advanced in this document help those in the new Administration to secure such change **for the benefit of all Americans.**

***2021 Update: Nothing has changed.**

**Shame.
APPENDIX**

SUMMARY OF SUPPORT

Thirty-five states have legislatively recognized marijuana's medical value.

State courts in the District of Columbia, Idaho, Washington and Florida have recognized marijuana can be a drug of "medical necessity."

In 1988, DEA's Chief Administrative Law Judge ruled current **federal policies prohibiting marijuana's medical use are "unreasonable, arbitrary and capricious."**

The American Bar Association, the National Association of Criminal Defense Attorneys, the American Civil Liberties Union, the National Association of Attorneys General, the Conference of Episcopal Bishops, the National Association of People with AIDS, Mothers Against Misuse and Abuse, have called for a repeal of the medical prohibition of marijuana.

Polling data, available from a variety of sources over a period of more than a decade, consistently indicates between 70% to 80% of the American people believe marijuana should be legally available, by prescription, for the treatment of life-and sense-threatening diseases.

A 1991 Harvard survey of the nation's leading oncologists found that 44% of the cancer specialists had recommended patients break the law to obtain the marijuana they medically required. An astonishing 89% of those expressing an opinion felt marijuana should be legally available, by prescription.

In 1991, San Francisco became the first political jurisdiction in the U.S. to put the question of marijuana's medical availability on the ballot. Eighty percent of the electorate voted in favor of making marijuana legally available for medical purposes.

In 1992, a similar ballot measure in conservative Santa Cruz County received support from 77% of the voters.

In April 1992, the Physicians Association for AIDS Care (PAAC), the nation's largest organization of doctors involved in the treatment of H.I.V.-infection, and the National Lymphoma Foundation joined in suing DEA for refusing to recognize marijuana's medical value.

Significant Legal Cases

While federal agencies adamantly maintain marijuana has "no accepted medical use in treatment in the United States," **the medical prohibition has come under strong legal challenge from seriously ill Americans who have been arrested on marijuana-related charges.**

U.S. v. Randall

In 1976, a Washington D.C. man afflicted by glaucoma employed the little-used Common Law doctrine of necessity to defend himself against criminal charges of marijuana cultivation. On November 24, 1976, federal Judge James Washington ruled Randall's use of marijuana constituted "medical necessity." In part, Judge Washington ruled:

"While blindness was shown by competent medical testimony to be the otherwise inevitable result of the defendant's disease, no adverse effects from the smoking of marijuana have been demonstrated... **Medical evidence suggests that the medical prohibition is not well-founded.**"

Judge Washington dismissed criminal charges against Randall. **Concurrent with this judicial determination, federal agencies responding to a May, 1976 petition filed by Randall, began providing this patient with licit, FDA-approved access to government supplies of medical marijuana. Randall was the first American to receive marijuana for the treatment of a medical disorder.**

Randall v. U.S.

In 1978 federal agencies, disquieted by Randall's outspoken opposition to the medical prohibition, sought to silence him by disrupting his legal access to marijuana. In response, Randall, represented pro bono publico by the law firm of Steptoe & Johnson, brought suit against FDA, DEA, the National Institute on Drug Abuse, the Department of Justice and the Department of Health, Education & Welfare.

Twenty-four hours after the suit was filed, federal agencies requested an out-of-court settlement. The resulting settlement provided Randall with prescriptive access to marijuana through a federal pharmacy located near his home.

The settlement in Randall v U.S. became the legal basis for the FDA's Compassionate IND program. Initially, this program was limited to patients afflicted by marijuana-responsive disorders and some orphan drugs. In the mid-1980's however, the Compassionate IND concept was expanded to include HIV-positive people seeking legal access to drugs which had not yet received final FDA marketing approval.

In the Matter of Craig Reichart

In response to pleas from the parents of a young man afflicted with terminal cancer, Imperial County Superior Court Judge Don Work issued three orders to facilitate the legal availability of marijuana to treat the symptoms of nausea,

vomiting and weight loss. Judge Work ordered the Sheriff of Imperial Court to provide the young man's physician with contraband supplies of marijuana; immunized the patient from criminal liability for possessing the marijuana provided to him by his treating physician.

State of Washington v. Diana

A man afflicted by multiple sclerosis (MS) was arrested and charged with possession of marijuana. At trial, Sam Diana argued his use of marijuana was a "medical necessity." The court refused to hear medical evidence and convicted Diana. The Washington Court of Appeals overturned the verdict and returned the case to the lower court for retrial. The appeals Court ruled that "medical necessity" was a valid defense and instructed the lower court to consider evidence of Diana's medical need.

On retrial Diana presented testimony from numerous medical experts, his treating physicians, his family and other multiple sclerosis patients who endorsed marijuana's medical value in relieving severe muscle spasms. The Court concluded that Diana was **"not guilty by reason of medical necessity."**

State of Florida v. Musikka

A middle-aged woman afflicted with glaucoma was arrested for growing six marijuana plants. At trial, Musikka, who had already lost sight in one eye as a result of failed surgical interventions, argued her use of marijuana was a "medical necessity." Musikka's treating physician, a noted ophthalmic researcher at Miami's famous Bascom-Palmer Eye Institute testified that "if marijuana were legal I would have prescribed it for Elvy Musikka's medical use in the treatment of glaucoma." He further testified that, without marijuana, Musikka would go blind.

The Court, after hearing from other medical experts, concluded Musikka's use of marijuana was protected by the Common Law defense of "medical necessity" and found Ms. Musikka not guilty. In reaching this verdict, Judge Mark E. Pollin wrote:

"This is an intolerable, untenable legal situation. Unless legislators and regulators heed urgent human needs and rapidly move to correct the anomaly arising from the absolute prohibition of marijuana which forces law abiding citizens into the streets - and criminality - to meet their legitimate medical needs, cases of this type will become increasingly common in coming years.

There is a pressing need for a more compassionate, humane law which clearly discriminates between the criminal conduct of those who socially abuse chemicals and the legitimate medical needs of seriously ill patients whose welfare and very lives may depend on the prudent therapeutic use of those very same chemical substances."

U.S. v. Burton

Mr. Burton, a glaucoma patient, argued his use of marijuana was a "medical necessity." Testimony was received from Burton's personal physician, an ophthalmic physician who had researched marijuana's use in glaucoma therapy, from his uncle who was blinded by glaucoma, and relatives and others who testified to Burton's good character and work habits. The jury refused to convict Burton on the felony charge of marijuana cultivation with intent to distribute, but found him guilty of simple misdemeanor possession. **A Reagan-appointed federal judge, however, sentenced Burton, a Vietnam Veteran with no prior criminal record, to serve one year in federal prison. Federal drug agencies seized Burton's home, truck and farmland.** After serving his criminal sentence, **Burton and his wife fled the United States.** The couple now live in Holland, where Burton can legally obtain the marijuana he medically requires.

State of Minnesota v. Gordon Hanson

A man suffering from epilepsy was arrested for growing marijuana. At trial he argued his use of marijuana was "medically necessary" to control the debilitating seizures. Research neurologists from New York and Washington D.C. testified that Hanson's use of marijuana was medically appropriate. The local court dismissed this medical testimony and found Hanson guilty. On appeal, the Minnesota Supreme Court ruled that "medical necessity" could not be used as a

defense against criminalization for marijuana cultivation. The ruling drew sharp editorial criticism from many local newspapers. **Hanson served nearly one year in prison. During that time he had numerous gran mal and petit mal seizures.**

State of Florida v. Kenneth & Barbra Jenks

Kenny Jenks, a hemophilic, and his wife, Barbra, were arrested in March, 1990 for growing two marijuana plants. They were charged with three felony counts. At trial, however, the young couple revealed they both were infected by the deadly AIDS virus, and argued that their use of marijuana was “medically necessary” to control the nausea, vomiting and rapid weight loss caused by advanced HIV-infection. The local court refused to heed medical testimony from their treating physician and other experts and they were convicted on all three felony charges.

In April, 1991, the Florida Court of Appeals reversed the lower court, overturned the young couple’s criminal conviction and ruled their use of marijuana was a “medical necessity” in the treatment of AIDS. In October, 1991 the Florida Supreme Court upheld the Appeals Court’s verdict and ordered the prosecutor to file no further appeals in the landmark case.

State of Idaho v. Hastings

A woman afflicted by crippling arthritis was arrested for growing a few marijuana plants. At trial she argued her use of marijuana was “medically necessary” to control the debilitating pain caused by her arthritis. Her treating physician, other patients afflicted by chronic pain and muscle spasm, testified in her defense. The local court refused to consider the medical evidence, but withheld judgement. On appeal the Idaho Supreme Court ruled the defendant did have the right to “introduce evidence relating to the common law defense of necessity.” The Court ordered the lower court to consider all evidence of Ms. Hasting’s medical needs. At this juncture the prosecutor dropped all criminal charges against Ms. Hastings.

About the Authors (1993)

Robert Randall is president of the Alliance for cannabis Therapeutics (ACT), a Washington-based patient rights group. A glaucoma patient, Mr. Randall was the first American to secure legal, medical access to marijuana and is the nation’s leading advocate for marijuana’s medical availability. He has authored numerous articles, books, and is a frequent lecturer on the topic of marijuana’s medical uses.

Alice O’Leary is publisher at Galen Press. Ms O’Leary formerly worked for the Marijuana Reclassification Project, the National Women’s Health Network, and for nearly a decade as administrative officer of the Society for Scholarly Publishing. She is secretary-treasurer for Alliance for cannabis Therapeutics. Her publishing company, Galen Press, is the nation’s leading source of information on marijuana’s medical uses.

- *[Alice O’Leary Randall](#) is a senior spokesperson for the medical marijuana movement, co-founded in 1976 with her late husband, Robert C. Randall, the first person in the U.S. to legally receive medical marijuana. Following her husband’s untimely death in 2001, Alice took a well-earned break from the frontlines of the medical marijuana movement and embarked on a nursing career. Following her retirement in 2012, Alice has returned to the medical cannabis issue to educate and celebrate the contributions of many brave individuals who courageously fought for medical access to cannabis.*

Once called “First Lady of the medical marijuana movement,” Alice O’Leary-Randall communicates her singular perspective on the emotional and long-running movement to legalize marijuana as medicine. She was literally

there at the start. For two decades, she and her husband, Robert C. Randall, were advocates for medical access to marijuana. Robert, who had advanced glaucoma at a young age, discovered that he actually saw better after smoking pot. In 1976 he became the first U.S. citizen to have marijuana prescribed for a medical condition. Their personal battle is chronicled in their memoir, the highly respected [Marijuana RX: The Patients' Fight for Medicinal Pot](#). In the late 1970s Alice and Robert helped enact 35 state laws that recognized marijuana's medical value and attempted to establish state-sponsored research programs (the federal government thwarted these efforts).

In 1980 they founded the Alliance for Cannabis Therapeutics (ACT), the first non-profit organization dedicated solely to resolving the medical marijuana issue and drafted national legislation that was introduced in the U.S. House of Representatives and had 110 co-sponsors. ACT served as the primary plaintiff in the historic DEA hearing on marijuana's medical utility in the mid-1980s. In the '90s, Alice and Robert secured funding from a Chicago-based backer and took the medical marijuana movement to new heights, paving the way for state ballot initiatives that have secured legal medical access to marijuana for citizens of seventeen states.

Hospice and nursing: From 2006 to 2012 O'Leary-Randall worked as a grief specialist and nurse for Tidewell Hospice, She also worked in oncology and emergency rooms in Southwest Florida. Additionally she utilized her nursing skills on medical missions to Haiti, Peru, Uganda and India where she was able to assist just one month after the tragic tsunami of 2004.

Association management: Alliance for Cannabis Therapeutics, Director, 1980-1995; Society for Scholarly Publishing, Administrative Officer, 1981-1989; National Organization for the Reform of Marijuana Laws (NORML), Coordinator Medical Reclassification Project, 1978-1980; and National Woman's Health Network, Membership Coordinator 1976-1977.

Publishing Company: Founded Galen Press that compiled and released five massive volumes of information collected between 1986-1987 during marijuana rescheduling hearings conducted by the Drug Enforcement Administration (DEA). These court-ordered hearings, spearheaded by ACT, constituted the most complete investigation of marijuana's medical utility in the 20th century. Galen Press has a second imprint, Looking Glass Publications, for non-marijuana related titles.

In addition to domestic hurdles outlined above, one issue has consistently been identified as a significant obstacle. This is not just a problem for the United States. **The War on Drugs is a global failure.** [The United Nations 1961 Single Convention on Narcotic Drugs](#) has been looming over drug reform for decades. As of December 2, 2020, it is no longer an obstacle. What follows is a letter from Veterans for Medical Cannabis Access, to the World Health Organization committee overseeing these global reforms.

[The United Nations: December 2, 2020.](#)

[E/CN.7/2020/NGO/7](#)

Final list of signees (total = 193 from 52 countries):

NGOs in consultative status with the UN ECOSOC:

European coalition for just and effective drug policies

DRCNet Foundation

Grupo de Mujeres de la Argentina - Foro de VIH Mujeres y Familia

Law Enforcement Action Partnership

National Advocates for Pregnant Women

In addition, the following 186 NGOs co sponsored the statement:

Albania: National Albanian Hemp Industry Association.

Argentina: Cultivadores Argentina; Cultivando ConCiencia; Cultivemos.

Australia: CommonUnity Foundation; Coolbellup community school; Help Lindsay Beat This Brain Tumour; MCUA; Queensland Council for Civil Liberties.

Austria: ARGE CANNA; Elternkreis Wien Verein, zur Förderung der Selbsthilfe für Angehörige von Suchtkranken.

Belarus: MS Society of Belarus.

Belgium: European Industrial Hemp Association; Mambo Social Club; Mu Sic Foundation; Tire Ton Plant.

Brazil: Latin American Industrial Hemp Association.

Bulgaria: Restart Bulgaria.

Canada: Clinique la Croix Verte; Moms Stop The Harm; NORML Canada; Patient Access.

Colombia: ASOMEDCCAM; ProCannaCol.

Costa Rica: ACEID.

Czech republic: CzeCHemp; Legalizace.cz; Konopa; KOPAC.

Ecuador: Cábamo Industrial Ecuador.

France: APAISER S&C; Cannabis Sans Frontières; Club Confluence; ECHO Citoyen; Espoir (im)patient; FAAAT; #jusquabout; Le sourire de Wael; NORML France; Police Contre la Prohibition; Principes Actifs; SOS Addictions.

French Polynesia: Institut Polynésien du cannabis; Tahiti Herb Culture.

Germany: Arbeitsgemeinschaft Cannabis als Medizin; Global Marihuana March Freiburg; Gruene Hilfe Hessen; Grüne Hilfe Netzwerk; Hanf Museum; Hanfparade.

Greece: Iliosporoi Network; MAMAKA Mothers for Cannabis.

Hungary: Hungarian Medical Cannabis Association.

India: Medicinal Cannabis Foundation of India; Wildleaf.

Ireland: Help Not Harm.

Israel: Green Leaf Party.

Italy: Cannabis Cura Sicilia Social Club; Osservatorio sulla cannabis CBD.

Kazakhstan: Kazakhstan Union of People Living with HIV.

Republic of Korea: Korea Medical Cannabis Organization.

Lao People's Democratic Republic: Lao Medical cannabis Group.

Luxembourg: Cannamedica Luxembourg; Ligue Luxembourgeoise de la Sclérose en Plaques.

Malaysia: Malaysia Society of Awareness.

Malta: Releaf Malta.

Mauritius: PILS.

Mexico: Cannapeutas.

Namibia: Cannabis and Hemp Association of Namibia.

Nepal: Dristi Nepal.

Netherlands: Cannabinoid Association Netherlands; Drugs in Debat; Drugs Peace Institute; Dutch Drug Policy Foundation; Foundation Patienten Groep Medicinaal cannabis Gebruikers; Legalize!; Netherlands Drug Policy Foundation; Piratenpartij; Tree of Life Medical Cannabis Society; VOC Nederland; Suver Nuver.

New Zealand: Auckland Patients Group; Green Fairies; Integrative Medicine Otago; CCNZ; Medicinal Cannabis Awareness New Zealand; New Zealand Medical Cannabis Council; NORML New Zealand; NZ Hemp Industries Association; The Hemp Foundation.

Paraguay: Observatorio Paraguayo de Cannabis.

Perú: cannabis Gotas de Esperanza.

Philippines: Sensible Philippines.

Portugal: Apcanna; CannaCasa; CASOrganizados; Observatório português de Canábis Medicinal.

Romania: Asociația Națională a Producătorilor de Câneță Industrială.

Sint Eustatius: Roots Foundation.

Slovakia: Why Not Hemp?

Slovenia: CannaGIZ; Društvo AREAL; Društvo zeliščarjev Pomurje; FIST human rights association; Institut ICANNA.

South Africa: Fields of Green for ALL; Tshwane Region 3 Traditional Health Practitioners.

Spain: ARSU; Asociación Cannabio Medicina y Adicción La Aldeilla; Aura Verda; Dosemociones; APDO; CATNPUD; Confederación de Federaciones de Asociaciones Cannábicas; FEDCAC; Flecha Verde; Fundación Renovatio; Los Mejores Humos; OECCC; Pla d'Accions sobre Drogues de Reus; Unión de Pacientes por la Regulación del Cannabis.

Suriname: Spindoctor Facilities.

Sweden: Svenska Cannabis Främjandet.

Switzerland: cannabis Consensus Schweiz; IG Hanf Schweiz.

Trinidad and Tobago: Caribbean Collective for Justice.

Ukraine: Athena Women Against Cancer; Cannabis Freedom March Kyiv; HOO ВБО "Подолання"; HPLGBT; Korolivskiy Iis; Preability; Ukrainian Association of Medical Cannabis; Urban Initiatives and Social Transformations; Veterans Pro Medical Cannabis.

United Kingdom: Beyond Green; British Hemp Alliance; CANCARD; Cannabis Trades Association; CCGUIDE; Faircann International; Hemp Think Tank; Northern Ireland Hemp Association; Seed our Future Campaign; UK Medical Cannabis Clinicians Society.

United States: Academy of Cannabis Education; A Therapeutic Alternative; Americans for Safe Access; Anishinaabe Agriculture Institute; Association of Patient Advocates; Balanced Veterans; Berkeley Patients Group; California NORML; Cannabis for Children International; Cannabis Health Advocates; C.A.R.E.; Center for the Study of Cannabis and Social Policy; Decriminalize Nature Tucson; Decriminalize Virginia; Drug Policy Forum of Texas; Ethical Data Alliance; Family Council on Drug Awareness; Full Spectrum Veteran; Hemp for the Future; International Medical Cannabis Patients Coalition; Last Prisoner Project; Live to Love Project; Louisiana Veterans for Medical Cannabis; Marijuana Policy Project; Mendocino Cannabis Alliance; National Cannabis Industries Association; New England Veterans Alliance; National Organization for Reform of Marijuana Laws; Oaksterdam University; Patients Out of Time; Project PC; Raha Kudo Design for Dying; Seattle Hempfest; Society of Cannabis Clinicians; Texas Veterans for Medical Marijuana; The Grateful Veteran; **The Veterans Action Council**; TRUCE; Veterans Alliance for Compassionate Access; Veterans Chapter Pro Cannabis Medicinal Inc.; Veterans Ending the Stigma; Veterans for Medical Cannabis Access; Veterans Initiative 22.

Zimbabwe: Zimbabwe Civil Liberties and Drug Network.

NGO Statement - 64th CND

Statement submitted by the European Coalition for Just and Effective Drug Policies [ENCOD], a non-governmental organization in consultative status with the Economic and Social Council of the United Nations on behalf of the Veterans Action Council of the USA.

RE: 64th session of the United Nations Commission on Narcotic Drugs;

Normative segment - 5. Implementation of the international drug control treaties:

(d) International cooperation to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion;

(e) Other matters arising from the international drug control treaties.

The Veterans Action Council is a group of venerated professionals in their respective fields, committed to setting higher standards of care for the military Veteran community in the United States. As equals, each member of the council brings a unique perspective and a wealth of experience both in and out of service. The purpose of this letter is to put on record what we feel are important details of our experience as military Veterans accessing medicine since the passage of the Single Convention Drug Control Treaty.

Then President of the United States, Richard Nixon, was the one who declared a “war on drugs” and the USA has played a major role in enforcement of the Single Convention Treaty. Ironically, despite the USA playing a big role in other countries making progress in national access to cannabis medicines we haven’t been able to access those treatments inside the USA. Since the early 1960’s, the USA - National Institutes of Health have been providing scientists in the member state of Israel with grants to research the cannabis plant, its compounds, and potential for medicinal use. United States taxpayers have paid for research which has led to the state of Israel becoming the world leader in cannabis science and many Israelis use cannabis on a regular basis which is supplied to them by their government. It is time for the United States to treat her citizens with the same respect and compassion.

We find ourselves looking at the history of the Opium Wars, 100 years or so ago and the start of our drug control treaties, and how they represented the end of a practice of colonial trade and it was in fact this colonial trade that the war fought to end. We identify with those who were looking to free themselves from the grip of opiates however a side effect of the eventual elimination of this imperial trade in mind altering substances would cause cannabis to be no longer seen as a widely accepted ancient traditional herbal remedy and instead a dangerous narcotic. As we understand, India, with a long, bold, important and fascinating cannabis culture stood up for cannabis access and were at least able to protect the long standing practice of consuming preparations made from the leaves.

As we begin to see more and more of the globe consumed by opiate overdoses and death we can't help but imagine how many lives could have been already spared by access to cannabis medicines which not only have proven themselves impossible to cause a death by overdose but also known to have a "pill sparing effect" helping medical patients like us reduce our overall use of opiates and for some of us we are able to put the opiates aside completely. The cannabis plant has an ancient history, and its use among humans is well documented.

In the United States, we have inherited a long effort to create patient access to cannabis medicine. In the mid 1800's Dr O'shaughnessy brought cannabis to the attention of the medical profession inside of the United States and by 1900 cannabis had undergone serious inquiry by some of USA's most prestigious institutions and cannabis was enshrined in the US pharmacopeia and dispensatory. By the 1930's the medical drug industry inside the USA namely Parke Davis and Eli Lilly had mastered cannabis cultivation within the USA and modern pharmacies boasted dozens of cannabis containing medicines. In the late 1930's and 1940's cannabis was removed from the pharmacy shelves inside the USA and erased from our formulary and other reference books. This was done in contradiction to the available scientific evidence by hardline activists, abusing their public offices and power.

Citizens across our country have acknowledged the therapeutic potential of cannabis as witnessed by their voter initiatives and state legislation. Even still not all state programs are created equal, the federal government refuses to acknowledge the medical utility of cannabis, and our communities are inundated with pharmaceutical [opiate] narcotics.

For individuals who have lost their identities, careers, professions, and even spouses, children, and friends, these potentially destructive substances are too easy to abuse. We have lost more troops to suicide and accidental overdoses than from combat, many more. Death is an ever-present reality in combat environments. Through training, repetition, teamwork and accountability, the warfighter hardens themselves against this fact. To protect what they love, they knowingly enter into the fight. Nobody was ready for this epidemic. The status quo further aggravates hardships faced by all medical cannabis patients, not just the Veteran community.

Monopolizing patents, obstructing objective research, and working to subvert patient access to the healing properties of cannabis, are all themes played out time and again within the United States. This is not hyperbole. It is documented in myriad court cases spanning decades, leading right into the present moment. These difficulties include a lack of federal funding, a complex research approval process, and a shortage of government-approved cannabis for clinical trials. To put the process into perspective, it took the first rigorous clinical trial looking at cannabis as a treatment for post-traumatic stress disorder in Veterans seven years of applications and review boards just to get started.

We need to point out that we have been able to, as a grassroots voluntary association of patients, medical professionals and legislators, create over 31 modern state medical cannabis access programs delivering state of the art cannabis medicines that are quality controlled, have reliable reproducible dosage and reliable and noteworthy benefits to patients. This was only possible because we have been able to show real positive results of this treatment modality with comparatively very little negative side effects. While federal agencies adamantly maintain cannabis has "no accepted medical use in treatment in the United States," the medical prohibition has come under increasingly strong legal and legislative challenges.

Among the victims of the government's "war on drugs" : The disabled, the sick, and the dying being denied treatment that is known to relieve suffering and inadvertently replace those herbal treatments with deadly alternatives.

Surely if physicians can be trusted to prescribe morphine, they can be trusted to employ cannabis in a safe, medically appropriate manner. Seriously ill Americans are suffering because of federal policies which prohibit the prescriptive medical use of cannabis. To maintain this irrational prohibition federal agencies have ignored the will of the people and the needs of seriously ill Americans, stifled research, obstructed the intent of state legislatures, blamed the treaty and refused to abide by administrative and judicial rulings. We want the world to know.

Making cannabis legally available for medical purposes may seem simple however creating a rational system of prescriptive medical access encompasses complex regulatory and legal issues. There are also concrete concerns of appropriate governmental control over, and involvement in, programs of research, cultivation, manufacturing and distribution. These questions require careful, public consideration.

No one is advocating that all patients with cannabis-responsive disorders be forced to use cannabis. Ultimately the decision to employ any medication is a profoundly personal decision which is best left to the patient and physician. In a more rational world natural cannabis and synthetic pharmaceutical drugs would all be medically available and patients and physicians would determine which drug was most appropriate for a particular treatment need.

About one hundred and eighty years ago the United States, British, French, and other world powers forced their will upon our Chinese brothers and sisters. Today we have a plea to the world to repair the damage caused by colonial control of the trade in ancient medicines, recognize the complete mess we have made with our efforts to prohibit drugs and refresh our pledge to ensure medicinal access. Let's abandon prohibition, a cure that adds more dis-ease and less control with each passing year and work together to prepare future generations for the challenges ahead.

Due to word-count considerations for this letter, for further reading we humbly refer you to our "[Green Paper](#)" which we have included. It expounds upon our position regarding medical cannabis in greater detail.

Thank you for your time, and consideration.

Aaron Pluff

(b)(6)

Slater, Sandy R. EOP/ONDCP

From: Deborah Smith <(b)(6)>
Sent: Monday, August 2, 2021 11:38 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Response to Drug Policy Priorities

To Whom It May Concern,
First as a recovery I appreciate the efforts by the Administration to help stem the tide of deaths and overdoses.

A few things I wish to comment on....

1. My greatest hope is that these areas of concern were developed with the voice of recovery heard primarily in developing these contents. The lowering of stigma requires that the recovery voice and narrative is at the center of determining how best to approach the epidemic.
2. Evidenced based treatment is for the acute care interventions. Prevention events - education, social model recovery, family intervention and other technologies that address the chronic nature of addiction.
3. Harm reduction is inclusive of social model recovery and is good. Again this is more wide than the definition provided. Harm reduction occurs all along the continuum and it impacts families, workforce development and stigma reduction efforts.
4. Prevention is not just for adolescents - there is family prevention and recoveries with families that need prevention strategies. There are relapse prevention strategies under this heading.

--

Deborah J. Smith, PhD, LPC, CADC, MAC
NCC AP National Certified Peer Recovery Support Specialist
Co-Owner and Clinical Director
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Find our community recovery community on FACEBOOK
Lifeboat Addiction Recovery
m.me/114537856646927

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PUBLIC SUBMISSION

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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0008

Comment from Dennis, Ewing

Submitter Information

Name: Dennis Ewing

Address:

San Antonio, TX, 78239

Email: (b)(6)

Phone: (b)(6)

General Comment

I have been a chronic pain patient for over 30 years. At the middle of 2020 my pain doctor stopped taking insurance to get rid of his opiate patients. I spent 6 months trying to find a doctor that would continue the treatment I have been on for 20 years. I have been through all the PT and injections, along with countless MRIs and other treatments. I worked until I was no longer able to push through after my primary physician telling me for over 10 years I needed to take disability. Opiate medications made it possible for my to run my small business until my children were all grown as well as providing a couple of jobs for my employees. I will grant you that I have a physical dependence on my medication. I am not an addict. An addict will do whatever it takes and ruin relationships to get a drug. I have been married to the same woman for 43 las month. The fear of the DEA has made pain treatment a hope that lives in the past. Lack of pain management is going to cost the US billions as workers leave the workforce due to injury. I see the future of pain management as nonexistent due to the harassment of the DEA of older practitioners who have worked hard all their livers treating their patients and accumulating wealth so that they confiscate it and make a faked charge to arrest the poor doctor. We need to stop the continued treatment of the medical problems of addiction and dependence as a law enforcement issue and treat it like the medical problem it is. It is time to legalize, regulate and treat the users that want help with tax monies raised by sales to recreationally users. Lawmakers need the look at this issue like they doe alcohol as the similarities are there. This will put an end to most overdose episodes as the user would be buying safe clean taxed medication at a known dosage unlike the street drugs which are a crap shoot for dose. At the same time we could reduce the prison population most of which are people of color returning them to work and family. This would also include a wiping of criminal records to help the get good jobs removing the stigma for a offense that would have been done away with.

Slater, Sandy R. EOP/ONDCP

From: Aaron Pluff <(b)(6)>
Sent: Tuesday, August 3, 2021 2:09 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Public submissions Thoughts on cannabis & VHA

<https://www.today.com/video/veterans-in-hawaii-battle-for-reform-of-marijuana-laws-116813381812>

Aaron Pluff
(b)(6)

PUBLIC SUBMISSION

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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0010

Comment from Drug Policy Alliance

Submitter Information

Email: (b)(6)

Organization: Drug Policy Alliance

General Comment

See attached file(s)

Attachments

DPA Comments on Equity in U.S. National Drug Control Policy 8-6-21 Final

August 6, 2021

Robert Kent, General Counsel
White House Office of National Drug Control Policy
1600 Pennsylvania Ave., NW
Washington, DC 20500



Board Members
Alejandro Madrazo
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Rev. Edwin Sanders
Susan Kane

RE: FR Doc. 2021-14365 - Application of Equity in U.S. National Drug Control Policy

The Drug Policy Alliance, the nation's leading nonprofit fighting for drug policies grounded in science, compassion, health, and human rights, respectfully submits these comments in response to the Office of National Drug Control Policy's request for information on whether and to what extent ONDCP's policy development process, drug budget review and certification processes, and Grant Administration Programs perpetuate systemic barriers to opportunities for underserved communities and individuals from those communities and how its future proposed policies, budgets, regulations, grants, or programs might be more effective in advancing equity. We recommend that ONDCP adopt the following recommendations to improve equity in its operations and policies:

- Evaluate the impacts of current drug laws and support policy changes to improve equity;
- Develop a roadmap for an equitable, health-based approach to drug policy;
- Divest from law enforcement and supply-side tactics and invest in communities most harmed by the war on drugs;
- Include voices of people who use drugs; and
- Set requirements for grantees to ensure equity in their policies and data collection.

The war on drugs was designed as a tool for racial and social control. Laws criminalizing drug possession were spurred by racist tropes and fear mongering. Enforcement of criminal drug laws has always disproportionately targeted communities of color. Black people are three times more likely to be arrested for drug use than white people, despite similar drug use prevalence estimates.¹ Criminalization stigmatizes people and authorizes law enforcement to target, harass, arrest, prosecute, incarcerate, and deport. Involvement with drugs – real or perceived – is consistently used by law enforcement and the media to justify state violence, especially when the victim is a person of color. Modern police forces have not only failed to break from historic roots in racial oppression, but they have also become more powerful and more lethal in large part due to the drug war. Once a person has a drug conviction, they are precluded from vital public support programs, and finding employment becomes exceedingly difficult. Without the opportunity and resources to generate a sufficient income, communities bearing the brunt of drug law enforcement become trapped in cycles of generational poverty.

At the same time, communities of color are less likely to have access to harm reduction and substance use disorder treatment services. Rural communities, where rates of fatal overdose are among the highest, similarly experience lack of access to services, especially medications for treating opioid use disorder. Evidence suggests that a person's ability to access these medications is largely dependent on their race, gender, and geographic location.² Where people are able to access treatment and other services, many are

¹ REPORT OF THE SENTENCING PROJECT TO THE UNITED NATIONS SPECIAL RAPPORTEUR ON CONTEMPORARY FORMS OF RACISM, RACIAL DISCRIMINATION, XENOPHOBIA, AND RELATED INTOLERANCE 3-4 (2018), <https://www.sentencingproject.org/publications/un-report-on-racial-disparities/>.

² See, e.g., OFF. OF INSPECTOR GEN., U.S. DEPT. OF HEALTH AND HUM. SERVS., OEI-12-17-00240, GEOGRAPHIC DISPARITIES AFFECT ACCESS TO BUPRENORPHINE SERVICES FOR OPIOID USE DISORDER (2020); Matthew Robbins et al., [Buprenorphine Use and Disparities in Access Among Emergency Department](#)

deterred by the negative attitudes and stigma they confront from healthcare providers. Services as a whole are inaccessible and unattractive; a direct outgrowth of our drug policies and failure to invest in the resources communities need.

For over 50 years, federal drug laws and policies have perpetuated racial and economic inequity. ONDCP will not be able to ensure equity in its policies and programs so long as it operates within the paradigm of the war on drugs and punishing people for drug use. Accordingly, the most influential tact ONDCP could adopt to improve equity is to critically analyze current laws and policies, recommend and support legislative and other reforms, and outline a plan to achieve equitable, health-based drug policies.

ONDCP should evaluate the impacts of current drug laws and support changes to improve equity.

ONDCP requested recommendations for short-term and long-term goals that it should consider in measuring progress towards equity in drug policy. As a primary goal, ONDCP should thoroughly analyze current federal laws, regulations, and policies to identify inequities baked into the structure of federal drug policy and provide recommendations for how to reduce these inequities through reform. Examples of questions that should be analyzed include:

- How to amend the Controlled Substances Act to reduce criminalization of people who use drugs and support effective public health programs like safe consumption spaces;
- How to eliminate collateral consequences of convictions for drug offenses, such as restrictions from access to federally subsidized housing and benefits and the seizure of property under civil and criminal asset forfeiture; and
- How to revise other agency regulations to increase treatment access, including Substance Abuse and Mental Health Services Administration and Drug Enforcement Administration regulations pertaining to methadone and buprenorphine for treating opioid use disorders.

As the office tasked with oversight of federal drug policy, ONDCP could play a crucial role in coordinating efforts across agencies, identifying structural inequities in federal drug policies, and leading to solutions. Evaluation of the equity of current drug laws is essential. Without critical analysis and reform, attempts to ensure equity will have minimal impact in an inequitably designed system.

ONDCP should develop a roadmap for an equitable, health-based approach to drug policy.

ONDCP requested recommendations for long-term goals that it should consider in measuring progress towards equity in drug policy, and on how it can broaden its formal consultations to gain broader perspectives earlier in the policy development process. ONDCP should consult a variety of public health experts and people who have been directly impacted by drug criminalization to develop a plan to ensure an equitable, health-based approach to drugs.

A national equitable, health-based approach to drugs would transform drug policy across many agencies that have played a historic role in perpetuating the war on drugs. It would drastically reduce the role of law enforcement and ineffective supply-side tactics, which have long exacerbated social and racial inequality. This approach should focus on implementing evidence-based solutions, including expanded access to harm reduction services, substance use disorder treatment, and other necessary health and social services for all in need, with a particular focus on repairing the harms caused by drug law enforcement in underserved communities and communities of color. ONDCP should encourage the adoption of public health approaches

Patients with Opioid Use Disorder: A Cross-sectional Study, 130 JSAT, Nov. 2021, at 108405; Pooja A. Lagisetty et al., Buprenorphine Treatment Divide by Race/Ethnicity and Payment, 76(9) JAMA PSYCHIATRY 979 (2019).

that have not yet been implemented in the United States, including safe consumption spaces and safe supply of controlled substances to people with substance use disorders.

This health-based approach will also require ONDCP to shift its approach to drug education for youth, which has traditionally been based exclusively on abstinence. Drug education should be based in reality and center health, which requires an acknowledgment that people, including youth, may use drugs. Youth should be provided the information to make informed decisions about whether to use, and if they decide to use, how to do so in a manner to reduce the potential risks. An example of such an approach is the “Safety First” program, the nation’s first harm reduction-based drug education curriculum for high school students.³

As the key office focused on federal drug policy, ONDCP could play a pivotal role by laying the path toward effective, equitable solutions to improve the health of people who use drugs and reduce harms associated with drug use.

ONDCP should divest from law enforcement and supply-side tactics and invest in communities most harmed by the war on drugs.

Given the historic disparate enforcement of criminal drug laws and the overt failures of the criminal legal system approach, ONDCP should do all it can to divest from law enforcement and supply-side tactics. The evidence is clear— supply-side drug control tactics do not reduce substance use or potential harms associated with drug use. It is expensive and does nothing to decrease the supply of drugs.⁴ ONDCP should move away from these tactics, which “have no measurable public health benefit,” and focus, instead, on assisting “the most efficient and cost-effective public health programs.”⁵

Drug law enforcement is a primary driver of inequity in federal, state, and local drug policy. Black, Latinx, Indigenous, and other people of color are disproportionately targeted, arrested, and incarcerated for drug offenses. Therefore, ONDCP should prioritize divesting from law enforcement and supply-side tactics, including defunding the High-Intensity Drug Trafficking Area program. There is simply no way to make these types of programs equitable.

Where support remains for criminal legal system interventions, ONDCP should prioritize funding for programs that intervene at the earliest stages, including pre-arrest and pre-booking diversion. The drug court model should be deemphasized because it gives the criminal legal system control over treatment decisions and keeps people entangled in the system by forcing compliance with strict supervision requirements. ONDCP should also prohibit programs from including strict eligibility requirements that disproportionately impact people of color, such as exclusions based on prior convictions.⁶

Funding that would have been wasted by investing in ineffective supply-side interventions should be redirected to support communities that have been most harmed by drug law enforcement. Communities should determine what the best use of these funds would be, but some examples of services that these

³ Safety First, DRUG POLICY ALLIANCE, <https://drugpolicy.org/resource/safety-first-real-drug-education-teens> (Oct. 8, 2019).

⁴ See Gregory J. Madden, Ammunition for Fighting a Demand-Side War on Drugs: A Review of Contingency Management in Substance Abuse Treatment, 41(4) J. APPL. BEHAV. ANAL. 645, 645-651 (2008).

⁵ Evan Wood et al., Impact of Supply-side Policies for Control of Illicit Drugs in the Face of the AIDS and Overdose Epidemics: Investigation of a Massive Heroin Seizure, 168(2) CMAJ 165, 165-69 (2003).

⁶ See Shivani Mantha et al., Racial Disparities in Criminal Legal System Involvement among New York City Overdose Decedents: Implications for Diversion Programs, 226 DRUG & ALCOHOL DEPENDENCE 108867 (2021).

communities may desire include expanded harm reduction services, substance use disorder treatment, housing, and economic support.

Our current drug policies were built to perpetuate racial and social inequity. So long as ONDCP continues to support law enforcement through its budget and policies, it will sanction inequity in drug policy.

ONDCP should include voices of people who use drugs, particularly people of color who use drugs and formerly incarcerated people who use drugs.

ONDCP requested recommendations for how it can involve people who use drugs, especially those not typically included in household surveys, in the policy development process. National drug control policy has unquestionably failed, in part, because people who use drugs have been excluded from its development. To be effective, drug policy must meet the needs of the people it impacts because they are in the best position to identify and highlight the potential consequences and solutions. To ensure that national drug control policy serves the needs of the people it affects, ONDCP should review its employment policies to ensure people with lived experience are not being excluded from employment opportunities due to drug use or prior convictions. Rather, this type of experience should be sought after, and applicants with lived experience should be encouraged to apply and integrated into the office in policy making positions.

ONDCP should regularly seek the input of drug user unions and drug policy reform advocacy organizations in the development and review of all policies. Drug user unions and advocacy organizations regularly interact with people who use drugs and witness the far-reaching implications of the war on drugs. Additionally, ONDCP should develop focus groups, in coordination with drug user unions and drug policy reform advocacy organizations, to engage people who use drugs in the policy development process. ONDCP should ensure people of color who use drugs and formerly incarcerated people who use drugs are included. If these people are not otherwise compensated, ONDCP should provide reasonable compensation to the people with whom they engage.

ONDCP Should Set Requirements for Grantees to Ensure Equity in Policy and Data Collection

ONDCP should develop equity requirements for grantees of funds administered by the office. Among these should be the requirement that grantees implement policies meant to ensure equity and measure actual equity outcomes, including an examination of how the potential grantees' current policies and operations impact different populations and a plan to ensure equitable provision of services. Further, ONDCP should ensure that grantees do not discriminate or deny services to people who use methadone and buprenorphine for opioid use disorder. All grantees should be required to adopt policies that support access to these life-saving medications.

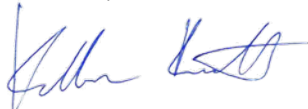
As part of the plan to ensure equitable provision of services, ONDCP should require grantees to track demographic data and impacts for underserved populations. ONDCP should provide a uniform system of reporting to ensure data from different grantees are comparable. ONDCP should analyze the data from grantees and generate reports describing equity impacts of ONDCP programs and ways to improve equity and data collection.

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The Drug Policy Alliance supports ONDCP's efforts to build equity into its policies and operations. We urge you to implement our recommendations to ensure a thorough approach to improving equity in drug policy. Should you have any questions or concerns, please do not hesitate to contact me at

(b)(6) or (b)(6)

Sincerely,



Kellen Russoniello, JD, MPH
Senior Staff Attorney, Drug Policy Alliance

Slater, Sandy R. EOP/ONDCP

From: Kris Furnish <(b)(6)>
Sent: Tuesday, August 3, 2021 11:07 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Public Comment Application of Equity in U.S. National Drug Control Policy



To the Office of National Drug Control Policy:

OGC@ondcp.eop.gov

Question: Are existing policies creating systemic barriers to opportunities for underserved communities?

Answer: Drug policy and racism has kept some of the best and brightest from being major contributors to quality of life in our communities and society. Drug laws have kept far too many qualified and needed people from important roles in commerce, critical infrastructure and community. For example, the Harris rider is an appropriations bill that prevents D.C. from using its locally raised funds to create a tax-and-regulate system for cannabis. This amendment has tied local officials' hands when it comes to creating a structure for the dispensaries that other jurisdictions now have in place. Those who would like to participate in the legal cannabis industry have no opportunity to do so in D.C. which creates an ongoing grey market that has many dangers such as no testing of products, no tracking of where they came from, illegal pop-ups where people have been shot and killed, and eliminates the opportunity for Black and Brown people to legally participate and earn an income. The underground, unregulated market leaves cannabis workers vulnerable to wage theft, sexual exploitation, and other predatory behavior. It also leaves them at risk of felony charges and deprives them of access to standard labor protections. [A 2020 review](#) of the data by the ACLU found that African Americans are more than 3.6 times as likely as whites to be arrested for marijuana possession, despite similar marijuana use rates. We cannot go on with the same fear-based unscientific and racist approach on cannabis. For many, it is a life-saving plant, and because of prohibition, consumers have to make a tough decision; address their medical concerns safely and holistically, but break the law, or go without, and live a life of pain and discomfort, for fear of breaking the law and losing everything. For people like Demonte Ward-Blake of Prince George's County, MD, the smell of marijuana and an expired tag is the reason he will never walk again. He is now paralyzed from the waist down, due to police officers tackling him to the ground and hitting his neck on the curb of the road. Or for people in federal housing, who are denied the right to use cannabis even in legal states, because it is still federally legal. According to the ACLU, enforcing cannabis prohibition laws costs taxpayers approximately \$3.6 billion a year.

There have been more than 16 million marijuana arrests in the United States since 1995, including an estimated 545,602 in 2019 — significantly more than for all violent crimes combined. One person is arrested for marijuana every 58 seconds. More than 90% of marijuana arrests are for possession, not manufacture or distribution.

Marijuana laws have been enforced unequally: A 2020 review of the data by the ACLU found that African Americans are more than 3.6 times as likely as whites to be arrested for marijuana possession, despite similar marijuana use rates.

I also have a personal testimony to share. I worked on a political campaign in Salisbury, Maryland in 2018. One night, while I was driving with my friend to the store to get some food, I was pulled over by Salisbury Police for "failure to stop at the white line at the stop sign." The officer that pulled me over claimed he smelled

marijuana in my vehicle and proceeded to ask if I had any drugs or weapons in the car, to which I answered, "no." The officer then asked my friend in the passenger seat for his I.D., which was a violation of his rights, as he was not the driver. Mind you my friend is Black, and was friends with Sandra Bland, who died mysteriously in jail. Many people strongly believe she did not kill herself. That experience for my friend was very traumatizing and led to the way he deals with law enforcement to this day, he records everything. After complying with the officer's request to see I.D., the officer demands that we get out of the vehicle, as he had probable cause to search because of the "smell of marijuana." Over and over again I told the police he had no right to search my vehicle, so then the police surrounded my car, and I watched the police drag my friend out of the car by any body part they could manage to grab, his arms, his legs, even his dreadlocks. They slammed him on the concrete and busted his eye, arrested him, and took him away in an ambulance. They treated me with respect, they didn't deal with me with force, or abuse their power with me. They gave me a warning for the "traffic violation" and sent me on my way. My friend ended up doing 30 days in county jail and now has a permanent criminal record. He lost both of his jobs while he was in jail. This story has been told over and over again, but I lived it. Cannabis is a tool used in racial profiling by law enforcement. It's an easy target. Arrests on non-violent, victimless charges keep law enforcement from pursuing violent crime and criminals. Unfortunately, chasing drug charges has become low-hanging fruit for law enforcement.

Question: Could future programs be developed to better promote equity?

Answer: Equity should be a cornerstone of the foundation for ending prohibition. Social equity deals with justice and fairness within social policy. These programs aim to ensure that people of color, including those with marijuana offenses prior to legalization, be afforded an opportunity to participate in not only this burgeoning cannabis industry, but in all industries. Cannabis prohibition has been disproportionately harmful to minority populations. This has led to many young people that have been deprived of educational opportunities and a future by virtue of being arrested for marijuana possession.

Question: How to better involve people who use drugs in the creation of policies that affect them?

Answer: You first have to take away the stigma and the fears in order to get people to be comfortable enough to participate. The most effective way to widen participation is to remove substances and substance abuse from the criminal justice system and introduce it into the healthcare and education universes. We cannot continue to have penalties that cancel careers, housing, and educational opportunities. And the White House knows this. The firings of the White House staffers for their admitting to cannabis use is a great example of why these policies need to change. Careers were ruined.

Kris Furnish
Co-Founder, MDMJ

(b)(6)

(b)(6)

Slater, Sandy R. EOP/ONDCP

From: LOST DREAMS AWAKENING RCO <(b)(6)>
Sent: Tuesday, August 3, 2021 1:03 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] COMMENTS: Application of Equity in U.S. National Drug Control Policy

Dear ONDCP,

The contained link below embodies and contains the comments that Lost Dreams Awakening RCO would like to contribute to the complex request from ONDCP to contribute to ONDCP's policy development process, drug budget review and certification processes of the 18 National Drug Control Program Agencies, and Grant Administration Programs that perpetuate systemic barriers to opportunities for underserved communities and individuals from those communities.

This article also offers ONDCP input on how our future proposed policies, budgets, regulations, grants, or programs might be more effective in advancing equity.

<https://www.tandfonline.com/doi/full/10.1080/08897077.2020.1867288>

If you should need any further input relevant to our comments, please contact Laurie Johnson-Wade, Co-Founding Director, at (b)(6)

Thank you for your inquiry.

PUBLIC SUBMISSION

As of: 8/6/21 1:22 PM
Received: August 03, 2021
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Tracking No. krw-qgfc-asfu
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Docket: ONDCP-2021-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0009

Comment from Thaddeus, Pham

Submitter Information

Name: Thaddeus Pham

Address:

Honolulu, HI, 96822

Email: (b)(6)

General Comment

Aloha,

Thank you for this opportunity to provide comment on national drug control policy.

The disparate impact of U.S. incarceration on black and latinx communities, especially in the context of the drug war, has been explicated in numerous research articles and studies (e.g., https://journals.lww.com/jan/Abstract/2018/01000/Racialized_Mass_Incarceration_and_the_War_on.10.aspx). These findings have strong similarities with current criminalization disparities experienced by Native Hawaiian communities in Hawai'i (and beyond). According to a recent report from the Office of Hawaiian Affairs (OHA; https://www.oha.org/wp-content/uploads/2014/11/factsheets_final_web_0.pdf), Native Hawaiians are disproportionately more likely to be imprisoned, sentenced, and denied parole. Furthermore, Native Hawaiians are more likely to be imprisoned for drug-related offenses, even though they do not use substances at dissimilar rates from other races/ethnicities in Hawai'i.

In its report, OHA implicates structural and policy issues for the overincarceration of Native Hawaiians, including biased policing, mandatory sentencing, and inequitable access to treatment. The report also notes that generational trauma from post-colonial dynamics and social marginalization can contribute to substance-related encounters with law enforcement. For many, the pervasiveness of colonialism in Hawai'i is thus a major factor in imprisonment disparities among local communities. Perpetuation of negative stereotypes, destabilization of families, and commodification of bodies in Hawai'i can be tactics to maintain colonial structures, even if they are reframed as "criminal justice" or "public safety" (recall the New Jim Crow by Michele Alexander).

As such, I beseech ONDCP to consider how national drug control policy can be utilized to maintain systemic inequities for many vulnerable communities. Given the lack of success to improve these communities through the ongoing drug war, more effective and less costly policy initiatives must be considered.

Mahalo for your time.

PUBLIC SUBMISSION

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Docket: ONDCP-2021-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0005

Comment from Benjamin, Daffron

Submitter Information

Name: Benjamin Daffron

Address: United States,

Email: (b)(6)

General Comment

Absolutely not. Stop wasting taxpayer money promoting this lie of “underserved communities” and systemic racism. You are the ones promoting racism with this shill. More money is wasted on lies such as this and more money is sunk into low-income communities that is wasted or stolen. This money comes from those that actually pay taxes. The same people of all colors that pay taxes that already support these communities through housing, food benefits, SSI benefits and numerous other public services. Do not waste money on this. Just stop.

PUBLIC SUBMISSION

As of: 8/6/21 1:21 PM
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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0006

Comment from Syracuse Youth Substance Abuse Prevention Coalition

Submitter Information

Email: (b)(6)

Organization: Syracuse Youth Substance Abuse Prevention Coalition

General Comment

As a coordinator of a Urban DFC Coalition, there are special challenges which Suburban and Rural Coalitions do not face. And as CADCA is the only institution ONDCP funds to provide technical assistance and training, it would be great if we had access to:

1. Someone who specialized in different types of urban DFCs (Northeast/Mid-Atlantic, Southeast/Central South, Midwest, Mountain/Great Plains, Southwest, and West-coast)
2. A forum for Different size or designed urban communities (more condensed vs sprawling)
3. Having workshops which focus on the specific challenges of urban communities especially those of color like:
 - mistrust of the government due to systemic bias
 - White top heavy organizations functioning in communities of color
 - your policy of food and not allotting for more per person
 - a town hall for urban DFC to voice their concerns and ideas.

Thank you
Charles Jackson
YSAP Coalition Coordinator

PUBLIC SUBMISSION

As of: 8/6/21 1:21 PM
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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0007

Comment from Opioid Crisis Response Fund

Submitter Information

Email: (b)(6)

Organization: Opioid Crisis Response Fund

General Comment

The most fundamental driver of inequity in U.S. national drug control policy (and in state, county, municipal, local drug control policies) is whether the policy/intervention under consideration falls on the favorable or unfavorable side of public opinion. Policies/interventions on the favorable side of public opinion receive funding beyond their evidence of efficacy, and the people who benefit from these policies/interventions (across demographic groups) benefit disproportionately well versus people who would benefit from the unpopular policies/interventions that remain un- or underfunded.

The adherence of U.S. national drug control policy to what plays well with popular opinion drives inequity--and here, "drives inequity" means literally paying more to save one person's life versus another's--in at least two major ways.

--Policies/interventions that are in tune with public morality receive more funding than policies/interventions that have better evidence, but are more unpopular. For example, law enforcement-facilitated naloxone distribution, peer recovery counselors, drug abuse prevention campaigns have less evidence of life-saving efficacy than naloxone distribution by syringe service programs directly to people who use drugs...but the former receives 10s of \$ millions of direct grants from SAMHSA, while the latter hasn't.

--Evidence-based policies/interventions are funded disproportionately well in regions that have "progressive" cultures versus regions that have "conservative" cultures. For example, and to use one evidence-based policy/intervention as basis of comparison, in California community-based syringe service programs have their naloxone distribution (both supply and staff costs) funded by the state. In West Virginia, that state legislature has passed regulations making it effectively impossible for syringe service programs to operate, even if they are operated by county health departments. In Louisiana, the vast majority of naloxone distribution reaching people who use drugs is performed by unpaid volunteers, not public health staff or paid nonprofit staff. In Alabama, community-based naloxone distribution is entirely illegal. U.S. national drug control policies could help correct these inequities by providing funding that circumvents politics at the state and county levels, either through direct grants to implementing organizations and/or by requiring that state and county agencies use Federal funding on a menu of evidence-based interventions (the ones already recommended by the CDC would be a good place to start: <https://www.cdc.gov/drugoverdose/featured-topics/evidence-based-strategies.html>).

In sum, if I could recommend a means of correcting inequity in U.S. national drug control policy, it would be: 1) prioritize funding for policies/interventions that evidence shows will have the highest probability of saving the most lives fastest, and 2) have the courage to consciously remove public opinion as a criterion for funding decisions...no "community stakeholder" has the right to demand life-saving care should be withheld from someone else, and we wouldn't treat such a demand seriously in any other area of healthcare.

PUBLIC SUBMISSION

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Docket: ONDCP-2021-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0004

Comment from Emilie, Junge

Submitter Information

Name: Emilie Junge

Address:

Portland, OR, 97266

Email: (b)(6)

Phone: (b)(6)

General Comment

One of the biggest barriers to opportunity and equity is the criminal record of someone attempting to move past their drug abuse past. Criminal records block job, housing and many other opportunities. Yet few (perhaps less than 7% of those eligible) can access expungement services. We need to modernize and streamline the expungement process in each state to make it more accessible to the millions who suffered collateral consequences of drug prosecution. This means providing grants for attorneys to conduct expungement "clinics" and other events that will make expungement easier. I am an attorney that provides pro bono expungement services in Oregon (previously in Chicago) and I see this service as essential to leveling the playing field for persons of color, and helping everyone with a drug offense to move past their past.

Slater, Sandy R. EOP/ONDCP

From: Kaye Meier <(b)(6)>
Sent: Wednesday, August 4, 2021 9:05 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] RFI Comment
Attachments: Masimo Comment to ONDCP RFI 8.6.21.pdf

Thank you for giving us the opportunity to comment.

Kaye Meier, JD
Masimo | Senior Policy Advisor
(b)(6)

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Masimo
52 Discovery
Irvine CA 92618

August 6, 2021

Via Electronic Submission:
OGC@ondcp.eop.gov

Regina LaBelle, Director
Office of National Drug Control Policy
Executive Office of the President
Washington, D.C. 20503

RE: Application of Equity in U.S. National Drug Control Policy

Dear Director LaBelle:

Masimo appreciates the opportunity to provide comments on the Request for Information, and appreciates your dedication to a comprehensive approach to advancing equity in national drug control policy. We support your efforts and believe that innovative medical technology can be used to provide increased access to quality healthcare for underserved populations.

Simply put, technology available today can bring the care *to the patient*, which eliminates many of the barriers standing between individuals and quality healthcare and treatment.

Masimo has devoted over 30 years to improving the quality of healthcare and saving lives. We are very proud that our breakthrough technology is now used on more than 200 million patients in leading hospitals and other healthcare settings around the world, and is the primary pulse oximetry at 9 of the top 10 hospitals in the United States. With the help of our solutions, premature infants are having their eyesight protected, congenital heart disease is being detected, overdoses from opioids are being prevented, and COVID-19 patients are being continuously monitored from the comfort of their homes, freeing up much-needed ICU beds and saving limited PPE supplies for our nurses and doctors.

But we need to do more. The past year has taught us that we need to establish programs and policies that can reach individuals where they are – at home. Remote physiologic monitoring is playing an extremely important role during the pandemic, and will continue to improve patient safety, enhance infection control measures, protect healthcare workers, and reduce the demands on PPE supplies in the future. Remote patient monitoring is making a difference for so many patients, but this comment will focus on the benefits for vulnerable and underserved populations.

We applaud President Biden's commitment to addressing the overdose and addiction epidemic and look forward to working with you on this critical issue. We have seen that, even with responsible prescribing, public education, decreased availability of illegal opioids, and increased services to treat addiction, far too many people are misusing opioids and dying.

Masimo RFI Comments

Recommendations on how the ONDCP can broaden its formal consultations to gain broader perspectives earlier in the policy development process.

Masimo appreciates ONDCP's commitment to organizing and conducting formal consultations with key external stakeholders. In order to break down barriers and save lives, federal agencies must expand engagement and partner with state and local agencies, as well as the private sector. Such collaboration will enable us to reach vulnerable and underserved communities. There are numerous federal agency programs relevant to the opioid crisis, but those same programs do not engage with private sector industries that can provide expertise and resources.

Federal agencies should assist in matching academic, community, federal, state and local resources with private industry experts and partners to promote education, demonstrations, and pilot programs that demonstrate the benefits of medical technology to vulnerable populations.

Recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of National drug control policy.

It is challenging to treat and address opioid use disorder where access to healthcare and treatment are scarce, and populations are already vulnerable due to an increased prevalence of chronic medical conditions, social stigma, housing instability, unemployment, or incarceration.

ONDCP should coordinate with local harm reduction programs, correctional substance abuse programs, and the Department of Defense to develop appropriate outreach efforts for people who are currently excluded from the National Survey on Drug Use and Health (NSDUH).

Recommendations for short-term and long-term goals that ONDCP should take into account to measure progress towards equity in drug policy.

Not only are the most vulnerable individuals largely the ones most impacted by the opioid epidemic, but they are also the most underserved populations in terms of access to quality healthcare services. Individuals using opioids receive consistently lower quality of care across preventive and chronic illness care and care coordination.

We applaud the efforts of groups like the National Hispanic Leadership Agenda (NHLA) that have developed policy recommendations focused on eliminating racial inequity for non-white groups. As part of the NHLA's recommendations for opioid policy, they note that medical technology can play a significant role in preventing overdoses and providing access to quality care for underserved populations.

ONDCP needs to support and encourage the use of technology to bring quality care to underserved populations:

Underserved and Rural Areas: The Centers for Disease Control has confirmed that people

with a low income who live in rural areas are particularly vulnerable to prescription opioid overdose. Patients in underserved and rural areas normally have fewer healthcare providers and services. Because rural residents often live a great distance from healthcare resources, they have insurmountable barriers to treatment, including lack of transportation, longer distances to be traveled, additional expenses related to that travel, and employment-related constraints to travel.

Pregnant Women: Opioid use during pregnancy has increased substantially over the past decade and increasing rates of substance use disorders contribute to rising rates of severe maternal morbidity and mortality in the United States. There has been extensive research and literature concluding that the impact of neonatal morbidity associated with opioid use in pregnancy is substantial and neonatal abstinence syndrome accounted for \$3 billion in hospital costs between 2004 and 2014. Sadly, in rural areas, access to addiction treatment for pregnant women is often inadequate.

The Elderly: While progress has been made to address a rising death toll caused by opioids, major gaps in protection against opioid risks for older adults remain. In the first 8 months of 2020, 31,651 Medicare beneficiaries suffered an opioid overdose. The Department of Health and Human Services Office of Inspector General (HHS OIG) recommended that steps be taken to mitigate the risk of misuse and overdose in Medicare beneficiaries. Further, over 12 million Americans over age 65 live alone, where they may not have an available caregiver to provide medical assistance in emergencies, and major health emergencies can be overlooked as “age-related changes” when in fact the person is experiencing an opioid overdose. Using opioids alone is a well-documented overdose risk factor which magnifies the need to bring the treatment to the individuals that need it.

Incarcerated Individuals: Multiple experts have concluded that mass incarceration and opioid overdose are interrelated. It has been estimated that up to 20% of individuals housed within prison in the United States have opioid use disorder. Opioid-related overdose is the leading cause of death among people released from jails or prisons

The Impact of the COVID-19 Pandemic on the Opioid Crisis: The need to address the opioid crisis is even more urgent because the COVID-19 pandemic exacerbated the opioid crisis and overdose deaths have increased dramatically. From September 2019 through August 2020, there were over 88,000 overdose deaths, which made 2020 the deadliest year for overdoses on record.

The factors that have worsened the crisis have been amplified in the underserved populations that we need to reach. The pandemic further disrupted medical care with clinician office closures, discontinuation of in-person therapy, recovery and peer-support groups, and hesitance to seek treatment due to concerns about exposure to COVID-19.

Research has shown that joint, muscle and chest pain, and chronic neuropathic pain are prevalent in patients that have had COVID-19. Further, the unknown and potentially severe impacts of “long COVID” will increase the need to ensure that all individuals that are given a prescription for opioids have access to the appropriate care. For example, one study showed

that doctors wrote nine more prescriptions for opioids for every 1,000 “long COVID” patients who were treated at a Veterans Affairs facility than they normally would have.

Examples of the Ways the Technology Can Save Lives:

Monitoring Patients to Prevent Overdose: Masimo was one of eight companies selected out of more than 250 applicants as part of the Food and Drug Administration’s challenge to develop “Devices to Prevent and Treat Opioid Use Disorder.”

This technology, which received breakthrough device status in 2019, can continuously monitor blood oxygen levels and provides alerts when dangerous oxygen levels are detected. The system includes a wearable sensor, a chip, a bedside station, and an app. Information is communicated via a secure cloud. This monitoring and alert notification system notifies the patient, family and friends so they can intervene and harm can be avoided.

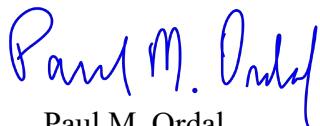
Helping Individuals Through Opioid Withdrawal: The fear of withdrawal from opioids can prevent those who are addicted from even attempting to seek treatment. To most patients with opioid use disorder, the anticipatory withdrawal phase is worse than the *physical* phase of withdrawal. Research has found that unassisted withdrawal can be life threatening, and the threat of relapse is as high as 91%.¹⁰

Technology available today enables individuals to use a FDA-cleared, drug-free, non-pharmaceutical medical device to aid in the reduction of symptoms associated with opioid withdrawal. In a study of 73 adult patients with opioid use disorder, a significant reduction in opioid withdrawal symptoms was observed. Withdrawal symptoms (such as increases in resting pulse rate, sweating, restlessness, bone or joint aches, tremors, and anxiety) were reduced by 85% after the first hour of using the device and 97% after 5 days of use (measured using clinical opiate withdrawal scale). Using this device also helped 88% of patients successfully transition into a medically assisted therapy (MAT) program.

Medical innovation and technology enable people to live longer, with more independence, with less pain, and greater quality of life. Medical technology can also save patients, insurers, employers, governments and hospitals billions of dollars by keeping patients healthy and out of the hospital.

If you have any questions or would like to address any aspects of our comments, please feel free to contact Kaye Meier at (b)(6)

Sincerely,



Paul M. Ordal
Vice President, Government Relations and Public Policy

Sources:

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Slater, Sandy R. EOP/ONDCP

From: P Dun <(b)(6)>
Sent: Wednesday, August 4, 2021 6:09 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Public Comment for Equity in Policies

Thank you for the opportunity to provide public comment on such an important matter.

In order to be more effective, you must remember the roots of why drugs were made illegal throughout the years and why their sentencing disparities have been constructed to the disadvantage of people of color. Please ensure you are factoring in works such as "The New Jim Crow" and "Marijuana: The First 10,000 years" into your processes. Laws were made to discriminate against people of color, such as crack vs powder cocaine, and historically you can find several other examples, over and over again throughout time, notably, African Americans, Chinese, and Latinos.

- Rectify and repeal these inequitable laws. Strongly encourage states do the same.
- Change sentencing practices. Strongly encourage states do the same.
- Maintain and analyze data and use to correct deficiencies.
- Include people of color and consumer voice in your decision making
- Remove marijuana from being a Schedule 1 drug immediately and legalize it
- Remember mental health and substance abuse is a treatment issue
- Withhold funding and create grants that support equity in laws, sentencing, etc.
- Ensure you are being culturally appropriate and inclusive in all that you put together
- Make this swift as opposed to drawn out

Slater, Sandy R. EOP/ONDCP

From: Shane Sullivan <(b)(6)>
Sent: Wednesday, August 4, 2021 12:58 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Equity in US Drug Policy comments - DC-based harm reduction outreach worker
Attachments: DPA Comments on Equity in U.S. National Drug Control Policy 8-6-21 Final.pdf

Hello,

I'm emailing to affirm my support for the Drug Policy Alliance's letter of recommendations submitted to ONDCP (attached for reference); to add local, community-based context as a harm reduction outreach worker here in Washington D.C.; and relay my recommendations for drug policy equity as a follow-up to a meeting I had with ONDCP staff in 2019.

I work at HIPS, a harm reduction agency (that has also partnered with Drug Policy Alliance) in the District, where 84% of overdose fatalities in 2020 were among Black residents. Among the 411 opioid-related overdose deaths here, 94% involved fentanyl and/or fentanyl analogs. There were 511 total overdose fatalities in a city of just 700,000 people. (All of these statistics can be found [here](#), in the city's "modified strategic plan" for addressing drug use and overdose).

I spoke with your office shortly after my close long-term friend, Kelsey Blair Paulus, fatally overdosed on April 6, 2019. I highlighted the need for safe consumption spaces for people like Kelsey who felt too stigmatized by Prohibition to let me join her while she used. She died alone because of stigma fueled by criminalization coupled with the lack of a safe supply or safe space to use. Our toxic supply that killed 93,000 Americans in 2020, and the stigma that people who use drugs experience (speaking as a PWUD as well), is a direct result of Prohibition whose racist legacy continues to devastate under-resourced communities of color, including (primarily) Black people who inject drugs that HIPS serves in DC.

ONDCP staff defended James Carroll's support for Trump's border wall as a way to 'stop the flow' of drugs that I took issue with.

Support for a border wall is not only deeply racist and a tremendous waste of resources, it incentivizes street drug manufacturers to subvert law enforcement efforts through novel psychoactive substances that are typically more harmful than their traditional counterparts (NBOMes, for example, instead of LSD, as chemists know that the DEA surveils the starting chemicals required to produce the latter but not the former). This is most apparent in the proliferation of fentanyl, which has virtually taken over the street heroin supply along the East Coast and is on track to do so nationwide.

Carceral policies that target people who use drugs - as well as the people who sell them (especially considering they are often one and the same) - must be re-evaluated by the ONDCP if it hopes to achieve any sense of equity in drug policy. The level of surveillance and monitoring that Black clients of HIPS experience is constant and devastates families and communities, and stands in stark contrast to many friends and colleagues I know who are white and reside in suburban areas or wealthier city neighborhoods.

ONDCP staff also pointed out that a significant portion of the office's funding is allocated towards prevention programs as law enforcement has been de-emphasised in recent years. 'Prevention' programs that staff referenced are, in my experience, often simply a new iteration of D.A.R.E. programs that spread misinformation, stigmatize people who use drugs, shame people struggling with addiction into avoiding treatment altogether, and do not address the reality of our current drug poisoning crisis. People are using drugs and dying now.

The funding allocated to harm reduction by this administration, including ONDCP, is a small step towards some semblance of reshaping our drug policy into something resembling equity. We need significantly more - in particular, funding for community-based harm reduction programs, especially those led by PWUD and especially those such as HIPS

that serve primarily marginalized populations whose health outcomes are also determined by a lack of access to other basic resources. Any ONDCP policy that criminalizes drug use needs to be internally re-examined, and models that have successfully operated in Vancouver, Portugal, Denmark, and elsewhere - specifically safe supply, safe consumption spaces, decriminalization, and evidence-based treatment (including heroin-assisted treatment and other medication-based supports, such as MAT for stimulant users) must be considered now to promote public health and prevent people from needlessly dying.

Thank you for your consideration; please feel free to reach out with any questions or concerns.

Sincerely,
Shane Sullivan

--
***COVID-19 Public Health Emergency Update and HIPS Services: HIPS IS OPEN with a *modified* services schedule. More information on how to access our services can be found [here](#).**

Shane Sullivan
HIPS, Community Outreach Specialist

Pronouns *They/them/theirs* | Direct Line: (b)(6) | 24 Hr. Hotline: 1-800-676-HIPS

Mailing: P.O. Box 90738 Washington D.C. 20090 Physical: 906 H St. NE Washington D.C. 20002

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Slater, Sandy R. EOP/ONDCP

From: Cannabis Equity <(b)(6)>
Sent: Thursday, August 5, 2021 8:28 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Response to ONDCP Advancing Equity Public Comment Request

Good afternoon,

We hope you are doing well this afternoon and that this week has been treating you kindly. We are reaching out today to respond to the Public Comment request from ONDCP about system barriers to equity. We feel as though we can provide feedback on two of the questions laid out in the request. Please see our feedback below and let us know if you have any questions or feedback.

- **Provide recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of national drug control policy.**

The ONDCP must look to community harm reduction organizations that are most qualified and experienced in community outreach to people who use drugs in order to update its policy. There are organizations like Chicago Recovery Alliance, Sex Worker Outreach Project, and more across the nation, who do critical work to engage people who use drugs to ensure they have the resources they need to reduce harm (education, clean needles, cotton swabs, water, etc.). These organizations that are closest to the ground have the most comprehensive understanding of the issues that result from disparate & racist drug laws, and must be central to the solution.

- **What would be your recommendations for short-term and long-term goals that ONDCP should take into account to measure progress towards equity in drug policy?**

Short Term: Bring the harm reduction and justice-focused organizations to the table to help create principles for future policy that are centered on harm reduction and evidence-based best practices.

Long Term: There should be a 1, 3, 5, and 10-year strategy to undo the harm that communities have experienced. We need a long-term plan to repair the harm that was inflicted by the War on Drugs, and decades of racist and inequitable drug policies. This entire process should center the people most impacted and their families, so those most familiar with this issue can help rectify it.

Please let us know if you have any questions or feedback for us.

Thank you,

Cannabis Equity IL Coordinators

Slater, Sandy R. EOP/ONDCP

From: George Pertot <(b)(6)>
Sent: Thursday, August 5, 2021 4:02 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Input on how drug policy created systemic barriers for underserved communities
Attachments: ONDCP letter 07262021 George Pertot.pdf

Please read the attachment below

Thank you,
George Pertot
(b)(6)



TO: ONDCP policy

From: George S Pertot, (retired 30 year federal agent DHS)

Subject: A new direction for ONDCP policy

Date: July 27, 2021

The systematic barriers to opportunities for underserved communities is evident from the failed war on drugs that I personally participated as a federal agent for 30 years. Our governments' covert operations, unknown at the time, all started this disparity and developed these networks of drug distribution and money collection operations in underserved communities throughout the United States. We, the government, always used members of these communities for the validity of the mission to evolve. The agents were just consiglieres to a sequence of events of pursued policies that has now lead to our conservative Supreme Court judge, Clarence Thomas to announce that Federal Laws against Marijuana may no longer be necessary. The current government approach about being half-in, half-out regime that simultaneously tolerates and forbids marijuana has confused society. It has killed the soul of America.

The cartels used Marijuana as another transportation method to import more serious and fatal drugs like Cocaine, Heroin, Meth and fentanyl. The pipelines were initially established using Marijuana and then shifted to more profitable narcotics. Which are so well established now that decriminalization is the only solution. It is a epidemic that is killing our children and our brothers and sisters. Every day we wonder what child will be next in the roulette game of life.

The ONDCP policy fueled this horrible epidemic the agency ignored signs that the war on drugs was failing in the 1990's. The opioid addiction increased and deaths soared. We continued to bury our head in the sand and continue policies that hurt the underserved communities in furtherance of failed policy.

These communities since the eighties have been devoured by the cartels and the US government undercover operations within. These covert operations initially were to develop methods of operations but they further developed into a sophisticated network of smuggling operations nationwide run by the MS13...and Chapo organizations. We could not keep up and we lost control which started the epidemic from the ONDCP policies.

The reason is that all the covert operations ended up setting up shop in the same type neighborhoods around the country, the underserved and poor communities and black communities. This is where the ONDCP policies that were to help these communities unknowingly, that in the future, fueled the fire of failure, addiction, murder, rape and gang life.

ONDCP throughout my career and now a decade past is still underserving our society by depriving these poor communities and the underserved with other than drug dealing corner jobs instead of changing it into Hemp fiber, cement and food in all of these underserved communities bringing back both blue and white collar jobs. This will bring back our crumbling towns throughout America back to life.

ONDCP should lead a clear path of transformation of the “evil weed” plant to a blossoming cannabis industry which replaces a majority of crops for export and ONDCP ensures a healthy non contaminated product while also empowering those underserved communities by redoing old industry to new hemp factories.

It is now evident that legalization works and that generational learning is now starting. We must have the Biden administration to truly realize the benefits of transparency to the community. It would only take a few new factories bringing hemp to the forefront. The Marijuana, CBD and psilocybin controlled and regulated properly decades ago would have never created such a disaster of young children dying everyday of overdose of heroin laced with fentanyl or Methamphetamines that ruin the core value of a human. Most importantly having incarcerated so many hundreds of thousands of underserved community members for an epidemic assisted by the covert US operations over the past 40 years is the truth.

We have caused this mess and now we must fix this mess. We must assist in redeveloping these communities to start a new life. A life that is sustainable in future HEMP programs and recreational Marijuana that can be shipped worldwide. We need to help evolve these communities to understand a “NEW WAY”. We must stop sending a mixed message, the underserved need assistance to develop their own businesses and grow a new valued USA crop for international use. We can use failing infrastructure to develop a new “cotton” with hemp fiber. This would be sold worldwide and be used in the USA. Increase USA driven policy of sustainability, the opportunity exists but as simple as not being able to use a federal bank to conduct business are the types of policies that ONDCP need to speak out on and change. The oppressed standard must be reversed.

It has been 5 years that Sugar Magnolia Farms a recreational cannabis company in Colorado, that we lease farm land to, cannot legally use a federal bank like all other legal businesses. We are falling behind Canada, Columbia and Amsterdam in exports of Marijuana to Europe and other countries. These exports are critical to our future economic growth. We need to have ONDCP establish new policy methods that always update themselves as economic growth increases. The agency should not be a prison holding laws that are old and antiquated but should be always diverse in change to keep up with science and medicine. To take this commodity to the level where it helps people and positively affects our economy. Exports need to be freed and allowed and sanitary inspections which are federally controlled for export to occur. We must have one standard. Every state is running amok ... who has the Gold standard in legislation? We must have a federal standard in place ASAP...if not we will lose this battle again from ineptitude

Generational suffering that these policies have caused...

Will the underserved communities have a place to work?

Will they be able to apply for a business without the giant corporations taken it over?

This all rests in the new policies and direction the agency decides to follow.

Thank You.....

Slater, Sandy R. EOP/ONDCP

From: Miranda Poe <(b)(6)>
Sent: Thursday, August 5, 2021 11:08 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] ONDCP's policy public comment

The below are my comments for your consideration, based on my experience working with the Partnership for Substance Free Youth in Buncombe County, working under Drug Free Communities, State Opioid Response, North Carolina Preventing Underage Drinking Initiative, and Buncombe County Tipping Point grants.

Based on my experience and research, the reasons people use and sell drugs are complex and include a lack of opportunity and adequate income through legal means. To address the root causes of the issues we face, we need to pay reparations. The wealth of our nation is founded on the unpaid labor of enslaved Africans, to whom their "40 acres and a mule" are still owed. When people have what they need to survive and are not living in traumatizing conditions, they are less likely to use and sell drugs. We need more legal jobs that pay living wages that are also available to undocumented and formerly incarcerated members of our community.

As marijuana becomes legalized in more and more states, we need to work towards exonerating the disproportionately incarcerated number of people of color for selling a drug that now majority white businesses are profiting from legally. In North Carolina, African Americans are arrested for possession of marijuana at a rate that is 3.3 times higher than white Americans, even though both ethnicities use marijuana at similar rates. Marijuana arrests makeup 43% of all drug arrests, which is more than any other drug. A jail is not treatment. The availability of drugs within jails and prisons is well known. Time spent incarcerated exacerbates existing trauma and psychological distress – known risk factors for substance use.

Although African Americans only make up 6.4% of the population of Buncombe County, while Caucasians make up 89.5% of the population, from 2016-2018, there were 27 recorded drug overdose deaths of African Americans and 39 drug overdose deaths of Caucasians per 100,000 people. Nationally, rates of opioid deaths have been increasing for African Americans at a rate of 43% compared to rates for Caucasians of 22% from 2013-2018. Despite this data, there has been a significant lack of focus given to African American overdose deaths. People of color, in particular African American and Latinx communities continue to be disproportionately criminalized for drug use, addiction, and poverty while having less access to care.

I recommend corporations to be held financially and legally responsible for the damages incurred by the current opioid epidemic. Thankfully we have already seen this happening and I hope some of these funds can be relocated into prevention, treatment, and harm reduction. Based on evidence and best practice, I suggest decarceration and decriminalization, while increasing access to harm reduction and treatment services as the best route forward.

Miranda Poe
(She/Her/Hers)
RHA Health Services
Prevention Specialist
84 Coxe Avenue, Suite 1C
Asheville, NC 28801



Find us on 

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Slater, Sandy R. EOP/ONDCP

From: Amber Littlejohn <(b)(6)>
Sent: Friday, August 6, 2021 10:43 PM
To: MBX ONDCP OGC
Cc: Kaliko Castille; Brenden R. Chainey; William A. Kirk; Barry M. Hartman
Subject: [EXTERNAL] Comments of Minority Cannabis Business Association in Response to DOCKET NO: ONDCP FRDOC 0001-0008
Attachments: MCBA Respons to ONDCP Request for Information DOCKET NO- ONDCP FRDOC 0001-0008 (Final).docx

Good evening,

Please accept the attached comments of the Minority Cannabis Business Association in response to the July 7, 2021 Office of National Drug Control Policy [Request for Information](#) on the application of equity in national drug policy.

MCBA submits these comments on behalf of the minority cannabis business community and the individuals and communities most impacted by Federal cannabis prohibition. MCBA welcomes the opportunity for ongoing engagement and consultation.

Respectfully submitted,

Amber Littlejohn

Amber Littlejohn, Esq.
Executive Director
Minority Cannabis Business Association
(b)(6)
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DOCKET NO: ONDCP FRDOC 0001-0008

**BEFORE
THE OFFICE OF NATIONAL DRUG CONTROL POLICY**

**COMMENTS OF
THE MINORITY CANNABIS BUSINESS ASSOCIATION**

**REQUEST FOR INFORMATION
APPLICATION OF EQUITY IN NATIONAL DRUG CONTROL POLICY**

AUGUST 6, 2021

August 6, 2021

I. INTRODUCTION

The Minority Cannabis Business Association (“MCBA”)¹ is the largest national trade association dedicated to serving the needs of minority cannabis businesses and our communities. MCBA represents more than 300 minority and allied cannabis businesses, industry and community leaders who share a vision for an equitable, just, and responsible cannabis industry. Our mission is carried out by a 15-member Board of Directors composed of a diverse group of industry veterans, medical and legal professionals, advocates and community leaders.

On July 7, 2021, the Office of National Drug Control Policy (“ONDCP”) issued a Federal Register Notice (“July 7 notice”) requesting information on the application of “equity,” as defined in Executive Order 13985,² in national drug control policy. The Minority Cannabis Business Association offers these comments in response to the July 7 notice on behalf of the minority cannabis business community and the individuals and communities most impacted by Federal cannabis prohibition.

Executive Order 13985

On January 20, 2021, President Joseph Biden issued Executive Order 13985 (“Order 13985”) in response to our country’s “converging economic, health, and climate crises that have exposed and exacerbated inequities, while a historic movement for justice has highlighted the unbearable human costs of systemic racism.”³ Through EO 13985, the Biden Administration committed to “affirmatively advancing equity, civil rights, racial justice, and equal opportunity”⁴ by directing the (1) Domestic Policy Council (“DPC”) to “coordinate efforts to embed equity principles, policies, and approaches across the Federal Government,” and (2) the Office of Management and Budget (“OMB”), in partnership with the heads of agencies, to “study methods for assessing

¹ <https://minoritycannabis.org/who-we-are/>

² Exec. Order No. 13985, 86 Fed. Reg. 7009-7013 (Jan. 20, 2021).

³ *Ibid.*, 7009.

⁴ *Ibid.*

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whether agency policies and actions create or exacerbate barriers to full and equal participation by all eligible individuals.”⁵ Additionally, Order 13895 directs the head of each agency to consult with the Assistant to the President for Domestic Policy (“APDP”) and the Director of OMB to produce a plan for addressing:

- (i) any barriers to full and equal participation in programs identified pursuant to section 5(a) of this order (President’s Budget); and
- (ii) any barriers to full and equal participation in agency procurement and contracting opportunities identified pursuant to section 5(b) of this order (Federal contracting).

For purposes of EO 13895, the term “equity” means:

“the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities⁶ that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.”⁷

II. ASSESSING EQUITY IN FEDERAL CANNABIS POLICY

Accurately assessing equity, as defined in EO 13895, in Federal drug policy must include a holistic examination of the impact of the Federal Government’s cannabis policy on underserved communities with a focus on the Black, Latino, and indigenous communities disproportionately and unjustly targeted in the enforcement of Federal cannabis laws.⁸ To meaningfully address the

⁵ Ibid., 7010.

⁶ “Underserved communities” means: “Populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of ‘equity.’” Ibid., 7009.

⁷ Ibid.

⁸ See *infra* Section III.

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impacts of Federal cannabis prohibition and provide solutions to barriers to equity the assessment and subsequent solutions must be of depth and breadth equal to the harm. MCBA recommends the scope include the following:

1. **Equitable Justice:** preventing the deprivation of basic rights of citizenship to individuals incarcerated for nonviolent⁹ cannabis offenses, loss of immigration status or Federal benefits due to the use of state-legal cannabis products or affiliation with the state-legal cannabis industry, and addressing the disproportionate arrest and imprisonment for cannabis offenses within Black, Latino, and indigenous communities.
2. **Equitable Communities:** empowering communities to address generational economic, health, and educational disparities due to disparate enforcement of cannabis laws. The assessment and solutions should include identifying and implementing ways to improve and leverage existing Federal programs, utilize future cannabis tax revenues, and incentivize states to address these disparities within the communities most impacted by cannabis prohibition.
3. **Equitable Industry:** preventing the exclusion of the individuals and communities most impacted by cannabis prohibition from participating in the legal cannabis industry due to inequitable access to capital,¹⁰ lack of access to Small Business Administration loans and services,¹¹ denial of Federal benefits for cannabis industry owners and workers, including Veterans Administration home loans,¹² exclusion of immigrants and individuals with prior

⁹ Includes offenses involving violence enhancements not involving actual acts of violence.

¹⁰ Current Federal law exposing financial institutions to risk of Federal prosecution impedes equitable access to capital for the minority cannabis businesses lacking access to private equity funds and personal and general wealth.

¹¹ Cannabis and cannabis-related businesses are denied access to SBA loans and services including emergency COVID relief despite the “essential business” designation.

¹² See Patricia Kime, “Vets Denied VA Home Loans If They Work with Cannabis,” Military.com, June 5, 2019, <https://www.military.com/daily-news/2019/06/05/vets-denied-va-home-loans-if-they-work-cannabis.html>.

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cannabis convictions from participating in the legal cannabis industry,¹³ and the unconstitutional denial of Federal nonprofit status to cannabis advocacy organizations¹⁴.

Currently, it is estimated that less than 1- 4.3% of legal cannabis industry owners are Black. Without addressing the ways Federal cannabis policy creates barriers to equity in state-legal cannabis industries, the individuals and communities that have paid the greatest price, and whose plight serves as impetus for reform, will be excluded from realizing the potential for economic empowerment and restoration through the legal industry.

4. **Equitable Access:** ending the denial of access to safe legal cannabis medicine to immigrants, veterans, seniors, and disabled persons without risk of loss of immigration status, benefits, housing, or medical care.

III. EXISTING LEGAL CONSTRAINTS ON EQUITABLE CANNABIS POLICY

MCBA recommends the ONDCP consider the immediate removal of marijuana¹⁵ from the Controlled Substances Act (“CSA”) of 1970¹⁶ to end the ongoing injustice and constraints on obtaining equity in national cannabis policy. Marijuana’s status as a Schedule I drug is not the product of scientific evidence or sound public health policy.¹⁷ Marijuana was placed on Schedule

¹³ See José Chapa and Matt Sutton, “Immigrants Being Left Out of Marijuana Decriminalization Reform,” Immigrant Legal Resource Center, September 10, 2020, <https://www.ilrc.org/immigrants-being-left-out-marijuana-decriminalization-reform>.

¹⁴ IRS Bulletin No. 2019 –1 (January 2, 2019) provides the Service may decline to issue a determination letter for nonprofit status if the letter is requested by an organization seeking 501(c)(6) whose purpose is directed at “...the improvement of business conditions of one or more lines of business relating to an activity involving controlled substances (within the meaning of schedule I and II of the Controlled Substances Act, 21 U.S.C.S. § 801 et seq.) which is prohibited by Federal law regardless of its legality under the law of the state in which such activity is conducted...”. “Internal Revenue Bulletin: 2019-01,” Internal Revenue Service, January 2, 2019, https://www.irs.gov/irb/2019-01_IRB.

¹⁵ While MCBA recognizes the historical implications of the term “marijuana,” marijuana remains the term used throughout existing Federal policy. As such, MCBA uses “marijuana” and “cannabis” interchangeably throughout this document.

¹⁶ Comprehensive Drug Abuse Control and Prevention Act of 1970, (P.L. 92-513).

¹⁷ The Nixon Administration placed marijuana was placed on Schedule I of the Controlled Substances Act contrary to the advice of Shafer Commission experts who found marijuana to be no more harmful than alcohol. See Gabriel G. Nahas and Albert Greenwood, “The First Report of the National Commission on Marihuana (1972): Signal of Misunderstanding or Exercise in Ambiguity.,” Bulletin of the New York Academy of Medicine (U.S. National

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I of the Federal Controlled Substances Act (“CSA”) of 1970 due to Federal actions rooted in racism and politics, not science and public policy.¹⁸

Marijuana prohibition remains a devastating weapon in our country’s War on Drugs (“WOD”) and continues to systematically discriminate against people of color and dilute their political power relative to whites.¹⁹ Proponents of Federal marijuana prohibition capitalized on the fears of changing society and shifted the blame for social unrest to marijuana to serve as a proxy for constitutionally prohibited means of suppressing and subjugating minorities and anti-Vietnam war protesters.²⁰ John Ehrlichman, former counsel and assistant to the President for Domestic Affairs under President Richard Nixon admitted,

“We knew we couldn’t make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.”²¹

The Federal Government cannot address inequity while upholding a system that maintains it. To assess, develop, and implement policies to remove barriers to equity in access to Federal programs and services, the Federal Government must end Federal cannabis prohibition. Removing marijuana from the CSA would effectively end cannabis prohibition and provide access to additional remedies for the injustices from which communities of color have suffered dire consequences across every social determinant of health,²² including poverty, housing, education, and criminal justice engagement.

Library of Medicine, January 1974), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1749335>; see also David Downs, “The Science behind the DEA’s Long War on Marijuana,” *Scientific American* (Scientific American, April 19, 2016), <https://www.scientificamerican.com/article/the-science-behind-the-dea-s-long-war-on-marijuana>.

¹⁸ See *Ibid.*

¹⁹ See John Hudak, *Marijuana: A Short History* (Brookings Institution Press, 2020), pg. 50.

²⁰ See Dan Baum, “Legalize It All: How to Win the War on Drugs,” *Harper’s Magazine*, March 31, 2016, <https://harpers.org/archive/2016/04/legalize-it-all/>.

²¹ See *Ibid.*

²² Alex Wodak et al., “Costs of Cannabis Controls May Outweigh the Benefits,” *BMJ Clinical Research* 324, no. 7329 (December 2002): pp. 105-106, <https://doi.org/10.1136/bmj.324.7329.0/f>.

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IV. RESPONSES TO REQUEST FOR INFORMATION

Jurisdictions at the State, local, Tribal, and territorial levels have implemented equity assessment tools to inform their policymaking or budgetary processes. What are the lessons these jurisdictions have learned from implementing or interacting with those tools?

In advance of cannabis legislation, some states have undertaken equity assessments to understand how the failed prohibition of cannabis has disproportionately impacted certain communities. Virginia commissioned a study from their legislature’s non-partisan research agency, the Joint Legislative Audit and Review Committee (JLARC).²³ Similarly, in 2014 Hawaii conducted an assessment,²⁴ while other states maintain regular reporting on crime statistics to monitor disproportionate enforcement. The ACLU conducts an annual analysis of disproportionate enforcement of cannabis prohibition.²⁵ Reports from across the country have shown that Black Americans face disproportionate enforcement — they are more likely to be arrested, more likely to be convicted, and face harsher sentences. Latino and Indigenous people share similar experiences. While the state data²⁶ has yet been used to support racial classifications in state social equity policies, the data enables state lawmakers to understand the barriers to equity and develop effective remedies to address them.

ONDCP should learn from state lawmakers’ failures to adequately assess the breadth and depth of the impact of cannabis prohibition on Black, Latino, and indigenous communities before attempting to implement solutions. Such failures have led to (1) constitutional challenges of

²³ “Key Considerations for Marijuana Legalization,” Joint Legislative Audit and Review Commission (JLARC), accessed August 6, 2021, <http://jlarc.virginia.gov/landing-2020-marijuana-legalization.asp>.

²⁴ “The Disparate Treatment of Native Hawaiians in the Criminal Justice System,” Office of Hawaiian Affairs, Accessed August 6, 2021, https://www.oha.org/wp-content/uploads/2014/11/factsheets_final_web_0.pdf.

²⁵ See “A Tale of Two Countries: Racially Targeted Arrests in the Era of Marijuana,” American Civil Liberties Union (ACLU, April 20, 2020), <https://www.aclu.org/report/tale-two-countries-racially-targeted-arrests-era-marijuana-reform>.

²⁶ Virginia included a social equity program racial proxies in the legalization bill signed into law April 21, 2021. However, the State has yet to promulgate regulations to effectuate the statute. Hawaii did not include social equity in its medical cannabis program.

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cannabis social equity programs designed specifically to remedy the impacts of prohibition on the communities and individuals most impacted by prohibition and the broader War on Drugs,²⁷ and (2) social equity programs tailored too broadly to provide meaningful remedies²⁸.

Various states and localities have implemented²⁹ cannabis social equity programs with remedial racial classifications (or proxies for race³⁰ to address the consequences of cannabis prohibition). However, many of these programs have faced Equal Protection challenges for failing to initially present support for a compelling government need for this remedial action - despite ample evidence that proving such interest could only be established through a large scale assessment of the scope of historic and ongoing discrimination against Black, Latino, and indigenous communities in the enforcement of cannabis laws. Such legal challenges have undermined and eliminated social equity programs³¹ and with them the potential to economically restore and empower the communities most impacted by cannabis prohibition through access to cannabis tax revenues or through ownership and development opportunities. Other states and localities³² have avoided the use of racial classifications in their cannabis social equity programs, instead opting for broadly tailored criteria that does not effectively remedy the harms of prohibition and often serves as alternate routes for ownership by large non-minority-owned cannabis companies and investors.

Federal cannabis prohibition is rooted in systemic racism. As such, race-based solutions are critical to remedying the extensive harms. We encourage ONDCP and other Federal agencies to conduct the studies and gather data necessary to sustain race-based remedial measures for the individuals and communities most impacted by cannabis prohibition. Additionally, ONDCP should provide

²⁷ Examples of lawsuit based on race or other criteria used as proxy- Ohio (race) Detroit, Los Angeles and others (residency requirement when residency in a given area is a proxy for race.

²⁸ Example of state without meaningful SE program due to lack of race criteria- California, Michigan.

²⁹ Virginia, New York, New Jersey, and Connecticut have passed adult use cannabis legislation but have yet to implement the programs or complete the promulgation of regulations to effectuate the statutes.

³⁰ Proxies for race have included residency in neighborhood or other areas with disproportionate cannabis arrests combined with other factors including unemployment rates and income qualification.

³¹ See Sarah Ganley Alex Malyshev, "The Challenges of Getting Social Equity Right in the State-Legal Cannabis Industry," Reuters (Thomson Reuters, July 22, 2021), <https://www.reuters.com/legal/litigation/challenges-getting-social-equity-right-state-legal-cannabis-industry-2021-07-22>.

³² See Ibid.

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grants for State and Local Governments to conduct the necessary studies or reports that support meaningful solutions to address state and local inequities born from Federal cannabis prohibition.

Formal consultations for the National Drug Control Strategy often involve direct relationships between ONDCP and the consulting group, organization, or subject matter expert. What are recommendations on how the agency can broaden its formal consultations to gain broader perspectives earlier in the policy development process?

As previously stated, to address the impact of Federal cannabis prohibition on Black, Latino, and indigenous communities and provide meaningful solutions to barriers to equity, the process of assessment and the subsequent solutions must be of equal depth and breadth to the harm. To that end, ONDCP should solicit perspectives from individuals, community and advocacy groups from impacted communities; patient and veterans rights advocates; minority and small business trade associations; and diverse economic and public health experts including the Association for Cannabis Health Equity and Medicine³³.

MCBA welcomes the opportunity for formal and ongoing consultation with ONDCP and for the opportunity to provide additional recommendations and perspectives to help facilitate a holistic assessment of barriers to equity in Federal cannabis policy.

Further, MCBA recommends that ONDCP engage communities and stakeholders through local hearings and roundtables similar to those³⁴ conducted through the Small Business Administration Office of Advocacy with evidentiary value given to the testimony in shaping ONDCP and agency policy. Lastly, MCBA proposes that ONDCP limit the timetable to engage stakeholders to ensure that ONDCP's future cannabis policy is shaped with feedback from the communities most impacted by Federal cannabis policy and enforcement.

³³ <https://www.achemed.org/about>

³⁴ See Office of Advocacy, "Agency Roundtables," SBA's Office of Advocacy, July 26, 2021, <https://advocacy.sba.gov/category/regulation/agency-roundtables>.

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Provide recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of National drug control policy.

Federal cannabis prohibition will significantly impair the collection of accurate data about cannabis use. Cannabis consumers, patients, industry and state and local regulators will remain reluctant to expose themselves or others to risk of criminal, social, and economic consequences for cannabis use permitted under state law.

Prior to eliminating the risk of providing the Federal Government with cannabis use data by ending prohibition, ONDCP may consider the use of third parties and anonymized data to gather representative information on cannabis use beyond the context of criminal justice engagement and use disorders. To that end, there is an increasing amount of data from states with legal cannabis programs about responsible adult consumption and patient use patterns. This includes population level data that can be anonymized that is collected through the Prescription Monitoring Program in states that require medical cannabis dispensing to be tracked.

What would be your recommendations for short-term and long-term goals that ONDCP should take into account to measure progress towards equity in drug policy?

On behalf of the minority business community, MCBA recommends that ONDCP take into account the following short- and long-term goals:

1. Ending Federal cannabis prohibition.
2. Release of individuals convicted of nonviolent Federal cannabis offenses.
3. Resentencing individuals with violence enhancements on Federal cannabis convictions not including actual acts of violence.
4. Studies on the use of state-legal cannabis products across diverse demographics.

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5. Research into the benefits of cannabis therapies including the treatment of conditions disproportionately affecting the communities most impacted by cannabis prohibition and the broader War on Drugs.
6. Cannabis research contracts to HBCUs and socially and economically disadvantaged communities.
7. The use of Federal cannabis tax revenue in impacted communities.
8. Increased provision of SBA loans, grants, and services to Blacks, Latinos, and indigenous persons, including individuals with previous nonviolent cannabis convictions.
9. Black, Latino, and indigenous ownership and employment in the Federally regulated cannabis industry.

V. CONCLUSION

The Minority Cannabis Business Association applauds the efforts to identify and address “the unbearable human costs of systemic racism” in Federal drug policy on the Black, Latino, and indigenous communities exposed and exacerbated by the “converging economic, health, and climate crises.” As individuals and communities of color disproportionately pay the cost, we strongly recommend the immediate removal of marijuana from the CSA to end the ongoing injustice and constraints on equity in national drug policy. We further recommend that ONDCP’s assessment of equity in national drug policy be of the depth and breadth equal to the harm caused by national drug policy to include, and properly value input from the individuals and communities most impacted by Federal cannabis prohibition.

On behalf of minority cannabis businesses and our communities, MCBA welcomes the opportunity provide necessary perspective and engage in open and ongoing dialogue to address

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Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Amber Littlejohn', with a long horizontal flourish extending to the right.

Amber Littlejohn, Executive Director
Minority Cannabis Business Association
1300 I St NW, STE 400E
Washington, DC 20005

A handwritten signature in black ink, appearing to read 'Kaliko Castille', with a long horizontal flourish extending to the right.

Kaliko Castille, President
Minority Cannabis Business Association
1300 I St NW, STE 400E
Washington, DC 20005

Slater, Sandy R. EOP/ONDCP

From: Andrew Freedman <(b)(6)>
Sent: Friday, August 6, 2021 3:56 PM
To: MBX ONDCP OGC
Cc: FT-CannabisCoalition
Subject: [EXTERNAL] Comment on Doc 86 FR 35828 Application of Equity in U.S. National Drug Control Policy
Attachments: 210806 ONDCP Comment from CPEAR.pdf

To Whom it May Concern,

Please find attached a comment on Doc 86 FR 35828 Application of Equity in U.S. National Drug Control Policy.

Please feel free to reach out with any questions you may have.

Sincerely,

Andrew Freedman
Executive Director



Disclaimer:

First of all I would like to thank those of you reading this for your time and apologize if anything stated is perceived as discourteous to any involved. I am not a lawyer, I do not work in law, nor do I even have a degree. I just like to read and would love for Marijuana to be legal.

In response to 86 FR 35828 I would like to make statements with regards to equity. That being said, I know many others will likely provide information as to how it has disproportionately affected/targeted the poor, disenfranchised and minorities so I would like to address this in another manner. In that sense, I would like to first provide definitions that will be used in the article with references as to where I received the information.

Legal definitions:

As per the document I am commenting on: E.O. 13985 defines "equity" as the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. It defines "underserved communities" as populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of "equity."

For every instance of the use of "sauce" in this document is intended to mean "source" For (referance) and academic purposes.

DEA means Drug Enforcment Agency

THC means tetrahydrocannabinol

INCB means International Narcotics Control Board.

The definition of hemp is as per 1639o of title 7:

(1) Hemp

The term "hemp" means the plant Cannabis sativa L. and any part of that plant, including the seeds thereof and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a delta-9 tetrahydrocannabinol concentration of not more than 0.3 percent on a dry weight basis.

sauce: <https://www.law.cornell.edu/uscode/text/7/1639o>

Marijuana is Legaly defined as:

(16)

(A) Subject to subparagraph (B), the term "marihuana" means all parts of the plant *Cannabis sativa* L., whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin.

(B) The term "marihuana" does not include—

(i) hemp, as defined in section 1639o of title 7;

or

(ii) the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination.

sauce: <https://www.law.cornell.edu/uscode/text/21/802>

Now I would like to start by stating that the difference between Marijuana and Hemp is the amount of Delta 9 THC. So in that sense I would like to mention that the federal government has known for a long time that delta 9 THC has medicinal properties and has in fact allowed companies to sell synthetic delta 9 THC and placed it in schedule 3.

Dronabinol (synthetic) in sesame oil in soft gelatin capsule as approved by FDA 7369N Marinol, synthetic THC in sesame oil/soft gelatin as approved by FDA

Sauce: https://www.dea.gov/sites/default/files/drug_of_abuse.pdf

Dronabinol study Quote:

Dronabinol is a synthetic delta-9-tetrahydrocannabinol (delta-9-THC). Delta-9-tetrahydrocannabinol is also a naturally occurring component of *Cannabis sativa* L. (marijuana). In summary the data in this application do establish that Syndros® is effective and safe for the treatment of anorexia associated with weight loss in patients with AIDS; and nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments

Sauce:

https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/205525Orig1s000SumR.pdf

In this study they recommend not labeling dromidol as thc, and I would highly recommend reading this to those of you who have the free time.

To further my argument I would like to provide a copy and paste of the information I pulled from the DEA website recently. According to the website, these are the requirements for the scheduling of drugs.

"Drug Schedules

Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. The abuse rate is a

determinate factor in the scheduling of the drug; for example, Schedule I drugs have a high potential for abuse and the potential to create severe psychological and/or physical dependence. As the drug schedule changes-- Schedule II, Schedule III, etc., so does the abuse potential-- Schedule V drugs represents the least potential for abuse. A Listing of drugs and their schedule are located at Controlled Substance Act (CSA) Scheduling or CSA Scheduling by Alphabetical Order. These lists describes the basic or parent chemical and do not necessarily describe the salts, isomers and salts of isomers, esters, ethers and derivatives which may also be classified as controlled substances. These lists are intended as general references and are not comprehensive listings of all controlled substances.

Please note that a substance need not be listed as a controlled substance to be treated as a Schedule I substance for criminal prosecution. A controlled substance analogue is a substance which is intended for human consumption and is structurally or pharmacologically substantially similar to or is represented as being similar to a Schedule I or Schedule II substance and is not an approved medication in the United States. (See 21 U.S.C. §802(32)(A) for the definition of a controlled substance analogue and 21 U.S.C. §813 for the schedule.)

Schedule I

Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are:

heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote

Schedule II

Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Some examples of Schedule II drugs are:

Combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin

Schedule III

Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV. Some examples of Schedule III drugs are:

Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone

Schedule IV

Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are:

Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol

Schedule V

Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes. Some examples of Schedule V drugs are:

cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, Parepectolin"

sauce: <https://www.dea.gov/drug-information/drug-scheduling>

Now I would like to state that this is a good argument for the start of rescheduling and or clarification of Marijuana as according to the our legal defenitions the lines are incredibly blurry. The main problem then becomes international treaties. In that sense I would like to refere to the INCB's recent statment with regards to the increase in the leagalization of marijuana. Pulled directly from their statment.

"Chapter II also deals with the monitoring of treaty compliance to which I referred

to in my opening statement to the Commission on Monday. Let me reiterate briefly some

important messages:

narcotic

- The three international drug control conventions limit the use of

scientific

- drugs and psychotropic substances exclusively to medical and

purposes

each other,

- This is an obligation that State parties have contracted with

not with INCB;

treaties and

- This is at the core of the international drug control

to-date,

- represents the broad consensus of the international community

protected

- namely that the health and welfare of humanity are best

medical and

- through the limitation of the use of controlled substances to

scientific purposes.
• Some States have moved to legalizing cannabis for non-medical use,
therewith breaching their obligations under the treaties, as the Board
has repeatedly and publicly expressed.
• INCB draws attention to this matter in the exercise of its quasi-judicial
treaty-mandated functions."

Sauce:

https://www.incb.org/documents/Speeches/Speeches2020/INCB_President_statement_item_5_c_at_63rd_CND.pdf

Now this document is in regards to equity. In my opinion, one cannot simply allow this wishy washy stance on Marijuana and Hemp as it allows for selective persecution of growers of Cannabis L. Sativa. Now I agree that licenses are required to ensure quality control. However, if we continue to allow this sort of stance then the communities who have suffered from Marijuana being illegal will continue to suffer and be held liable on a whim. For example in July of 2021 the DEA busted a marijuana growing operation in California, a state where Marijuana is considered legal. (If they have or do not have or had a license I do not know, but this is just an example of the DEA enforcing drug laws in a state where it is considered legal)

Sauce:

<https://www.cbsnews.com/news/marijuana-seized-california-billion-drug-bust-illegal-cultivation/>

This selective enforcement of Marijuana laws leads to the ability of the DEA and federal government to control who can enter into the industry and further bars disenfranchised communities from getting in on the ground floor. Another fun fact, the DEA is allowing some companies to import marijuana while people in our own country cannot grow the plant.

You will need to dig some, but here is your sauce:

<https://www.federalregister.gov/documents/search?conditions%5Bterm%5D=importer+of+controlled+substances#>

In my personal and unprofessional opinion, this is not allowable under the following statute:

15 U.S. Code § 1 - Trusts, etc., in restraint of trade illegal; penalty

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding \$100,000,000 if a corporation, or, if any other person, \$1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court.

Sauce: <https://www.law.cornell.edu/uscode/text/15/1>

NOTE:

I do not think that charging our own Federal Government and officials of a crime is the right course of action, if we do that then everyone in the government and in the law enforcement agencies will be worried not only for their jobs but their legal standing and risk of retaliation. The right course of action in my personal and unprofessional opinion would be a temporary halt on drug convictions and arrests until the Federal Government provides clarification on the matter in regards to every state individually.

The War on Drugs has been a war on people, I have heard many people say that but I do not know who to quote. That being said, I agree. What is done is done, if we continue to fight over the past we will be unable to look towards the future that we desire. "To err is human, to forgive is divine". In that sense, if we were to pay everyone for crossing them we would be in heavy debt for a long time and that alone is sadly enough to prevent many legislators from voting for any law to legalize Marijuana. However, we as a nation need to own up to our mistakes and do our best to reintegrate those affected back into society. The best way to do this in my personal and unprofessional opinion is to first clarify our federal laws. The federal government needs to take a stance officially and make clear and concise laws and execute them in a firm, fair and consistent manner. For example, If the difference between Hemp and Marijuana is the amount of Delta 9 THC, then officers need to be able to test for the amount at the time of the stop or at the very least test within a reasonable time frame that will not result in the seized product expiring. Another example, If we legalize Marijuana we cannot ban ex criminals from joining in on the business as this is not equity. They did the crime (at the time) and did time so forgive them. That being said, our jail systems are not the most ideal and I implore those of you that know someone who has been to jail or worked in one to ask them about it. From that I will say that if we just release these prisoners onto the streets there will most likely be an uptick on crime. (Objective you) try living in a cage for months if not years and see if you don't come out at least a little angry if the very "crime" you committed is legal when you get released. So, I would argue that there needs to be a support structure in place for them and assistance for at least a set period of time. The revenue created from Marijuana legalization is theorized to be in the trillions. If just a small portion goes to those who did time then we could theoretically easily create a base wage for them from taxes and can be used to provide healthcare to help with their reintegration into society. In this sense there is no initial payout to them, however they get healthcare (Especially mental health care) and a base wage so they will not have to resort to a life of other crimes due to a lack of social and economic skills due to time in prison. This can be done like a public health service, wick, or food stamps in opinion. I would also like to state that they should be automatically signed up for whatever benefits they are to receive, otherwise it could easily be made incredibly difficult for them to get the benefits they rightfully deserve. On a side note, we need to draw a clear line at who has been affected and there needs to be clear legislation as to if it is merely those who served time, or the single mothers and fathers, parents, and children who suffered from their loved ones being gone for a portion of their lives.

In conclusion, our country has been torn apart and ravaged by the failed war on drugs. There is a general hatred toward the police for enforcing the laws and a huge distrust of them. The age old saying of "Don't shoot the messenger" should be

applied to them as they are just following the law and doing their job. Sadly though, they are taking the fall for this quite hard and the people are left with a disdain of our own police that swear to "Protect and Serve" (I do not mean this in a condescending way, this is merely a quote from their oath. I respect the police and am saddened by the growing distrust of them however I understand why the people feel this way. I would like them to be given the opportunity to reclaim their honor and respect honestly.). If we truly wish to heal the divide and help with equity and equality of all people then Legalization of Marijuana is a great start. At the very least a rescheduling of Marijuana with a prohibition on federal resources being used in controlling Marijuana in the states AS WELL as a ban in the federal government getting tax money on it would ideal. This is under the mentality that if the federal government will not help with the control in the states and/or can decide to enforce whatever laws at any time and thus put people out of business and seize their assets, then they should be banned from getting any of the tax revenue until there is an official stance (The little Red Hen by Mary Mapes Dodge is a good example of this). We need those that have suffered to be helped, money doesn't solve all problems but it sure doesn't hurt to be able to afford a roof over your head and have food in your belly. This can be done with no additional expenses added on to the federal government by taking it directly from tax revenue from Marijuana legalization. In order to do this, both sides of the isle need to meet in the middle and compromise. This is not a battle of left vs right or us vs them, and just because I do not agree with you does not mean you are wrong or I am wrong. I feel our nation has forgotten this, we need to work together for the betterment of our nation and hopefully the world. That being said, "Those who do not learn from history are doomed to repeat it". I personally detest violence, but I feel I must state this as I worry for our country if this lopsided use of legislation continues. I love this nation. Not for what she has done nor her history, but because she is where I was born and what she stands for fundamentally. We live in a time where knowledge is easily accessible thanks to a quick google search, reddit news can tell you things faster than a major news outlet, laws are easily accessible online, and anyone can be friends with someone on the other side of the planet. If this lopsided use of legislation continues there will be no way to hide it from the people and it almost assuredly will lead to resentment, if not more. Whatever the government decides is their decision and I will stand by it, this is a democracy and it is partially my decision as to who gets elected. If I do not like it, then I will vote and comment more on the Federal Register as is my right under law. The United States may not be perfect, but she is our nation and our experiment in democracy that I desire to keep going long after myself and my children pass. In that sense, the only way to fix a problem is to admit that there is one. I feel we are on the right path, and I just wish to help guide a little bit to the best of my abilities. Finally, I hope that the information I provided is looked at and my ideas are at least considered even if they are completely disregarded. Thank you all for your time to those that read this and to those within the Government, thank you for your service and I wish you all a fantastic day or night wherever you are.

Slater, Sandy R. EOP/ONDCP

From: Asraa Alhawli <(b)(6)>
Sent: Friday, August 6, 2021 3:58 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] ONDCP Public Comment
Attachments: ACCESS_ONDCP_PublicComment.pdf

Importance: High

To Whom It May Concern,

On behalf of the [Arab Community Center for Economic and Social Services \(ACCESS\)](#) we submit this comment in response to the Office of National Drug Control Policy's request for information on whether and to what extent ONDCP's policy development process, budget review, and certification processes, and Grant Administration Programs perpetuate systemic barriers to opportunities for underserved communities and individuals from those communities and how its future proposed policies, budgets, regulations, grants, or programs might be more effective in advancing equity.

Thank you for your consideration of our comments and for your work in this vital institution.

Please do not hesitate to contact me for further information.

Best,

Asraa Alhawli

Public Health Coordinator

ACCESS Community Health and Research Center

6450 Maple St. Dearborn, MI 48126

O: (b)(6) | C: (b)(6)

(b)(6)

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ACCESS

assisting. improving. empowering.

August 6, 2021

Robert Kent, General Counsel
White House Office of National Drug Control Policy
1600 Pennsylvania Ave., NW
Washington, DC 20500

RE: FR Doc. 2021-14365 - Application of Equity in U.S. National Drug Control Policy

On behalf of the Arab Community Center for Economic and Social Services (ACCESS)¹ we submit this comment in response to the Office of National Drug Control Policy's request for information on whether and to what extent ONDCP's policy development process, budget review and certification processes, and Grant Administration Programs perpetuate systemic barriers to opportunities for underserved communities and individuals from those communities and how its future proposed policies, budgets, regulations, grants, or programs might be more effective in advancing equity.

ACCESS, a social services agency, is the largest Arab American community nonprofit in the United States. Founded by a group of dedicated volunteers in 1971 out of a storefront in Dearborn Michigan's impoverished south end, ACCESS was created to assist the Arab immigrant population adapt to life in the United States. ACCESS serves metro Detroit through 10 locations and more than 120 programs offering a wide range of social, economic, health and educational services to a diverse population.

ACCESS' Community Health and Research Center (CHRC) is a fully integrated community health "one-stop service center" that is comprised of medical, public health and research, substance use prevention, and mental health programs. Central to its mission statement is the strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since inception, CHRC has focused substance use prevention and treatment, violence prevention, health equity, positive youth development, and mental health and wellbeing.

We write to you today to recommend that ONDCP adopt the following recommendations to improve equity in its operations and policies:

- Develop a roadmap for an equitable, health-based approach to drug control policy;
- Include voices of people who use drugs; and
- Set requirements for grantees to ensure equity in their policies and data collection.

Throughout the history of war on drugs, measures to battle the use and sale of drugs have emphasized arrests and incarceration rather than prevention and treatment. Moreover, enforcement of criminal drug laws has always disproportionately targeted communities of color. Black people are

¹ www.accesscommunity.org

three times more likely to be arrested for drug use than white people, despite similar drug use prevalence estimates.² The harm inflicted by the war on drugs is not confined to arrests and incarceration. It has also infiltrated critical social systems — including education, employment, housing and public benefits — to the point that they frequently no longer serve their intended purpose. These conditions, or [social determinants of health](#),³ drive health inequities within communities of color, placing them at greater risk for [poor health outcomes](#).⁴

Moreover, communities of color are less likely to have access to harm reduction and substance use disorder treatment services. They often face more barriers to treatment than the general population when factoring in stigma, bias, and socioeconomic status. For the Arab American community in Southeast Michigan language and cultural barriers have also contributed to the gap in accessing and staying in treatment.⁵ However, the exclusion of the Middle Eastern and North African (MENA) community from our Federal statistical system makes it difficult to identify the specific needs and barriers faced by the Arab American community.⁶ Because of the lack of substance use available data on the Arab American community, the ACCESS team needed to invest time and resources to develop a research initiative to collection additional data on our local population, whose needs were plainly evident to those within our service centers but unrepresented in the Federal demographic data.

Federal drug laws and policies have perpetuated racial and economic inequity. Accordingly, the most influential practice ONDCP could adopt to improve equity is to critically analyze current laws and policies, recommend and support legislative and other reforms, and outline a plan to achieve equitable, health-based drug policies.

ONDCP should develop a roadmap for an equitable, health-based approach to drug policy,

ONDCP requested recommendations for long-term goals that it should consider in measuring progress towards equity in drug policy, and on how it can broaden its formal consultations to gain broader perspectives earlier in the policy development process. ONDCP should consult a variety of public health experts and people who have been directly impacted by drug criminalization to develop a plan to ensure an equitable, health-based approach to drugs.

ONDCP should focus on implementing evidence-based solutions, including expanded access to harm reduction services, substance use disorder treatment, recovery services, and harm reduction-based drug education. ONDCP should establish and fund community-based alternatives programs. An example of an alternative response models is the [ACCESS Opioid Response Team](#). Our program deploys community advocates and police officers to respond to crises involving suspected drug overdoses and direct people to treatment and social services rather than incarceration. This program and others like it improve health outcomes and reduce negative interactions with law enforcement, all while reducing costs to police and emergency departments.

² REPORT OF THE SENTENCING PROJECT TO THE UNITED NATIONS SPECIAL RAPPORTEUR ON CONTEMPORARY FORMS OF RACISM, RACIAL DISCRIMINATION, XENOPHOBIA, AND RELATED INTOLERANCE 3-4 (2018), <https://www.sentencingproject.org/publications/un-report-on-racial-disparities/>.

³ <https://www.cdc.gov/socialdeterminants/index.htm>

⁴ <https://www.cdc.gov/healthequity/racism-disparities/impact-of-racism.html>

⁵ Arfken, Cynthia & Berry, Alec & Owens, Darlene. (2009). Pathways for Arab Americans to Substance Abuse Treatment in Southeastern Michigan. *Journal of Muslim Mental Health*. 4. 31-46. 10.1080/15564900902785457.

⁶ Abuelezam NN and Galea S, “Generalizability of Arab American Health Outcomes. Results from a Population Based Survey in California,” *ACCESS Health Journal* 4th Issue, (Spring 2019): 223.

This health-based approach will also require ONDCP to shift its approach to drug education for youth and families, which has traditionally been based exclusively on abstinence. The ACCESS ASAP Community Coalition has established a youth program in four high schools across Wayne County that promote positive health and personal development for youth. Each year we engage and educate hundreds of youths and help them understand the consequences of substance use, risk-taking, and the influences of the media. Students are taught to recognize situations where they are likely to experience peer pressure to use drugs and effective ways to avoid or otherwise effectively deal with these high-risk situations. In addition, we provide service-learning activities where students can find creative ways to spread anti-drug use message, including the use of photos, videos and presentations. Harm reduction-oriented substance use education encompasses all of these approaches and acknowledges that individuals already using substances can reduce risk for serious health impairment or death by following safer use practices.

As the key office focused on federal drug policy, ONDCP could play a pivotal role by laying the path toward effective, equitable solutions to improve the health of people who use drugs and reduce harms associated with drug use.

ONDCP should include voices of people who use drugs, particularly people of color who use drugs and formerly incarcerated people who use drugs.

ONDCP requested recommendations for how it can involve people who use drugs, especially those not typically included in household surveys, in the policy development process. Through our peer-support program, we know first-hand that in order to be effective, drug policy must meet the needs of the people it impacts because they are in the best position to identify and highlight the potential consequences and solutions. To ensure that national drug control policy serves the needs of the people it affects, ONDCP should engage individuals with lived experience or ‘peers’ at different stages of policy, program and research development. In order to improve the health of individuals and make services more relevant to the target population, policies and practices must be based on the needs of that population. Allowing the voices of peers to be heard is crucial for developing a deeper understanding of complex health problems. By doing so, initiatives to tackle these health issues will have a greater impact on the target population by improving the acceptability and utilization of programs for these individuals and by extension, increase accessibility to these services.⁷ Individuals actively using substances should also have a voice in the development of drug policy. The National Harm Reduction Coalition identifies active involvement of people using drugs with the development of programs and policy as foundational principal of harm reduction.⁸

In addition, we believe that one of the most powerful voices is the family voice. ACCESS recognizes the strength and influence that stems from the voices of impacted family members; loved ones who experienced first-hand the unique challenge of the journey supporting a loved one toward regaining wellness and recovery. Family voices - including those in long term recovery themselves - are exceptionally positioned to lend an authentic voice toward cultivating lasting and systemic positive change. They are a force for change and its important that their voices be included in the development of new approaches to break down barriers and increase access to treatment.

⁷ Rhodes SD, Malow RM, Jolly C. Community-based participatory research: A new and not-so-new approach to HIV/AIDS prevention, care, and treatment. *AIDS Educ Prev.* 2010;**22**:173–183. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]

⁸ Foundational principles central to harm reduction. National Harm Reduction Coalition. <https://harmreduction.org/about-us/principles-of-harm-reduction/>.

ONDCP Should Set Requirements for Grantees to Ensure Equity in Policy and Data Collection

ONDCP should develop equity requirements for grantees of funds administered by the office. Among these should be the requirement that grantees implement policies meant to ensure equity and measure actual equity outcomes, including an examination of how the potential grantees' current policies and operations impact different populations and a plan to ensure equitable provision of services. Further, ONDCP should ensure that grantees do not discriminate or deny services to people who use methadone and buprenorphine for opioid use disorder. All grantees should be required to adopt policies that support access to these life-saving medications.

As part of the plan to ensure equitable provision of services, ONDCP should require grantees to collect disaggregated data to track the impacts for underserved populations including the Arab American community. ACCESS has worked with national partners to create alternate data collection options for more accurately counting Arab and MENA residents as part of surveys and research. However, a federal level change is a precondition for health equity. Nadia Abuelezam and Sandro Galea assessed data from the 2003-2016 California Health Interview Survey (CHIS) to better understand "the generalizability of the inferences from each of [the] strategies" to study Arab American health outcomes without a MENA category, and ultimately found that, "without MENA identifier ... [Arab Americans] remain a difficult population to identify in public health research."⁹ This inclusion will improve health disparities data and "[expand] the funding opportunities for health researchers to address and reduce [health] disparities among Arabs in the United States."¹⁰

To collect disaggregated data, ONDCP can add the following entry box for survey respondents or data collectors, which ACCESS developed with four other civil rights organizations – the Asian & Pacific Islander American Health Forum (APIAHF), UNIDOS US, National Urban League, and the National Congress of American Indians – in a set of "[Policy Recommendations](#)" for achieving health equity:

" Middle Eastern or North African – Print, for example, Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc."

A uniform system of reporting will not only help ensure data from different grantees are comparable, but also inclusive of each of our community's needs. ONDCP should analyze the data from grantees and generate reports describing equity impacts of ONDCP programs and ways to improve equity and data collection.

Thank you for your consideration of our comments and for your work in this vital institution.

Please do not hesitate to contact me for further information.

Sincerely,
Adam Beddawi
D.C. Policy Manager, ACCESS
(b)(6)

Arab Community Center for Economic and Social Services | ACCESS

⁹ Abuelezam NN and Galea S, "Generalizability of Arab American Health Outcomes. Results from a Population Based Survey in California," *ACCESS Health Journal* 4th Issue, (Spring 2019): 223.

¹⁰ Ibid

Slater, Sandy R. EOP/ONDCP

From: B. Siangonya <(b)(6)>
Sent: Friday, August 6, 2021 11:32 PM
To: MBX ONDCP OGC
Cc: Ann Marie Foster; Justin Shaw; Alexis Vien; Yareka Carter
Subject: [EXTERNAL] ONDCP Equity Request for Information Comment Submission

To Whom it May Concern,

Please see the comment below in response to the Office of National Drug Control Policy (ONDCP) call for public comments on the ONDCP's policy development process, drug budget review, and certification processes being submitted by Phoenix House of New York and Long Island.

Thank you,

Bella Siangonya

Begin comment below:

Phoenix House of New York and Long Island commends that the Biden-Harris Administration has made expanding access to evidence-based treatment one of its top National Drug Policy priorities for year one. We are submitting our public comment to the Office of National Drug Control Policy (ONDCP) to recommend a new funding program to support new supportive housing infrastructure and programs for behavioral health organizations aimed at helping newly released individuals from incarceration who are on treatment for substance use disorders. Past funding priorities for the ONDCP through the Drug Free Communities Support Program has primarily focused on supporting efforts to increase collaboration among community partners and prevent and reduce youth substance use and treatment. Moreover, the High Intensity Drug Trafficking Areas (HIDTA) program has contributed to the continued disproportionate incarceration of adult and young adult racial and ethnic minorities, including in New York state, due to racial inequities in the criminal justice system especially for young adults and adults. As a result, a subset of these individuals go into and leave prison requiring substance use disorder treatment. One of the biggest challenges behavioral health organizations, including ourselves, face in supporting recently incarcerated individuals is the lack of access to supportive housing infrastructure.

As the Biden-Harris Administration seeks to advance racial equity in its approach to drug policy, the administration must invest in funding to support behavioral health organizations that lack access to supportive housing infrastructure and programs. Access to supportive housing services is an evidence-based component of substance use disorder treatment for individuals who lack a stable housing environment. As one of the many organizations at the forefront of substance use disorder treatment, we firmly believe behavioral health organizations have a role in advancing equity in the U.S. National Drug Control Policy. Funding for supportive housing services for organizations such as Phoenix House of New York and Long Island is needed to develop sustainability protocols for supportive housing, including certification, payment models, evidence-based practices, and technical assistance.

Supportive housing is a critical component of a comprehensive approach to advancing equity for all individuals on the path to recovery from substance use disorders. Racial and ethnic minorities seeking treatment for substance use disorders face poorer health outcomes than their counterparts due to persistent poverty and inequality. Supportive housing services offered by behavioral health organizations such as Phoenix House of New York and Long Island can reduce these well-documented health disparities.

PUBLIC SUBMISSION

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Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0011

Comment from Decriminalize Va

Submitter Information

Email: (b)(6)

Organization: Decriminalize Va

General Comment

Remove cannabis from the schedule 1 drug list.
Prohibit felony arrest of possession of cannabis.

Slater, Sandy R. EOP/ONDCP

From: Dustin McDonald <(b)(6)>
Sent: Friday, August 6, 2021 3:16 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Americans for Safe Access Comments on FR: 2021-14365
Attachments: ASA Comment Ltr-FR2021-14365.pdf

To Whom It May Concern:

I am writing on behalf of Americans for Safe Access(ASA) to submit comments to the Office of National Drug Control Policy in response to *FR 2021-14365-Application of Equity in U.S. National Drug Control Policy*. ASA is the nation's oldest and largest 501(c)(3) member-based medical cannabis advocacy organization with a mission to advance access to cannabis for therapeutic use and research, and we look forward to collaborating more deeply to help the administration navigate this challenging policy area.

Please do not hesitate to contact me if you have any questions or would like to discuss any details included in our comment letter. Thanks, -Dustin

--

Dustin McDonald | Interim Policy Director
Americans for Safe Access

1629 K Street NW | Suite 300 | Washington, DC 20006
Phone: (b)(6) | Toll Free: (b)(6)

Slater, Sandy R. EOP/ONDCP

From: Faye Coleman <(b)(6)>
Sent: Friday, August 6, 2021 6:48 PM
To: MBX ONDCP OGC
Cc: Adrina Walker
Subject: [EXTERNAL] Office of National Drug Control Policy - Pure Genesis Testimony 8.6.21
Attachments: PG Testimony 8.6.21.docx

To The Executive Office of The President
Office of National Drug Control Policy
Docket No: ONDCP FRDOC 0001-0008
Document Citation 86 FR 35828
Document No. 2021-14365
OGC@ondcp.eop.gov

Enclosed is a copy of the testimony of Pure Genesis, LLC regarding the impact of Drug Policy on BIPOC communities and current challenges and potential remedies as it relates to opportunities within the cannabis industry.

Thank you for the opportunity to comment. Any questions please advise.

Best regards,

Faye

Faye E. Coleman

Co-founder & CEO, Pure Genesis, LLC

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Pure Genesis, LLC Testimony presented on Drug Policy Impact

The Executive Office of The President
Office of National Drug Control Policy
Docket No: ONDCP FRDOC 0001-0008
Document Citation 86 FR 35828
Document No. 2021-14365

Presented on August 6, 2021

By: Faye Coleman
Co-founder & CEO
Pure Genesis, LLC

As a citizen of the state of New Jersey for more than 20 years, my company, Pure Genesis, LLC (PG), a Minority & Women-Owned Business Enterprise (MWBE), is a multi-state hemp operator and has served as educators of cannabis throughout the state of New Jersey and nationally. Our goal is to operate a full vertical medical cannabis ecosystem as a cannabis operator and consultant offering safe, quality driven, and efficacious products and services, with a community first and business-centric engagement.

As we look at the impact that drugs have had on black, indigenous and people of color (BIPOC), it is clear that we have been disproportionately impacted in a way that has led in part, to the negative economic, environmental, social and health equity of families. To move forward and commit to righting this wrong, there must be a focus on providing opportunity for these communities of color to enter into this industry that systematically disenfranchised us. PG believes that while it is the goal of the newly appointed cannabis regulatory commission to reduce the disparity of opportunity within this industry as it relates to licensing opportunities within New Jersey, there are several challenges that may prevent this goal from being realized. PG wants to speak on a few areas of focus that we believe, with collaborative input from minority and women ancillary leaders and operators (within the industry), PG will have the necessary support to start, run and grow a successful medical cannabis operation.

In an industry that has been legal in many states for at least 10 years, nationally only 4% of African Americans own a cannabis business and only 1% are African American women-owned. If the goal is to create a robust cannabis market that drives revenue for the state, the communities, and equally important, the cannabis businesses, we have to change the state of play to create a path towards success for all.



- Let's consider revenue generation for the state. For example, Oklahoma, where they currently have 10,000 licenses and at a fee of \$2500 per year that is \$22M annually (fees only). Now let's look at Colorado which brought in \$1.75B in sales in 2019 and received \$302M in tax revenue. With New Jersey projected to be a \$2B market (mature), the state will be poised to bring in approximately \$345M in tax revenue.
- The communities will be impacted comprehensively through job creation as witnessed by Colorado's 40k cannabis specific jobs. However, the benefits are far beyond job creation. Tax revenue has been directed towards youth consumption prevention programs, investment in public school construction, health care, health education, substance abuse prevention and treatment programs, and law enforcement.
- Businesses aspiring to be operators, specifically those who are socially and economically disadvantaged, must be provided with a different approach that does not include "winning" a license. This current process requires businesses to spend hundreds of thousands of dollars to compete for a chance at a license - with a 90% failure rate. This has led to a significant number of socially and economically disadvantaged businesses to suffer financial hardship and thus prevented from the opportunity to continue to apply due to a process that was developed for businesses with significant financial support. This strategy has led the state to provide 6 licenses in 3 years with minimal diversity impact. As a solution, is it possible to follow in the footsteps of most industries (e.g. legal, pharmacy...) where applicants are to meet specific requirements set by the state and local governments and by meeting those requirements are able to acquire a license? The free-market approach in Oklahoma also has proven successful where of the 10,000 license holders, 60% in operation, approximately \$800M in revenue is projected for 2020.

Another solution that has been successfully adopted in several states are social equity programs. As a result, not only do those socially and economically disadvantaged businesses benefit, but the communities by which they reside benefit and therefore the states benefit. Let's take for example the impact of Black Lives Matter (BLM) and George Floyd – For the longest time, cannabis regulators with social equity goals have been trying to salvage poorly designed policies and frameworks purposely intended to keep previous marijuana offenders, a large majority Black, Indigenous or Hispanic, from participating in a legal cannabis market. However, in the wake of George Floyd's murder and subsequent protests in all 50 states, there has been a huge momentum shift in the policy conversations across the country with regards to cannabis equity. Legislative leaders have a strong motivation to find ways to support, build and reinvest in Black lives. Now, after nearly 5 years of debating the need for a social equity program in Colorado, the state passed HB 20-1424 establishing social equity licenses in the adult-use cannabis program within **20 days** of being introduced as new legislation in June 2020. Similarly, in the same month, Portland's city council divested \$2.3M of cannabis tax revenue that was originally allocated to go to the police bureau. A portion of that was added to the city's Social Equity & Educational Development (SEED) Initiatives to provide \$1M in ongoing annual funding to communities most



impacted by cannabis prohibition. These examples not only set precedent for other states, but they also demonstrate how quickly the government can move if properly educated and motivated. This is exciting to see, and I believe New Jersey is equipped to follow a similar path.

Now, PG has shared how we can remove barriers to entry to gain access to licenses. Next, we want to address the barriers that we believe will significantly limit future license holders from effectively competing.

- Note, current license holders (all non diverse) have the opportunity to expand without merit with 2 additional licenses. If the goal is to create a robust cannabis market that drives revenue for the state, communities, and cannabis operators, it must be competitive. Those that secure licenses post 2020 may find it a challenge to compete and remain viable because current license holders will set price that will greatly reduce revenue and ultimately profit margins. This is a common business practice. PG realizes that New Jersey wants the cannabis industry to be successful and is looking at catalysts that will spur such growth. However, we are asking that the Commission have confidence in those yet to secure a license. Specifically, those Minority, Women-Owned and Veterans-Owned businesses who are not only primed to compete but are prepared with the necessary resources. It is critical that we understand that we need the Commission to provide equitable access to business and allow the fair and competitive market to take shape and drive revenue where all productive businesses have an opportunity to win.
- This winning strategy can be further extended by removing the barriers of licensing caps. The thought may be that with the licensing cap more businesses will be able to apply. If that is the intent, then first a cap must be placed on the current license holders to ensure a competitive market. Second, socially and economically disadvantaged businesses will not be able to survive with licensing caps due to a lack of control of their ecosystem. For example, a minority business owns a dispensary and sales spike. If the dispensary must rely on an outside grower, they may not receive product during that spike which dilutes sales, reduces profit margins, and makes it challenging to remain operational. If socially and economically disadvantaged businesses had no licensing caps they could pursue their own full vertical ecosystem and compete on equal footing.

PG is excited that New Jersey citizens, businesses and government are all aligned on the medicinal and financial value of cannabis within the state. We share our thoughts to convey the importance of social equity as an integral part of legislation. We want to believe that the possibility of being an operator within the state exists for Minority, Women-Owned and Veterans-Owned businesses. The language has been included in our current policies. It is our hope that execution of awarding licenses is fair and appropriate. Our cannabis regulatory commission is the most diverse commission in the US so we are on the right path. That coupled with an inclusive bill that fundamentally supports inclusion through a new process for license acquisition, a comprehensive social equity program, as well as elimination of licensing caps and license expansion of current license holders is the solution needed.



On behalf of Pure Genesis, LLC, thank you so much for allowing me the time to convey thoughts regarding the impact that drug policies have had on our communities, but more important how we can in part remedy today through our now legal (by state) cannabis industry. The time for action is now.

Faye

Faye E. Coleman

Co-founder & CEO, Pure Genesis, LLC

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Slater, Sandy R. EOP/ONDCP

From: Frank Harrington <(b)(6)>
Sent: Friday, August 6, 2021 7:12 AM
To: MBX ONDCP OGC
Cc: Adam Horgan
Subject: [EXTERNAL] AANP Comment on Equity RFI
Attachments: ONDCP RFI Equity.pdf

To Whom it May Concern,

Please find the attached comments from the American Association of Nurse Practitioners regarding the request for information on the Application of Equity in U.S. National Drug Control Policy. We appreciate the opportunity to comment on this RFI and thank you for your consideration of these comments. Please let us know if there is any additional information that we can provide, and we look forward to working with ONDCP on improving equity throughout its policies and programs.

Have a great day,

Frank

Franklin Harrington
Director of Reimbursement and Regulatory Affairs
American Association of Nurse Practitioners
1400 Crystal Drive, Suite 540
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Phone: (b)(6)
(b)(6)

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August 6, 2021

Regina LaBelle, Acting Director
Office of National Drug Control Policy
Executive Office of the President
Washington, D.C. 20503

RE: Application of Equity in U.S. National Drug Control Policy

Dear Acting Director LaBelle,

The American Association of Nurse Practitioners (AANP), representing more than 325,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to comment on the request for information on advancing equity within the Office of National Drug Control Policy (ONDCP) policies and programs. AANP is committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities through practice, education, advocacy, research, and leadership (PEARL).¹ Nurse practitioners have been heavily engaged in the efforts to address the opioid epidemic. We applaud actions already taken by ONDCP to increase access to medication-assisted treatment (MAT) for opioid use disorder (OUD) by reducing barriers on the clinicians providing that necessary treatment. We look forward to working with ONDCP on other priorities including expanding the addiction workforce and telehealth special registration.

NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care (including treatment for substance use and mental health disorders) to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform more than one billion patient visits annually.

NPs practice in nearly every health care setting including mental health and substance use disorder settings, hospitals, clinics, Veterans Health Administration and Indian Health services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health care settings.

Nurse practitioners provide a substantial portion of the high-quality², cost-effective³ care that our communities require. As of 2019, there were more than 163,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.⁴ Approximately 40% of Medicare patients receive billable services from a nurse practitioner⁵ and approximately 80% of NPs are seeing Medicare and Medicaid patients.⁶ NPs have a particularly large impact on primary care as

¹ <https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid-19>

² <https://www.aanp.org/images/documents/publications/qualityofpractice.pdf>

³ <https://www.aanp.org/images/documents/publications/publications/costeffectiveness.pdf>

⁴ <https://www.cms.gov/files/document/2019cpsmdcrproviders6.pdf>

⁵ <https://www.cms.gov/files/document/2019cpsmdcrphysysupp6.pdf>

⁶ NP Fact Sheet (aanp.org)

approximately 70% of all NP graduates deliver primary care.⁷ In fact, NPs comprise approximately one quarter of the primary care workforce, with that percentage growing annually.⁸

The COVID-19 pandemic has exposed and exacerbated severe and pervasive health and social inequities in America,⁹ and has highlighted long-standing vulnerabilities in the American health care system.¹⁰ Nurse practitioners have long been essential health care providers in underserved communities and are critical participants in providing health care to vulnerable populations. As providers of care in rural areas and areas of lower socioeconomic and health status, NPs understand the barriers to care that face vulnerable patients on a daily basis.^{11, 12, 13}

NPs have been essential to addressing the opioid epidemic, particularly in rural and underserved communities. As of November 2020, the Drug Enforcement Administration (DEA) reported that over 18,000 NPs and PAs obtained a Drug Addiction Treatment Act (DATA) waiver to treat patients with OUD.¹⁴ Studies have found that NPs have greatly increased access to MAT in rural and underserved communities.¹⁵ In rural communities, NPs and PAs were the first waived clinicians in 285 rural counties covering 5.7 million residents.¹⁶ The Medicaid and CHIP Payment and Access Commission found that the number of NPs prescribing buprenorphine for the treatment of OUD, and the number of patients with OUD treated with buprenorphine by NPs increased substantially in the first year NPs were authorized to obtain their DATA waiver. This was particularly true in rural areas and for Medicaid beneficiaries.¹⁷ As ONDCP evaluates equitable solutions to national drug policy priorities, NPs will be a critical component of these efforts.

We appreciate the administration's executive actions addressing the structural inequalities in health care facing underserved communities.¹⁸ As noted in the National Academies of Science, Engineering and Medicine (NASEM) report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* "nurses work in areas that are underserved by other health care providers and serve the uninsured and underinsured."¹⁹ It is important that the efforts to address the challenges facing underserved communities recognize the important role of nurse practitioners in addressing the diverse needs of these patients. Ensuring that vulnerable populations have the necessary access to care, including treatment for substance abuse and behavioral health, is a critical missing link in the health care system, and NPs are well positioned to provide care for these populations.

⁷ <https://www.aanp.org/about/all-about-nps/np-fact-sheet>.

⁸ Rural and Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners, Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsof, *Health Affairs* 2018 37:6, 908-914.

⁹ <https://www.govinfo.gov/content/pkg/FR-2021-01-26/pdf/2021-01852.pdf>

¹⁰ [Notes from the Field: Opioid Overdose Deaths Before, During, and After an 11-Week COVID-19 Stay-at-Home Order — Cook County, Illinois, January 1, 2018–October 6, 2020 | MMWR \(cdc.gov\)](#)

¹¹ Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine*, 4–6. <https://doi.org/10.1007/s11606-017-4287-4>.

¹² Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. *Journal of the American Medical Association*, 321(1), 102–105.

¹³ Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. *Medical Care Research and Review*, Epub ahead. <https://doi.org/10.1177/1077558718793070>

¹⁴ 85 FR 69153. (Nov. 2, 2020).

¹⁵ <https://jamanetwork.com/journals/jama/fullarticle/2730102?widget=personalizedcontent&previousarticle=2737024>.

¹⁶ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859>.

¹⁷ <https://www.maepac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/>

¹⁸ Federal Register :: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

¹⁹ NASEM: The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity

Nurse practitioner education and clinical training prepares them to address the complex needs of patients, including substance use disorder, behavioral health and social determinants of health (SDOH). NASEM highlights that “the role of nurses in these efforts is key, given their interactions with individuals and families in providing and coordinating person-centered care for preventive, acute, and chronic health needs within health settings, collaborating with social services to meet the social needs of individuals, and engaging in broader population and community health through roles in public health and community-based settings.”²⁰ Our comments on specific questions posted in this RFI are below. We look forward to working with ONDCP and the Biden-Harris Administration to improve equity throughout federal government programs and policies.

1. Formal consultations for the National Drug Control Strategy often involve direct relationships between ONDCP and the consulting group, organization, or subject matter expert. What are recommendations on how the agency can broaden its formal consultations to gain broader perspectives earlier in the policy development process?

As recognized in the *Biden-Harris Administration’s Drug Policy Priorities for Year One*, ONDCP’s mission to coordinate the nation’s drug policy involves a diverse group of stakeholders and programs. Thus, it is important that policy development not be siloed to one specific community. As ONDCP begins its policy development process, it is important to recognize that many of these stakeholders in diverse areas have common interests and concerns, and bringing them to the table simultaneously can lead to more comprehensive solutions. For example, clinicians such as nurse practitioners are often a patient’s most trusted source of information, and they have a deep understanding of a patient’s social needs. Bringing nurse practitioners and other clinicians together with experts in other fields (e.g. housing, education or criminal justice) could lead to more robust discussions and innovative solutions to pressing problems.

We also encourage ONDCP to engage underserved communities in rural areas or underserved communities that otherwise are not able to visit Washington, D.C. Throughout the course of the COVID-19 Public Health Emergency (PHE), federal agencies have held digital town halls and engagement opportunities for stakeholders. The digital format has been helpful to ensure geographic diversity, and access to these forums and opportunities should be continued after the COVID-19 PHE. We also encourage ONDCP to give stakeholders ample time to identify individuals to participate in the meetings, and potentially create a set schedule for meetings and roundtables that stakeholders can rely on. For NPs and other practicing clinicians who wish to attend these meetings, a predictable schedule is important so they can adjust their schedules accordingly. Timely transcriptions and recordings are also important to ensure that those who were unable to attend a live forum may still listen and provide feedback.

Federal agencies also need to ensure that advisory boards, task forces, and commissions are diverse and include a broad array of stakeholders. As noted previously, nurse practitioners are essential to the health care workforce, including for treating behavioral health and substance use disorders, yet this is often not reflected in the composition of federal commissions that advise on policy. The continued evolution of health care has increased the need for all federal agencies to recognize the diversity of the health care workforce. This will be increasingly important moving forward, as “nurses in particular are well prepared to create, partner in, and lead the complex work of integrating the social and health sectors in support of the health and well-being of individuals, families, and communities.”²¹

²⁰ *Ibid.*

²¹ *Ibid.*

2. **Provide recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of National drug control policy.**

We strongly believe there is a need for improved data collection by federal agencies to better understand the challenges certain populations face in developing policy. This data should be collected in a manner that is culturally sensitive and recognizes the diverse needs and identities of individuals, and that they can ensure is protected and confidential. This is a particularly acute concern with this population given the stigma surrounding drug use and concerns of individuals that they could face negative ramifications if their identities are not protected.

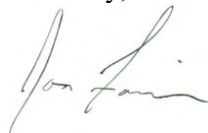
It is also important to acknowledge that individual and group barriers and challenges faced by minority and underserved populations differ among different patient populations. These differences need to be reflected in any future data collections, and ONDCP should ensure that there are methods which allow patients to self-identify as a member of a certain population. Feedback from our members has indicated that data collections will often combine multiple individuals into a homogenous category. Yet the individual members of that group face their own unique challenges that need to be addressed.

For example, according to the 2018 National Survey on Drug Use and Health, members of the LGBTQ+ community have higher rates of substance use than heterosexual adult populations and enter treatment with more severe substance use disorders.²² Thus, it is essential that we obtain robust data on this population to ensure that policies are crafted that meet their needs. However, the LGBTQ+ community is often combined into one group despite disparate experiences, which can contribute to a lack of accurate data related to the hurdles facing each individual. It is important that the data fields allow patients to self-identify so that the data is accurate when it is evaluated and operationalized. In addition, agencies should include a clear explanation of why this data is being collected, how it will be used and ensure that this is conveyed to patients when the data is requested. This helps provide individuals with a comfort level when they choose to provide their information which may lead to improved and increased engagement.

Conclusion

AANP appreciates the focus of ONDCP on advancing equity throughout its policies and programs. Advancing health equity is a core tenet of NP practice, and we look forward to continued partnership with ONDCP on improving health equity throughout its policies and programs. Should you have comments or questions, please contact MaryAnne Sapio, V.P. Federal Government Affairs, (b)(6) 703-(b)(6)

Sincerely,



Jon Fanning, MS, CAE, CNED
Chief Executive Officer
American Association of Nurse Practitioners

²² <https://www.drugabuse.gov/drug-topics/substance-use-suds-in-lgbtq-populations> .

Slater, Sandy R. EOP/ONDCP

From: John Dickinson <(b)(6)>
Sent: Friday, August 6, 2021 9:58 PM
To: MBX ONDCP OGC; US COOMS; WorldPerC Casting
Subject: [EXTERNAL] Comment

August 6, 2021

Respectfully Office of National Drug Control Policy.

I support the comments of Americans For Safe Access in their entirety, and add the following. My change recommendations:

1. change DEA to Drug Education Administration.
2. change marijuana, marajuana to cannabis.
3. change black to illicit market.
4. change medical to medicinal cannabis.
5. change legalize to decriminalize etheogenics.
6. change stakeholder to consumer.
7. change war on drugs to war on people.
8. /
9. /
10. /

At 16 I was diagnosed with Type 1, Insulin Dependent Diabetes, and told I had 20 years to live.

At 18 I tried cannabis.

At 20 I began my travels around the world in a search for Etheogenic help with diabetes.

At 30 I imported the cannabis from the Middle East that my searches showed offered the greatest help with diabetes.

At 40 I was freed and then gained a Masters in Public Service from Seattle University.

At 70+ I still ignore the doctors' dire warnings.

So I ask anyone in the Office of National Drug Control Policy to give me any answers why cannabis is illegal, regulated, and outlawed.
Our longest war, a war on people, has failed:

4.20, 2012 Town Hall

<https://www.seattlechannel.org/TownSquare?videoid=x23443>

note misstatements begin before anticipated passage.

6 November 2012

Days before the voters of Colorado, Washington passed Peoples Initiative 502, legalizing cannabis.

26 November 2012 00:01:54 blocked

The Telegraph Breaking the Taboo, trailer: Bill Clinton and Morgan Freeman back ending the war on drugs documentary

<http://goo.gl/sGFgkW>

11 December 2012 00:02:22

Richard Branson's Big Idea for 2013, Presented by LinkedIn, "End the war on drugs."

<https://youtu.be/rX1i39qFNc0>

9 March 2013 00:03:55

King County Sheriff agrees with John Dickinson that there must be an end to the war on drugs. "It has failed." "We must try something."

<https://youtu.be/hISu8dF38NE>

24 September 2013 00:02:00

On September 10, 2013, before the United State Senate Judiciary Committee, King County Sheriff, Seattle, Washington- John Urquhart 13th most powerful sheriff in the U.S. testifies the drug war has failed.

<https://youtu.be/IP0xPBZej4Q>

April 24, 2015

Dir DOH WA

Dear Dr. Wiesman:

Gov. Inslee signed 2SSB 5052, the [Cannabis Patient Protection Act \(PDF\)](#). This act creates licensing and regulation of all cannabis producers, processors and retail stores under the oversight of the renamed Washington State Liquor and Cannabis Board (LCB). It also directs the Department of Health to complete tasks that include contracting with a third party to create and administer an independent medical cannabis authorization database, and adopting rules relating to the operation of the database. Effective July 1, 2016, when the database underdevelopment becomes operational, patients and designated providers may then be entered into the database by presenting their authorization to a licensed retail store with a medical cannabis endorsement. At that time, cannabis possession amounts change depending on whether the patient or designated provider is entered into the database. (This Act hereby protects voters from any decisions about cannabis use.)

July 24, 2015

All medicinal cannabis Access Points regulated by the Department of Health are closed.

November 17, 2015

Sheriff John Urquhart,

Last night I testified at the Departments of Alcohol and Health comment session as I have done since the first forum in Olympia two years ago. I was cautiously excited with the potential of legalization of cannabis back then. Upon first reading of I-502, I predicted, and told many that this peoples' initiative would make cannabis illegal in 502 more ways. Until last night's meeting I held out hope for some sanity in the State's rush for money.

[.O. 13985](#) defines "equity" as the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.
><https://drugpolicy.org/issues/race-and-drug-war><

Medicinal Studies

><https://youtu.be/XUVUS79qbR0><

><https://youtu.be/n3fkiwTABa><

><http://goo.gl/rsAUj1><

><https://youtu.be/PWabJ6DS55Q><

><https://youtu.be/iil2ZApXcNk><

Commercialization consumes real estate, \$3,000,000,000 yearly energy, water, landfills with the tons of one-use plastic, prison cells and more.

[>https://youtu.be/BgLsnxwe1YE<](https://youtu.be/BgLsnxwe1YE)

[>https://youtu.be/Icq9oTKF0BY<](https://youtu.be/Icq9oTKF0BY)

[>https://youtu.be/Icq9oTKF0BY<](https://youtu.be/Icq9oTKF0BY)

[>https://www.thestranger.com/slog/archives/2014/06/27/who-thought-it-was-a-good-idea-to-wear-google-glass-to-a-stranger-endorsement-interview<](https://www.thestranger.com/slog/archives/2014/06/27/who-thought-it-was-a-good-idea-to-wear-google-glass-to-a-stranger-endorsement-interview)

[>https://youtu.be/eu2rwaw1t_0<](https://youtu.be/eu2rwaw1t_0)

[>http://thaistickbook.com/<](http://thaistickbook.com/)

[>https://youtu.be/w87tAi_Axc4<](https://youtu.be/w87tAi_Axc4)

[>https://vimeo.com/156963454<](https://vimeo.com/156963454)

[>https://www.michaellinnell.org.uk/michael_linnell_archive/the_big_blue_books/pdf/BBB8_Cannabis.pdf<](https://www.michaellinnell.org.uk/michael_linnell_archive/the_big_blue_books/pdf/BBB8_Cannabis.pdf)

I remain sincerely yours,

John Dickinson

(b)(6)

=access since 1991

Slater, Sandy R. EOP/ONDCP

From: Katharine Neill Harris <(b)(6)>
Sent: Friday, August 6, 2021 3:04 PM
To: MBX ONDCP OGC
Cc: Bill Martin
Subject: [EXTERNAL] Response to RFI -- Rice University's Baker Institute
Attachments: BIPP Response to ONDCP RFI 8.6.21.docx

Good afternoon,

Attached please find our comments in response to ONDCP's request for information regarding how to address racial inequities in U.S. drug policy.

Thank you for the opportunity to provide input on this critical issue. If you have questions or if we can be of additional assistance, please let us know.

Best,

Katharine Neill Harris, Ph.D. (she/her)
Alfred C. Glassell, III, Fellow in Drug Policy
Rice University's Baker Institute for Public Policy
6100 Main St., MS-40
Houston, TX 77251

(b)(6)

(b)(6)

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Reducing Racial Inequities in U.S. Drug Policy

Response to Office of National Drug Control Policy's Formal Request for Information regarding Racial Inequities in U.S. Drug Policy

Katharine Neill Harris, Ph.D., and William Martin, Ph.D.
Drug Policy Program, Baker Institute for Public Policy, Rice University

August 6, 2021

Thank you for the opportunity to submit comments regarding strategies for addressing systemic racial inequities in U.S. drug policy. By making this request, ONDCP demonstrates a willingness to take seriously the racially disparate harms fostered and perpetuated by drug policies that contribute to mass incarceration, heighten the risks of illicit drug use, and erect barriers to treatment and harm reduction services. We are encouraged by the Biden Administration's official drug policy priorities, which include racial equity and harm reduction as policy goals and which this request for information is intended to advance.

Given ONDCP's historical emphasis on drug interdiction and enforcement, we have reservations regarding whether ONDCP as it is currently conceived can lead the nation toward more effective and racially equitable drug policies. To the extent that ONDCP does continue to play an active role in federal drug policy, we urge the office to use its power and position to concentrate primarily on addressing the racial disparities caused by the War on Drugs. This requires a reorientation in mission to focus on promoting drug law reform at the national and state levels, collecting and disseminating accurate information about drug use and drug policy, and distributing funds to communities to increase access to treatment and address drug-war harms. Funding and support for supply-side law enforcement and interdiction should be reduced.

To reduce racial inequities in U.S. drug policy, we offer the following specific recommendations.

- 1. Issue a formal apology through a public relations campaign recognizing ONDCP's role in causing racially disparate drug policy.**

As a product of the Anti-Drug Abuse Act of 1988, the ONDCP has been a key player in the War on Drugs. ONDCP policies have not just, as this RFI puts it, "perpetuated systemic barriers to opportunity"—they have created those barriers. Black, Hispanic/Latinx, and Indigenous individuals and communities are actively harmed by prohibitionist policies that

lead to arrest and incarceration of people who use drugs (PWUD), that increase the risks related to drug use, and that create obstacles to health care and drug treatment.¹

Decades of unequal and punitive enforcement have resulted in collateral consequences that extend beyond isolated incidents of arrest or violence to include long-term damage to family structures, economic opportunity, mental wellbeing, and overall quality of life. The drug war undermines public confidence in the legal system and fosters distrust of government and law enforcement. Despite its costs, the War on Drugs has failed to achieve a “drug-free America,” made tragically obvious by the two-decades long overdose epidemic.

ONDCP and the agencies it coordinates with should formally take responsibility for their role in creating the damages they now seek to address. Public service announcements on a variety of media platforms can communicate this message to the American public. This is an important step to reducing stigma surrounding drug use and to repairing the government’s relationship with minority communities.

2. Reduce the role of law enforcement in drug policy.

Though ONDCP’s FY 2022 budget request allocates more funding for treatment and prevention services, \$17.5 billion (42.5% of the total budget) is still directed at supply-side interventions.² ONDCP’s request for a 6.3% increase to DEA’s domestic law enforcement budget, for example, indicates a continued commitment to prohibition as a central pillar of U.S. drug policy. So long as law enforcement interventions remain a primary response to drug use, systemic racial/ethnic inequities and barriers to treatment will persist.

Uprooting drug policy from the criminal justice system is a substantial undertaking that will not happen overnight. Thus, moving forward, law enforcement spending should focus primarily on aiding the transition away from justice system interventions for drug use in favor of building capacity for strategies grounded in harm reduction and public health. Any continued interdiction and enforcement efforts must much more narrowly target actors at the highest levels of illicit networks than they do currently.

2a. End support for class-wide drug bans and mandatory minimum penalties.

DEA has argued that a class-wide ban on all fentanyl-related substances is critical to aiding prosecution of people selling these drugs. But additional bans—and the power and emphasis they give to drug enforcement—are not needed to prosecute trafficking cases.³ Regarding overdoses, zealous enforcement can do more harm than good. Recent empirical research finds that law enforcement seizures of fentanyl are associated with an increase in overdose deaths.⁴

Nearly two-thirds of fentanyl-related trafficking convictions in FY 2019 were at the level of a street dealer or below, too low to dismantle a drug trafficking organization but high enough to disrupt the immediate drug supply and cause PWUD to turn to unfamiliar, and riskier, sellers.⁵ And without substantial demand reduction, any longer-term dent in the fentanyl supply could cause the market to adapt by finding an alternative drug that is just as lethal, if not more so.⁶

The present emphasis on prohibition and punishment for fentanyl-related offenses is reminiscent of the U.S. response to crack-cocaine and the racially disparate consequences of that response. In FY 2019 Black individuals were overrepresented in prosecutions relating to fentanyl and its analogues.⁷ Those convicted of fentanyl and fentanyl analogue offenses were less likely to receive relief from mandatory minimum penalties compared to individuals convicted of trafficking other drugs, and across all drug offenses, Black individuals continue to receive mandatory minimum sentences more often than their white counterparts.⁸

Black individuals also experienced the sharpest rate of increase in overdose deaths from 2011-2018, driven mostly by fentanyl.⁹ Aggressive enforcement practices worsen this crisis by enhancing the risks of illicit drug use and deepening mistrust of public authorities within the Black community, which is a barrier to accessing care. Resources spent enforcing prohibition should be redirected to increasing access in minority communities to low-barrier MAT, syringe service programs (SSPs), naloxone, and fentanyl testing strips.

2b. Emphasize pre-arrest diversion programs over court-based diversion programs.

In the short-term, diversion programs that redirect PWUD from jail to community services can serve as an intermediary step toward replacing justice system interventions with community-based public health responses.

But post-arrest and court-based diversion programs, though an improvement over incarceration, ensure continued criminalization of drug use and its attendant racial and ethnic disparities. Because Black and Hispanic/Latinx individuals are disproportionately likely to come into contact with law enforcement for drug-related activity, they are also more likely to be required to participate in diversion programs.¹⁰ Research has also demonstrated an association between drug court implementation and an increase in misdemeanor drug arrests for Black (but not white) individuals.¹¹ Investigations into the quality of treatment to which courts refer diversion participants has found that it often does not adequately address individual needs and that Black participants have had negative experiences with treatment service providers.¹²

ONDCP should expressly endorse and, when applicable, request and provide funding for, pre-arrest diversion programs over court-based interventions for individuals involved in nonviolent drug-related activity. These programs should help with accessing mental health and drug treatment and other social services without requiring participation. ONDCP grants should fund local efforts to build drug crisis response teams that involve police only as a last resort.

3. Provide direct funding to communities harmed by the War on Drugs.

ONDCP should work with other federal agencies to provide funding to communities that demonstrate significant hardship from the War on Drugs. Such a funding program could be structured in a number of ways but important elements to consider are:

- a. Designing a process for identifying eligible communities that includes a variety of stakeholders, including communities themselves, but which does not require state involvement.

- b. Eligibility criteria that include historical and present-day rates of and racial/ethnic disparities in drug-related arrests and incarceration and present-day racial/ethnic composition.
- c. Allowing communities flexibility to use funds to address unique needs not limited to drug-related services.
- d. Ensuring that funds are allocated specifically to drug-war affected neighborhoods and zip codes and not spent on other local projects.¹³

4. Enhance data collection and service provision for Native American/Alaskan Native populations.

Centuries of racist U.S. policies have caused long-term socioeconomic and health disparities for American Indians and Alaskan Natives (AI/AN). This population has the highest rate of drug overdose deaths among any demographic group, 30.5 per 100,000 people in 2019.¹⁴ From 2011 to 2018, AI/AN deaths involving methamphetamine more than quadrupled from 4.5 to 20.9 per 100,000 people.¹⁵ These figures are undercounts, as AI/AN are more likely to be categorized as a different race or as “other.”¹⁶

Like overdose data, information on AI/AN arrest and incarceration patterns is also lacking due to incomplete, inconsistent, and inaccurate reporting. The data that do exist indicate that AI/AN are incarcerated at two times the rate of white Americans nationwide, and at up to seven times the rate in states with larger Indigenous populations.¹⁷

Lack of access to treatment and other services is also more severe for AI/AN. The Indian Health Service (IHS) is tasked with providing care to over 2.2 million AI/AN, but it is critically underfunded.¹⁸ ONDCP’s FY 2022 budget requests \$142 million in funding for the IHS, mostly directed toward its treatment services. This would be a 5% increase from last fiscal year but is not enough to make up for current shortages in care.

Incomplete data on overdoses and addiction, treatment access, and arrest and incarceration rates for AI/AN makes it difficult to develop effective response strategies. In addition to addressing this knowledge gap, ONDCP and its partner agencies must work immediately to expand access to the following services for AI/AN populations:

- a. MAT, SSPs, naloxone, and fentanyl testing strips to reduce opioid-involved overdoses.
- b. Contingency management therapy (CMT) to address stimulant use and high rates of methamphetamine overdoses. ONDCP must work with IHS and the Centers for Medicare and Medicaid Services to remove barriers to CMT, which include strict limits on financial incentives that can be given to CMT patients.¹⁹
- c. Naltrexone/extended-release naltrexone for alcohol use disorder, which contributes to overdose deaths and other poor health outcomes.
- d. All of the above services should be made available through mobile service providers and telehealth (when applicable) to reach individuals in remote areas.

5. Pressure states to reform drug sentencing laws and expand harm reduction services.

As some states advance efforts to promote harm reduction and reduce racial disparities caused by drug policy, others retreat. ONDCP should use its bully pulpit to push states toward reform. Acknowledging the harms caused the War on Drugs, as outlined in Recommendation One above, would aid this endeavor by shifting the national conversation on and public opinion about acceptable interventions for drug use.

ONDCP can also work with other federal agencies to make state grant funding contingent on implementing specific reforms, like reducing penalties for low-level drug possession and permitting low-barrier SSPs. States also must be encouraged to use their own dollars to increase funding for treatment and harm reduction so that these services are not entirely dependent on short-term grants.

6. Fund “housing first” initiatives.

The Biden Administration’s drug policy priorities include support for recovery housing. This is an important option, but the sobriety requirements that generally accompany recovery housing can present challenges for high-risk individuals who are not ready or able to abstain from alcohol and other drug use. Housing options not contingent on abstinence provide individuals with a stable environment, a precondition to addressing issues like addiction.²⁰ Housing first can be paired with access to recovery and support services that this clientele likely would not have contact with otherwise.

Given the comorbidity of homelessness and substance use disorders and the disproportionate rates of homelessness among Black, Hispanic/Latinx, and Indigenous populations, funding housing first initiatives is an important step to addressing systemic barriers to drug treatment and harm reduction.²¹

7. Fund research to study decriminalization of drugs other than cannabis.

In the 2020 election, Oregon became the first state in the nation to decriminalize the possession and personal use of all drugs, offering an option of paying a \$100 modest fine or completing a health assessment.²² While new in the United States, several countries, including Portugal, the Netherlands, and Switzerland, have decriminalized possession of small amounts of “hard” drugs for some time. The key pioneer of this trend is Portugal, which began its new national strategy in 2001, but more than two dozen other countries have moved in this direction.²³ We urge ONDCP to examine and assess various options for decriminalizing the use of a wide range of currently illegal drugs.

8. ONDCP should work with Congress to:

- a. Repeal current law prohibiting the director of ONDCP from supporting the study of legalization of Schedule I drugs.
- b. Pass the EQUAL Act and the MORE Act.

- c. Amend or repeal provisions of the Child Abuse Prevention Treatment Act and the Adoption and Safe Families Act that require and incentivize states to remove children from their homes and terminate parental rights due to substance use.²⁴
- d. Bar discrimination and denial of benefits in areas including but not limited to employment, healthcare, housing, and education based on prior convictions for low-level drug possession and incentivize states to do the same.
- e. Amend the Drug-Free Workplace Act so that it applies only to people whose work involves hazards to physical safety.
- f. Repeal the Solomon-Lautenberg amendment that urges states to suspend driver's licenses of individuals convicted of drug-related offenses.

9. As markers of progress on reducing racial inequities in U.S. drug policy, consider the following metrics:

- a. Improved data collection on overdose, arrest, and incarceration rates that includes more accurate accounting of Hispanic/Latinx and NA/AN populations.
- b. Reduction in state arrests and convictions for drug possession.
- c. Reduction in racial/ethnic disparities for all drug arrests and convictions.
- d. Increased participation of individuals or organizations that represent, serve, or advocate for PWUD in setting federal policy recommendations.
- e. Increase in number of states that reduce penalties for low-level drug possession, authorize low-barrier SSPs, and provide funding for harm reduction.
- f. Increases in state and local capacities to offer low-barrier housing, MAT, SSPs, naloxone, and fentanyl testing strips.
- g. Decreases in racial disparities in access to services outlined above (e).
- h. Reductions in race/ethnic-specific fatal and nonfatal overdoses rates.

If followed, these recommendations would be a significant but sensible pivot away from the failed policies of prohibition toward a realistic and racially equitable approach to drug use. By taking the lead on research and communication with the public about policy alternatives, the White House could provide political cover to legislators and encourage bipartisan solutions at all levels of government.

¹ Supply-side interventions increase risks of drug use by creating incentives for people selling drugs to dilute purity of illicit drug supply with alternatives that are easier to transport and more profitable, but which also may be more dangerous to users. The transition in the illicit opioid market from prescription opioids to heroin to fentanyl is one example. Prohibition also increases risks of drug use by making harm reduction interventions, such as clean needles, inaccessible to PWUD.

² Office of National Drug Control Policy, 2021, *National Drug Control Budget, FY 2022 Funding Highlights*.

³ In FY 2019 only two cases regarding fentanyl analogues involved substances not already listed in the Controlled Substances Act, and in neither case did the courts appear to rely on DEA's 2018 emergency scheduling order to issue rulings. Kristin M. Tennyson et al., 2021, *Fentanyl and Fentanyl Analogues*, U.S. Sentencing Commission, <https://bit.ly/3rrZZ9A>

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- ⁴ Jon E. Zibbell, et al., 2019, Association of law enforcement seizures of heroin, fentanyl, and carfentanil with opioid overdose deaths in Ohio, 2014-2017, *JAMA Network*, <https://bit.ly/3s064ez>.
- ⁵ Blythe Rhodes, et al., 2019, Urban, individuals of color are impacted by fentanyl-contaminated heroin, *International Journal of Drug Policy*, 73, <https://bit.ly/3Alduf8>; Jennifer J. Carroll, et al., 2020, The protective effect of trusted dealers against opioid overdose in the U.S., *International Journal of Drug Policy*, <https://bit.ly/3rWaEum>.
- ⁶ Katharine Neill Harris, 2018, The drug overdose epidemic: not just about opioids, Issue Brief, Rice University's Baker Institute for Public Policy, <https://bit.ly/3jyeHck>.
- ⁷ Black individuals accounted for 40.5% of people charged with fentanyl offenses and 58.9% of fentanyl analogue offenses, compared to 26.5% of offenses involving other drugs, U.S. Sentencing Commission, note 3.
- ⁸ U.S. Sentencing Commission, 2018, *Federal drug mandatory minimum penalties*, Report-at-a-glance, <https://bit.ly/3Aj42cw>.
- ⁹ National Institute on Drug Abuse, 2021, Methamphetamine overdose deaths rise sharply nationwide, <https://bit.ly/3lxmXPw>.
- ¹⁰ Helen F. Sanchez et al., 2020, Racial and gender inequities in the implementation of a cannabis criminal justice diversion program in a large and diverse metropolitan county of the USA, *Drug and Alcohol Dependence*, 216.
- ¹¹ David R. Lilley et al., 2019, Drug courts and arrest for substance possession: Was the African-American community differentially impacted? *Crime and Delinquency*, 65(3), 352-374.
- ¹² Katharine Neill Harris and Jay Jenkins, 2019, *Diverted opportunities: Gaps in drug treatment for justice-system involved populations in Harris County, Texas*, Rice University's Baker Institute for Public Policy, <https://bit.ly/2X47auo>; John R. Gallagher and Anne Nordberg, 2018, African American Participants' suggestions for eliminating racial disparities in graduation rates: Implications for drug court practice, *Journal for Advancing Justice*, 89-105, <https://bit.ly/377mqS8>.
- ¹³ For a more detailed account of one way to provide community-based funding, as well as other noteworthy recommendations for the Biden Administration's drug policies, see John Hudak, 2021, Reversing the War on Drugs: A five-point plan, The Brookings Institution, <https://brook.gs/3lm7qij>.
- ¹⁴ CDC, 2021, *Drug Poisoning Mortality, by State and by Race and Ethnicity: United States, 2019*, <https://bit.ly/3jpPKQf>.
- ¹⁵ See note 9.
- ¹⁶ Associated Press, 2018, Native American overdose deaths surge since the opioid epidemic, <https://bit.ly/3AsMhaP>.
- ¹⁷ Roxanne Daniel, 2020, What data exist about Native American people in the criminal justice system? Prison Policy Initiative, April 22, <https://bit.ly/3lw3cVz>.
- ¹⁸ "For example, to match the level of care provided to federal prisoners, funding would have to nearly double, according to an analysis by the National Congress of American Indians. Funding would need to be even higher to match the benefits guaranteed by programs such as Medicaid." Mary Smith, 2016, Native Americans: A crisis in health equity, *American Bar Association Magazine*, <https://bit.ly/3rZT9cG>.
- ¹⁹ Joseph E. Glass et al., 2020, Contingency management: A highly effective treatment for substance use disorders and the legal barriers that stand in its way, *Health Affairs*, <https://bit.ly/3Clq93x>.
- ²⁰ Sharon McDonald, 2019, Why housing first? National Alliance to End Homelessness, <https://bit.ly/3l6PfgA>.
- ²¹ Black people make up 12% of the U.S. population but 39% of people experiencing homelessness. Hispanic/Latinx people are 16% of the U.S. population, 23% of homeless population. Indigenous populations are 1% of U.S. population, 5% of the homeless population. Department of Housing and Urban Development, 2021, *The 2020 Annual Homeless Assessment Report to Congress*, <https://bit.ly/3ydmK4y>.
- ²² Oregon Measure 110, Estimate of Financial Impact, <https://bit.ly/2WcUSvP>.
- ²³ Portugal drug policy, see bit.ly/3ncK50z; other countries decriminalize many drugs, see bit.ly/379CpqD.
- ²⁴ For a comprehensive review of the relationship between the drug war and the foster care system, see Lisa Sangoi, 2020, *How the foster system has become ground zero for the U.S. drug war*, Movement for Family Power, <https://www.movementforfamilypower.org/ground-zero>.

Slater, Sandy R. EOP/ONDCP

From: Mondragón, Mercedes <(b)(6)>
Sent: Friday, August 6, 2021 2:25 PM
To: MBX ONDCP OGC
Cc: Joel K. Johnson
Subject: [EXTERNAL] ONDCP Public Comment Opportunity
Attachments: ONDCP Comment Letter -TASC Input.pdf

Good afternoon,

Thank you for the opportunity to provide input on suggestions to further embed equity into ONDCP's policies and practices. Attached you will find input from TASC President and CEO, Joel K Johnson. Please do not hesitate to contact us if you have any questions.

Best,
Mercedes Mondragón

--

Mercedes Mondragón | Director of Policy
TASC (Treatment Alternatives for Safe Communities)
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www.tasc.org

This message and any attachments are solely for the intended recipient and may contain confidential or privileged information that is exempt from disclosure under applicable law, including but not limited to the Confidentiality of Substance Use Disorder Patient Records regulations, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, as amended (HIPAA). If you are not the intended recipient, any use, disclosure, storage, copying, or distribution of the information included in this message and any attachments is STRICTLY PROHIBITED. If you have received this message in error, please notify the sender by reply e-mail and immediately and permanently delete this message, any attachments, and any copies from your device and system. If you are the intended recipient please note that 42 CFR Part 2 prohibits you from re-disclosing this information without patient consent or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of this information is NOT sufficient for this purpose.

Slater, Sandy R. EOP/ONDCP

From: Natalie Papillion <(b)(6)>
Sent: Friday, August 6, 2021 3:55 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Comment Re: Application of Equity in U.S. National Drug Control Policy
Attachments: Comment_ApplicationOfEquityInUSDrugControlPolicy_LastPrisonerProject.pdf

Please see the attached PDF for our response to the request for public comment for "Application of Equity in U.S. National Drug Control Policy".

Thanks so much!

Natalie Papillion | She/Her/Hers

c :: (b)(6)

e :: (b)(6)

Announcing [Criminal Injustice: Cannabis and the Rise of the Carceral State](#), our four-part study detailing the impact of cannabis prohibition on American policing practices and the country's criminal justice system.



August 6, 2021

Re: Application of Equity in U.S. National Drug Control Policy

To Whom It May Concern,

Thank you for the opportunity to comment on the application of equity in U.S. National Drug Control Policy. My name is Natalie Papillion, and I'm writing on behalf of the Last Prisoner Project, a nonpartisan, not-for-profit organization focused on advancing just and equitable criminal justice and drug policy reforms.

I am writing to provide ONDCP with our input as to how the agency's future proposed policies, budgets, regulations, grants, or programs might be more effective in advancing equity. Please see below for some of our observations and recommendations.

- Accessibility.
 - There exists no publicly available repository of the ONDCP's policy positions. This should be remedied.
- Accountability.
 - We recommend a review of all federally funded supply and demand reduction activities, which would ideally measure the effectiveness of those activities, identify the contribution of those activities to demand reduction activities funded by state, local, and tribal governments, and assess whether there exists duplication or inefficiencies in federally funded supply or demand reduction activities.
 - Furthermore, we recommend ensuring that efforts originally intended for greater transparency (i.e the Drug Control Data Dashboard) are updated in a timely manner.
- Transparency
 - The current ONDCP website is bare-bones (especially when compared to its predecessors) only containing a high-level overview of ONDCP priorities, a link to ONDCP press releases, a link to ONDCP grant programs, and a link to an overview of The Drug-Free Communities Support Program. In the interest of transparency, this website should include much more information (i.e the National Drug Control Strategy, ONDCP budgetary information, links to partner organizations and agencies, etc.)
 - Currently, policy research funding for ONDCP has not been appropriated since FY 2011. Instead, the ONDCP draws primarily from research conducted by third parties, individuals, and institutions who are not governed by the same guidelines regarding transparency and public accountability as the ONDCP.



August 6, 2021

- Consistency
 - The ONDCP's policy development process is in need of heightened transparency, particularly regarding issues in which the stated policy position of the ONDCP diverges from the shared consensus of the medical and/or scientific community. For example, the ONDCP website maintains that the agency uses the latest evidence and research to set the National Drug Control Strategy. However, some of the stated policy positions of the ONDCP—for example, marijuana's categorization as a Schedule I drug (meaning a substance with no recognized medical application and a high potential for abuse) are not supported by the broader scientific and medical community.
- Inclusivity
 - In order to gain broader perspectives during the policymaking process, we recommend the ONDCP broaden its formal consultations to include individuals (as well as organizations that represent the interests of said individuals) who have been incarcerated on drug-related charges. Furthermore, we recommend that the ONDCP engage with individuals and institutions engaged in harm reduction work.
 - We also recommend that the ONDCP work with the Department of Justice and other relevant law enforcement agencies to conduct research that analyzes racial and socioeconomic disparities in drug-related arrests and incarceration.
- Goal-Setting
 - As opposed to strictly benchmarking drug policy success on illicit drug consumption rates, we recommend the ONDCP consider grading themselves, as well as their grantees, according to goals that focus more on traditional public health metrics (i.e the number of overdose deaths attributable to drug consumption).

We welcome the opportunity to discuss our observations and suggestions further.

Sincerely,
Natalie Papillion

Natalie Papillion
Director of Strategic Initiatives, Last Prisoner Project
(b)(6)



August 6, 2021

Office of the National Drug Control Policy
Executive Office of the President
1600 Pennsylvania Avenue
Washington DC, 20006

Re: Doc 86 FR 35828 Application of Equity in U.S. National Drug Control Policy

The Coalition for Cannabis Policy, Education, and Regulation (CPEAR) and its Center of Excellence appreciates the opportunity to provide comments on the Application of Equity in the U.S. National Drug Control Policy posted in the Federal Register on July 7, 2021. The Center of Excellence for CPEAR is a group of subject matter experts from academics, think tanks, public safety officials, medical and mental health professionals, and social equity organizations. The Center of Excellence works to develop policy while guiding the national conversation on the federal regulation of cannabis.

Formal consultations for the National Drug Control Strategy often involve direct relationships between ONDCP and the consulting group, organization, or subject matter expert. What are recommendations for broadening its formal consultations to gain broader perspectives earlier in the policy development process?

Create a task force dedicated to researching the impacts of state-led drug policies and its effect on local communities

ONDCP should engage with a task force to discuss the impacts of evolving state-led drug policies and its effect on local communities. A potential task force would be comprised of drug policy reform advocates, small business advocacy organizations, sovereign nations, community-based organizations, and state and local policymakers and regulators, and other stakeholder groups located in states where cannabis use is permitted. ONDCP should also take the opportunity to understand what actions the federal agency can take to understand how these policies have affected equity outcomes in the local communities that have been subject to these policy changes. This task force should establish national guidelines for equitable drug policy reform based on existing data and begin disparity studies where data doesn't exist yet.

As part of this consultation process, CPEAR would welcome the opportunity to introduce ONDCP to its Center of Excellence, an in-house think tank focused on getting federal regulation of cannabis right. The Coalition's Center of Excellence is comprised of leaders throughout the United States who are experts on a broad array of issues that will be affected by federal cannabis legalization, including:

- Data and research
- Regulatory and enforcement structures
- Legacy and state systems
- Financing and minority capital access
- Tax policy
- Public safety
- Product format and potency
- Criminal justice reform
- Social equity
- Patient access
- Medical benefits and mental health
- Substance use disorder
- Driving under the influence
- Youth use prevention
- Marketing and advertising
- Environmental sustainability
- Workplace safety



The Center of Excellence works to analyze the effect federal cannabis legalization would have on these policy areas and how they should be integrated into a national legal framework. We believe our Center of Excellence members, who volunteer their time, would prove to be an excellent resource for ONDCP.

How might research examine equity in the context of law enforcement actions against drug trafficking or transnational criminal organizations? Are there existing applicable research frameworks that might be applied to ONDCP's Grant Administration Programs or other multi-jurisdictional task forces?

Reform High-Intensity Drug Areas (HIDTA) Program Cannabis Impact Reporting

We urge ONDCP to evaluate its current data reports as being produced by the HIDTA Program. These reports have fallen out of step with the state-led policy changes that have taken place in states across the country. As a result, the cannabis-related data and the conclusions drawn by its authors in recent iterations of the report have illustrated an inaccurate understanding of cannabis use and its societal impact.

The Rocky Mountain High-Intensity Drug Trafficking Area Report published in 2015 and repeatedly updated, covering the impact of legalization of marijuana in Colorado, is a recent example of the problematic nature of these reports.¹ For example, the report misrepresented findings of a traffic safety study conducted by the U.S. National Highway Transportation Safety Administration (NHTSA), which assessed the risk of vehicle accidents associated with the use of cannabis and other substances. These inaccuracies were pointed out by the former Colorado Governor John Hickenlooper in a letter to former Attorney General Jeff Sessions.²

Others have engaged in statistical breakdowns of these reports, here we wish to highlight a few ways that methods used, or not used, in these reports hurt public dialog and prevent a deeper understanding of the impact of new drug laws:

First, these reports do not spend the requisite effort to add context to the data it presents. Data around cannabis-related issues are incredibly complex. The legislation enacting legalization often provides more training and resources for law enforcement to address cannabis-related issues. That additional training and resources may well account for the increases seen in the data. These sorts of biases exist throughout the data sets and warrant extremely careful handling of the data. Without this context, those who read and believe the report are liable to jump to false and counterproductive conclusions.

Second, the reports work hard to frame legalization in the worst light, and often in ways that do not align with the lived experience from these states. The driving data from the Colorado reports, presented as percentage increases in traffic deaths, makes Colorado's roadways look incredibly unsafe. However, the same data set, the Fatal Accident Reporting System, shows that Colorado's

¹ Rocky Mountain High Intensity Drug Trafficking Area Report Volume 3 (2015); <https://bit.ly/3Cg0yt6>

² Hickenlooper, John, to AG Jeff Sessions. (2017): <https://bit.ly/3xqvC5s>



death rate, both by population and by vehicle miles traveled, is below the national average.³ We believe that driving while intoxicated remains a prevalent problem that should be addressed, but by putting this data in such a biased context, the effort comes across as fearmongering rather than a legitimate raising of issues and challenges. This biased framing risks undermining actual potential challenges as they arise.

Third, the reports make minimal effort to highlight positive developments from cannabis reform. Youth use surveys from multiple states have shown flat or even decreased use since legalization. The reports only give a cursory acknowledgment of this fact. Additionally, the reports spend no time focusing on reduced incarceration rates, or other potential positives from cannabis legalization.

Fourth, the reports make little effort to delineate between causation and correlation. For instance, many of the reports show that cannabis usage amongst adults is some of the nation's highest. But of course, cannabis legalization is most popular in states that enjoy cannabis usage. These states were already amongst the highest users of cannabis before legalization.

Due to federal prohibition of cannabis, there are sadly very few sources of data or research on the impact of cannabis and cannabis legalization. What few sources of data that assess the impact of legalization are thus more important now than ever. Our subject matter experts are concerned that these agenda-driven data reports will erode public confidence that the federal government can accurately monitor the effects of cannabis legalization on communities. As a guidepost, ONDCP should guide these multi-jurisdiction taskforces to draw lessons from State of Colorado's biannual report on the impact of cannabis legalization.⁴ The report provides a more expansive view on data and objectively outlines the shortcomings of the available data streams. Moreover, ONDCP should be pushing for counter-reports on the impacts of prohibition on both individuals and communities. Finally, ONDCP should be gathering data on the potential benefits in the area of harm reduction for opioid abuse and other substance abuse.

Cannabis legalization continues to be a complex issue given its roots in the War on Drugs, and the disproportionate effect that campaign had on minority communities. HIDTA research needs to be reformed to highlight the complexities of the state-led evolution of cannabis legalization. Specifically, reports should analyze the effect cannabis legalization has had on public health and safety through an equity lens, wherein such data is broken down into race, gender, and location.

ONDCP Should Engage in Realtime Data Monitoring

Our subject matter experts suggests that ONDCP capitalize on the opportunity to play a larger role in the ongoing evolution of cannabis policy taking place in Congress and across the country. As a guarantor of public safety, ONDCP has the responsibility to guide the national conversation by utilizing its grants for research aimed at improving the understanding the societal impacts of cannabis policy

³ <https://www.iihs.org/topics/fatality-statistics/detail/state-by-state>

⁴ Impacts of Marijuana Legalization on Colorado (2021): https://cdpsdocs.state.co.us/ors/docs/reports/2021-SB13-283_Rpt.pdf



on minority communities. More importantly, ONDCP can be influential in crafting policies to improve public safety and health around cannabis use, including multiple substance use, and youth abuse prevention.

To that end, ONDCP should be monitoring track and trace data across legal states to understand the inventory of the entire market, the pattern of cannabis transactions and the rate of manufacturing and cultivation taking place. This data can provide insight into any potential diversion to the illicit market taking place across the country and aid with objective enforcement efforts carried out by federal and state authorities.

In states where cannabis use is permitted ONDCP should monitor state-led resentencing and automatic expungement programs. Additionally, mandatory reporting of discrimination based on cannabis in the provision of a) a federal public benefit b) recommendations and opinions regarding veteran participation in a state cannabis program by health care providers of the Department of Veterans Affairs or health care providers of Indian health programs and c) for purposes of the immigration laws.

ONDCP should monitor each state's data relating to cannabis-impaired driving, including a) the number of cannabis-impaired drivers; b) the rate of cannabis-related motor vehicle accidents; and c) the rate and severity of injuries because of cannabis-related motor vehicle accidents as well as ongoing and new research related to the development of an impairment standard for driving under the influence.

Conclusion

We appreciate the opportunity to provide you with our input on improving stakeholder engagement and data monitoring. We strive to be stewards of data, science, and best practices, and hope to be able to work with you in the future.

Sincerely,

The Center of Excellence at the Coalition for Cannabis Policy, Education, and Regulation

Slater, Sandy R. EOP/ONDCP

From: Ogadinma Obie <(b)(6)>
Sent: Friday, August 6, 2021 11:33 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Comments on Application of Equity in U.S. National Drug Control Policy (Docket No. ONDCP-2021-0001)
Attachments: ACHEM_Statement on the Application ONDCP.pdf

The Executive Office of The President
Office of National Drug Control Policy
Docket No: ONDCP FRDOC 0001-0008
Document Citation 86 FR 35828
Document No. 2021-14365
OGC@ondcp.eop.gov

To Whom It May Concern:

This letter contains comments provided by the Association for Cannabis Health Equity & Medicine (ACHEM) concerning the Application of Equity in U.S. National Drug Control Policy submitted on July 7, 2021.

ACHEM is a professional medical association within the broader Cannabis Health Equity Movement™ (CHEM) serving the needs of BIPOC health and medical professionals in the advancement of health equity in cannabis, founded by United States board-certified medical doctors who hold licenses in California, Louisiana, Massachusetts, New Jersey, New York, Oregon, and Texas. Our mission is carried out by an 18-member Board of Directors comprising a diverse and esteemed group of BIPOC healthcare leaders and health equity experts in the cannabis industry. This Association has thoroughly reviewed the application and has provided the following comments. Please see attached.

Thank you for the opportunity to participate.

Kind Regards,

Ogadinma Obie, MD
President & Founding Board Member, ACHEM



The Executive Office of The President
Office of National Drug Control Policy
Docket No: ONDCP FRDOC 0001-0008
Document Citation 86 FR 35828
Document No. 2021-14365
OGC@ondcp.eop.gov

To Whom It May Concern:

This letter contains comments provided by the Association for Cannabis Health Equity & Medicine (ACHEM) concerning the Application of Equity in U.S. National Drug Control Policy submitted on July 7, 2021.

ACHEM is a professional medical association within the broader Cannabis Health Equity Movement™ (CHEM) serving the needs of BIPOC health and medical professionals in the advancement of health equity in cannabis, founded by United States board-certified medical doctors who hold licenses in California, Louisiana, Massachusetts, New Jersey, New York, Oregon, and Texas. Our mission is carried out by an 18-member Board of Directors comprising a diverse and esteemed group of BIPOC healthcare leaders and health equity experts in the cannabis industry. This Association has thoroughly reviewed the application and has provided the following comments.

DEFINING EQUITY AND ASSESSING EQUITY IN FEDERAL POLICY

Adequately assessing equity in federal policy must begin with an accurate and holistic definition and understanding of equity. Executive Order 13985 defines “equity” as the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer

(LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. It further defines “underserved communities” as populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by the list in the preceding definition of “equity.”

E.O. 13985’s definition of equity falls short of describing what we at ACHEM regard as the gold standard of equity known as “health equity,” which is sometimes referred to as “total equity” or “universal equity.” Health equity moves beyond fair and impartial treatment and takes into consideration all that *creates* access to *prosperity and wellbeing*. This means that equity encompasses both facilitation and destination, and thereby equity cannot be assessed if Key Performance Indicators of equity (i.e., what creates or facilitates equity) have never been defined, and equity cannot be achieved without a clear endpoint described.

ACHEM would be pleased to provide necessary perspective on universal equity, including a review of [CHEM’s Pillars of Health Equity™](#) to help progress the definition and description of equity in federal policy, especially in terms of identifying KPIs as they pertain to monitoring, measuring, reporting, and reaching health equity within underserved, racially stigmatized, BIPOC communities.

EXISTING CONSTRAINTS IN FEDERAL POLICY

In solidarity with other organizations¹ submitting responses, ACHEM supports the immediate removal of all medicinal² plants³ (e.g., cannabis⁴) and entheogenic⁵ substances from the schedule of controlled substances under the Controlled Substances Act (CSA) of 1970.

¹ Cannabis Education Advocacy Symposium & Exposition (CEASE), Minority Cannabis Business Association (MCBA)

² Medicinal means having therapeutic potential.

³ According to the [DEA](#), “Marijuana is a mind-altering drug produced by the *Cannabis sativa* plant.” This is culturally and scientifically inaccurate in that “marijuana” is both a cultural and regulatory term for THC-dominant *Cannabis sativa* plants comprising hundreds of chemical substances (i.e., hundreds of drugs). As such, marijuana is neither a drug nor a substance, but a plant.

⁴ Referred to as “marijuana” throughout existing federal policy.

⁵ Entheogenic means relating to the properties of entheogens. Entheogens means a botanical specimen or chemical substance that is ingested to produce a non ordinary state of consciousness, enlightenment, and insight for religious or spiritual purposes.

Anthropological study has revealed the historical and contemporary cultural relevance of medicinal plants and entheogenic substances to numerous ethnic groups overrepresented in underserved communities for their reported therapeutic and spiritual value, as well as their purportedly broad safety profiles as supported by centuries of common use. Yet, and without scientific evidence or public health data to substantiate such action, the CSA listed cannabis and natural substances like DMT, mescaline, psilocybin, and psilocin (and synthetic substances such as LSD and MDMA with similar hallucinogenic characteristics) as Schedule I drugs at inception, where they remain to this day. The Schedule I designation denotes no accepted medical use and high potential for abuse, belying mounting preclinical and clinical evidence of the profound therapeutic potential of these plants and substances.

So robust is this body of science, in fact, that research on cannabis led to a 2003 patent award to the U.S. Government for cannabinoids as antioxidants and neuroprotectants useful in the treatment and prophylaxis of a wide variety of diseases, including aging, inflammatory and autoimmune disease, brain injury, stroke, and neurodegenerative disease such as Alzheimer's, Parkinsons, and HIV dementia.⁶ Likewise, DMT and mescaline are currently undergoing Phase I clinical trials, while psilocybin has entered into phase II trials for Major Depressive Disorder, Generalized Anxiety Disorder, and PTSD. Notably, the FDA labeled psilocybin “breakthrough therapy”⁷ for severe depression in 2018⁸. LSD is in phase 2 trials for cluster headaches, depression, and anxiety, and MDMA is in phase III clinical trials for PTSD.

What these dueling narratives represent is an unfortunate if not blatant systematic preservation of power that relegated the prohibition of cannabis and entheogenic substances to a weapon against the communities that used them most. Federal policy itself has been and continues to be wielded as a tool to divest underserved communities of equitable access to their wellbeing, making existing federal policy the greatest systemic barrier to opportunities for BIPOC communities and individuals who come from them.

⁶ USPTO Patent Database: [US6630507 - Cannabinoids as Antioxidants and Neuroprotectants](#)

⁷ U.S. Food & Drug: [Breakthrough Therapy](#)

⁸ [Psilocybin for major depression granted Breakthrough Therapy by FDA](#)

RESPONSES TO REQUEST FOR INFORMATION

Jurisdictions at the State, local, Tribal, and territorial levels have implemented equity assessment tools to inform their policymaking or budgetary processes. What are the lessons these jurisdictions have learned from implementing or interacting with those tools?

While we recognize that many states legalizing cannabis and psilocybin have taken great strides in assessing the long term impacts of federal prohibition in underserved communities, there exists a fundamental disparity that renders all assessment methods insufficient. In lieu of citing approaches and tools that have been more or less effective, we surmise that the largest lesson learned in a multi-level jurisdiction scenario involves a common pitfall of “multiple languages, one goal.” Just as medicine utilizes Latin as its universal language so that, regardless of location in the world, professionals could share ideas and still achieve common standards, we support the notion that equity is a universal concept and as such should carry a universal definition, one which can be used by any jurisdiction. This is what ACHEM refers to as “health equity,” which can be aptly termed *universal equity*. We recommend that the ONDCP calls for the development of a *universal equity assessment tool* to create parity across jurisdictions in the evaluation of policymaking and budgeting that may perpetuate systemic racism in drug policy and enforcement.

We also conclude that there is an acute need for the proactive creation of equity-enforcing agencies and permanent departments to facilitate more organic interagency and internal checks and balances, reducing the burden of creating often perfunctory and ineffective DEI (Diversity, Equity, and Inclusion) programs.

Formal consultations for the National Drug Control Strategy often involve direct relationships between ONDCP and the consulting group, organization, or subject matter expert. What are recommendations on how the agency can broaden its formal consultations to gain broader perspectives earlier in the policy development process?

We believe that policy development processes should include the broadest representation of stakeholders who might be directly and indirectly impacted. With respect to drug policy, such experts should include individuals with a history of drug use and/or who have been convicted of nonviolent drug crimes, business owners of cannabis or other drug-related enterprises, community and advocacy groups, patient and veterans rights advocates, trade associations, health and medical professionals, and economic and public health experts. ACHEM welcomes the opportunity to provide ongoing consultation and recommendations as one such resource to ONDCP around policy development.

We further recommend that ONDCP engage the public on a routine basis through hosting local forums and roundtables to glean insights and input from a larger cohort of community stakeholders.

Additionally, policy development processes should be ongoing and ever evolving. As such, we suggest that rather than merely broadening formal consultations early in policy development processes, subject matter experts should be appointed to key positions within these agencies. Thought leaders should be present throughout the development, implementation, review, and revision of every policy to ensure policies are equitable from inception and produce the outcomes intended. We further suggest the purposeful diversification of the ONDCP by employing people from underserved communities as an important KPI that can be regularly audited to ensure that this KPI be maintained.

Provide recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of National drug control policy.

First and foremost ACHEM acknowledges that individuals who use drugs are, by medical definition, a patient. Drug use is, therefore, the attempted use of a medication or medicinal substance for the purpose of relieving a mental, physical, or even spiritual condition or concern. This is true even in instances when drugs are used for purported recreational purposes. These empathic truths are undermined by the stigmatization of drug use relegating it socially unacceptable and prosecutable by law—two concepts that endanger transparency of use. Without

transparency of use, capturing accurate and consistent data around use trends and outcomes is not possible. This results inevitably in disparate data representation that can lead to misinformed insights and applications that create and propagate inequity across racially stigmatized populations.

Ongoing federal prohibition will preclude meaningful participation of people who consume cannabis and other Schedule I drugs, barring adequate and necessary involvement by this demographic in the development of federal drug control policy. As such, we recommend that ONDCP end prohibition. Those who use drugs must be protected before they are encouraged to share such vulnerable space with ONDCP, and we further recommend that ONDCP establish policies and programs that restore trust, such as the development and implementation of “safe to talk” standards, education campaigns aimed to eliminate stigma, or offering grants to 3rd party agencies to develop prevention, support, and treatment centers and respective care protocols.⁹

How might research examine equity in the context of law enforcement actions against drug trafficking or transnational criminal organizations? Are there existing applicable research frameworks that might be applied to ONDCP's Grant Administration Programs or other multi-jurisdictional task forces?

We suggest the following research:

Historical Research: Inequitable government practices have resulted in multi-faceted disparities in universal equity (i.e. racial, gender, economic, environmental, social, etc), and must be studied through historical research. We encourage understanding past inequities and their driving forces beginning with the impetus for and creation of the Federal Bureau of Narcotics¹⁰ and the Marihuana Tax Act of 1937¹¹ (or earlier with the 1850 Pharmacopeia of the United States of America where cannabis was first described for its medical utility) in order to properly contextualize the behaviors and trends within law enforcement actions for examination.

⁹ Example model: [Medicare Diabetes Prevention Program](#)

¹⁰ [DEA: The Early Years](#)

¹¹ [Marihuana Tax Act of 1937](#)

Statistical Research: Statistical data exists that quantifies both harm and benefit of prohibition, including the economic devastation and collateral consequences to specific communities, and the economic benefit to individuals and institutions enforcing and/or otherwise supporting prohibition.

Investigative Research: Based on an incredible amount of preclinical and clinical research elucidating the medicinal nature of many Schedule I drugs—not the least of which being cannabis and the chemical substances therein (e.g., cannabinoids)—not only has the federal government filed patents, but in 2018 the FDA approved Epidiolex[®] for rare and difficult to treat pediatric seizures which effectively gave prescribing clinicians the greenlight to prescribe a cannabis-derived drug off-label to any patient for any reason in accordance with their clinical judgement as guided by available science and research, and clinical experience. As such we understand and should agree that the Schedule 1 drugs we've referred to throughout this response do, in fact, have multiple medical benefits with manageable safety and addiction profiles. As a result, we strongly suggest the investigation of existing drug enforcement and research agencies including the DEA, FDA, NIDA, and even the NIH to analyze disparity in the use and misuse of data, research, and purported evidence-based literature by these agencies (as well as other institutions that form their operational policies based on them), and how that has 1) impacted the spread of disinformation and myths concerning these plants and substances, and 2) been leveraged for commercial, institutional, and otherwise political interests resulting in incongruent, maladaptive enforcement and regulatory priorities.^{12,13} Such an analysis and accounting will begin to illuminate many of the systemic mechanisms by which federal drug policy and its selective enforcement has been validated and maintained, and, conversely, the lengths to which efforts will be necessary to deconstruct them.

What would be your recommendations for short-term and long-term goals that ONDCP should take into account to measure progress towards equity in drug policy?

¹² USPTO Patent Database: [US6630507 - Cannabinoids as Antioxidants and Neuroprotectants](#)

¹³ [STANDING AKIMBO, LLC, ET AL., v. UNITED STATES](#)

On behalf of BIPOC healthcare leaders and health equity experts in cannabis, ACHEM recommends that ONDCP invest their economic, social, and human capital resources to assess, analyze, and report the root causes of the systemically disenfranchising nature of federal drug policy and its direct and collateral effects on individual and community wellbeing across the economic, environmental, human, and social determinants of health. We also suggest the following short and long term goals:

- Ending federal prohibition of cannabis and other entheogenic substances
- Removing cannabis and other entheogenic substances from the CSA (i.e., descheduling them)
- Releasing individuals convicted of nonviolent federal cannabis offenses and deploying mechanisms to monitor, measure, and report on process and health equity outcomes
- Eliminating barriers to reentry for individuals incarcerated for nonviolent federal cannabis offenses and deploying mechanisms to monitor, measure, and report on process and health equity outcomes
- Eliminating testing for THC in pre-employment or random workplace drug screening and deploying mechanisms to monitor, measure, and report on process and health equity outcomes
- Destigmatizing the selectively perjorative image of “drugs” and “drug users” by teaching, instead, about appropriate and responsible consumption through a federal education campaign as resourced and robust as D.A.R.E., and deploying mechanisms to monitor, measure, and report on process and health equity outcomes
- Drafting a truth and reconciliation report detailing the history of cannabis use, prohibition, scientific discovery, the War on Drugs, the role, ways, and degree federal drug policy and government agencies have promoted, benefited, and been burdened by prohibition, and the challenges barring equitable policy reform and regulation as states and the federal government wrestle with cannabis legalization
- Developing compulsory education based on the report above for ONDCP and other agencies, institutions, and the decision makers therein to undo and unlearn disinformation about cannabis and other Schedule I drug control in an effort to advance science-informed, health equity centered drug policy that focuses on harm reduction as

much as it does public benefit, and deploying mechanisms to monitor, measure, and report on process and health equity outcomes

- Reforming medical education, training, and continuing studies to include compulsory education on the endocannabinoid system, cannabis pharmacology, and the pharmacology of commonly used entheogens so that healthcare professionals are properly prepared to evaluate and manage patients who consume cannabis and other substances, and deploying mechanisms to monitor, measure, and report on process and health equity outcomes
- Assessing and reforming institutional policies in hospitals and healthcare systems, medical associations, and licensing boards that historically discriminate against “drug users” affecting individuals access to adequate quality care and medical services, and deploying mechanisms to monitor, measure, and report on process and health equity outcomes
- Studying and reporting on an ongoing basis the use and public health impacts of state-legal, market-grade cannabis products across diverse demographics looking at both potential benefit and harm, and deploying mechanisms to monitor, measure, and report on process and health equity outcomes
- Directing cannabis research contracts to HBCUs and other socially and economically disadvantaged community institutions to study the agricultural, industrial, medical, nutritional, and public health implications of cannabis, including clinical research to determine feasibility of cannabis use to address the leading causes of disease disproportionately impacting individuals within underserved communities
- Directing cannabis tax revenue as a direct investment into capacity building within underserved communities to increase the economic, environmental, human, and social capital circulating through these communities, and deploying mechanisms to monitor, measure, and report on process and health equity outcomes

CONCLUSION

The disproportionate application and enforcement of federal drug policy for close to a century has caused direct, unendurable, intergenerational harm to underserved communities, negatively

impacting every determinant of health in Black, Indigenous, and Latinx lives. These policies shaped disparaging social constructs now deeply embedded in nearly every institution that individuals from these communities engage with as they navigate society in pursuit of access, opportunity, and resource en route to wellbeing.

ACHEM is encouraged by the efforts of the ONDCP to reconcile the roles that federal processes, programs, agencies, and budgets continue to play in perpetuating systemic barriers to personal agency and community prosperity in underserved communities. We appreciate this opportunity to provide input regarding this undertaking, and are available to engage in ongoing dialogue.

Respectfully,



Dr. Ogadinma Obie, MD, President
Association for Cannabis Health Equity and Medicine
Email: (b)(6)



Dr. Rachel Knox, MD, MBA
Association for Cannabis Health Equity and Medicine
Email: (b)(6)

Slater, Sandy R. EOP/ONDCP

From: Orla Kennedy <(b)(6)>
Sent: Friday, August 6, 2021 2:49 PM
To: MBX ONDCP OGC
Cc: Alice Dembner
Subject: [EXTERNAL] Comments for ONDCP RFI FR Doc. 2021-14365: Application of Equity in U.S. National Drug Control Policy
Attachments: 2021 08 ONDCP Equity_RFI_FINAL.pdf

Dear Mr. Kent,

Community Catalyst appreciates this opportunity to respond to the Office of National Drug Control Policy's (ONDCP) *Request for Information: Application of Equity in U.S. National Drug Control Policy*. We support ONDCP's efforts to follow Executive Order 13985 through this RFI to "help ONDCP develop an approach to advance equity in drug policy."

Please refer to our full comments attached.

We thank you for considering these recommendations, and for your commitment to advancing equity in drug policy. Please contact Community Catalyst's Executive Director, Emily Stewart, by phone (b)(6) or email (b)(6) if you have any questions or would like to discuss further.

Sincerely,
Orla Kennedy



Orla Kennedy | Senior Policy Analyst
Substance Use Disorders Program
One Federal Street, Boston, MA 02110

O: (b)(6)

E: (b)(6)

Pronouns: she/her





To: Robert Kent, General Counsel, Office of National Drug Control Policy
From: Community Catalyst
Date: August 6, 2021
Re: Response to Request for Information: Application of Equity in U.S. National Drug Control Policy - FR Doc. 2021-14365

Dear Mr. Kent,

Community Catalyst appreciates this opportunity to respond to the Office of National Drug Control Policy's (ONDCP) *Request for Information: Application of Equity in U.S. National Drug Control Policy*. We support ONDCP's efforts to follow Executive Order 13985 through this RFI to "help ONDCP develop an approach to advance equity in drug policy."

[Community Catalyst](#) is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill. Our Program on Substance Use Disorders and Justice-Involved Populations works to advance racial justice by centering community needs, particularly of those most marginalized, and advocating for policy and practice changes to ensure addiction is treated as a health issue and not a criminal one.

We are pleased to see that advancing racial equity has already been named an ONDCP priority through [The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One](#), and the emphasis from President Biden "*to eradicate racial inequities in the criminal justice system*" and that "*people should not be incarcerated for drug use but should be offered treatment instead.*" Also important is that ONDCP has already acknowledged in the [Year One Priorities](#) that there are known racial inequities in substance use disorders treatment access and health outcomes, making this RFI particularly relevant.

Recommendations on how the agency can broaden its formal consultations to gain broader perspectives earlier in the policy development process, including from people who use drugs:

- We recommend ONDCP meaningfully engage people with lived experience of substance use disorders, current drug users and formerly incarcerated people, in every stage of

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice.

www.communitycatalyst.org

assessment of inequities and development of solutions. This is the most crucial step government can take to advance equity. Meaningful community engagement requires officials to genuinely [commit to listening, reflecting and working together with individuals and communities](#) directly affected by racism, discrimination, cultural incompetency and other inequities. This is especially important for drug policy, given the over criminalization of substance use in communities of color. Strategies for engagement with the populations we recommend include: working with community, state and national organizations focused on these individuals, such as peer recovery organizations, harm reduction organizations, drug user unions, and groups supporting formally incarcerated individuals reentering the community. Other strategies are working through trusted community leaders (especially unofficial leaders) and working through service providers. We would be happy to assist in these efforts.

- ONDCP should require health equity assessments when issuing regulations, guidance or other forms of policymaking. A health equity assessment could require the agency to assess the impact of the proposed policy on populations marginalized, discriminated against and/or excluded from justice. The equity assessments should be conducted at the outset of any agency decision or process, and should be made public to facilitate transparency and accountability. Equity assessments are crucial for drug policy, given the [disproportionately punitive](#) approaches to substance use in communities of color through the “War on Drugs.”
- Particularly in developing policy based on the performance or effectiveness of programs, we recommend that ONDCP use metrics that individuals/communities impacted by the program or policy have identified as important. Without this approach, research or policy proposals are unlikely to focus on what matters most to people, resulting in programs that aren’t always responsive to individuals’ needs and don’t achieve the best results. Community Catalyst recently conducted the first national examination of treatment and recovery services outcomes prioritized by people with substance use disorders, which provides input ONDCP can build on. Based on responses from nearly 900 people across the country, top desired outcomes include staying alive, improving quality of life, and reducing harmful substance use. Please see our [Peers Speak Out](#) report for more details and recommendations.

Recommendations for short-term and long-term goals:

- To enhance equity, we recommend ONDCP **prioritize major expansion of investments in community services** for prevention, harm reduction, treatment, and recovery, as well as initiatives to address social and economic factors underlying drug use and substance use disorders. Investment should target communities facing the greatest inequities, especially those harmed by the War on Drugs, and should be directed by those communities. Investment should deprioritize services run by law enforcement.
- We urge ONDCP to examine and act to **change federal policies that block access to these community services**, such as restrictions on [Medication Assisted Treatment](#), including those that contribute to [disparities](#), and policies that [bar](#) those with criminal convictions from access to essential community services.
- We also recommend that ONDCP **reduce investment in enforcement**, which has disproportionately harmed people of color. This includes reducing support of drug courts,

which perpetuate inequities and give the criminal legal system control over health decisions that should remain with the individual and their health providers.

- We urge ONDCP to build on its [Year One Priorities](#) to expand access to services, and to set short-term and long-term metrics to measure our recommended shift in resources from enforcement to public health and the extent that community engagement affected that shift.

We thank you for considering these recommendations, and for your commitment to advancing equity in drug policy. Please contact me by phone ((b)(6)) or email ((b)(6)) if you have any questions or would like to discuss further.

Sincerely,

Emily Stewart

A handwritten signature in black ink that reads "Emily Stewart". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Executive Director
Community Catalyst

Slater, Sandy R. EOP/ONDCP

From: Osaze Wilson <(b)(6)>
Sent: Friday, August 6, 2021 7:18 PM
To: MBX ONDCP OGC
Cc: Tahir Johnson; Chris Lindsey; Steven Hawkins; Bo Bryant
Subject: [EXTERNAL] US Cannabis Council's Comment on DN 2021 - 14365
Attachments: USCC Comment on Racial Disparities at the ONDCP.docx.pdf

To whom it may concern,

Please find attached to this email the US Cannabis Council's official response to the Office of National Drug Control Policy solicitation for comment on its application of equity in the US National Drug Control Policy.

Thank you,

Osaze Wilson
US Cannabis Council
Email: (b)(6)
Phone: (b)(6)



(b)(6)

| www.uscannabiscouncil.org

US CANNABIS COUNCIL

2370 Champlain St | NW Suite 12 | Washington, DC 20009

REFORMING CANNABIS POLICY TOGETHER

Response to Notice DN 2021-14365
Application of Equity in U.S. National Drug Control Policy

President Joe Biden took a decisive step toward racial equity in the United States when he signed Executive Order 13985 into law. By directing the Federal government to pursue a comprehensive approach to advancing equity for all, agencies were tasked with recognizing and addressing inequities in their policies and programs. This includes people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. The Office of National Drug Control Policy is one of many agencies that will improve by participating and learning from this important presidential directive.

The ONDCP seeks input to help it identify how agency policy and budget perpetuate systemic barriers to opportunities for underserved and minority communities. The agency also seeks recommendations on how its future proposed policies, budgets, and programs could be more effective in advancing equity. We at the US Cannabis Council believe the ONDCP's role as the main designer and director of the policies and programs of the War on Drugs set the stage for many of the barriers to opportunity, specifically Black, Latino, Native American, and Asian ethnic minorities that would follow in its wake. It should make efforts to ensure it is no longer interfering with state regulatory programs, and make recommendations to President Biden and members of Congress to update federal law to better fit the need for regulation and a health and safety, rather than law enforcement approach.

When the ONDCP was launched in 1989, it relied heavily on the use of law enforcement to prosecute cannabis consumers and those who provided to them. At the time,

the ONDCP's Drug Czar William Bennett referred to this new approach as the "War on Drugs" and today, the "war" is synonymous with failed policy. This so-called war was waged in the inner city, leading to ONDCP policies having directly contributed to racial disparities in American society because, as we have seen, drug laws that rely on law enforcement have not been evenly applied. Every year from 1980 to 2007, Black Americans were charged with drug crimes at rates 2.8 - 5.5 times higher than White Americans despite the fact that black and whites engage in possession, sale, and use at roughly comparable rates. Today, the disproportionate ratio of Black Americans currently incarcerated or saddled by damaging criminal histories related to cannabis remains unchanged because cannabis use in our country is treated as a law enforcement challenge, rather than a health and safety issue. ONDCP's dependence on law enforcement solutions, combined with the clear track record of disproportionate enforcement against people of color by law enforcement, both instituted harm and perpetuated the system for decades.

The agency has a responsibility to reduce harm associated with illicit drug use, not create new harm for those it seeks to protect. Yet since its inception in 1989, the ONDCP has both administratively and financially prioritized supply-side reduction policies of criminalization and law enforcement to address illicit drug use, minimally supporting education, health and safety solutions, and demand reduction. What came of that is 50 years perpetuating harm resulting in ballooning incarceration while cannabis usage rates remained largely steady since 1989 - the worst of both worlds. At the same time, states turned to new policies and rejected the War on Drugs approach. Instead, they adopted regulated approaches similar to alcohol, and those approaches work. State programs should be free to continue the regulatory approach over-incarceration without interference from the federal government.

In fact, the agency can correct the harms and injustice of its failed policy by acknowledging the role it has played and continues to play without changes to its mandate. It should instead prioritize its efforts and resources on developing ways for the ONDCP to align

with state regulatory goals, and combat a truly deadly challenge that continues to create harm - the growing prescription opioid epidemic.

Thirty-one states and the District of Columbia have legalized or decriminalized cannabis. Twenty-four states and Washington D.C. have gone a step further by including expungement and record sealing for non-violent cannabis crimes in their legalization laws. As our country continues to reconsider cannabis policies at both the state and federal levels, the ONDCP should minimize its role with respect to cannabis and minimize interference in state programs. It should also recommend to President Joe Biden and members of Congress that they support the removal of cannabis as an item of interest by the ONDCP until a more comprehensive regulatory framework administered at least in part by the federal government is in place.

Comment by: Tahir Johnson, Director of Social Equity and Inclusion at USCC
On behalf of the US Cannabis Council

PUBLIC SUBMISSION

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Docket: ONDCP-2021-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Comment On: ONDCP-2021-0001-0001

Request for Information: Application of Equity in U.S. National Drug Control Policy

Document: ONDCP-2021-0001-DRAFT-0013

Comment from Pain Advocacy Coalition

Submitter Information

Email: (b)(6)

Organization: Pain Advocacy Coalition

General Comment

See attached file.

Note the pop up window stating that the comment page is unavailable has discouraged public comment to this federal register, as a result the public comment date should be extended after resolving the issue.

Attachments

Failed Public Health Drug Policy

Drug policy has had a fatal impact upon patients who experience acute, chronic & intractable pain leading to patient abandonment, forced tapering, denial of care, and discrimination. Failed public health policy, including the Center for Disease Control (CDC) 2016 Guidelines & the implementation of the National Pain Strategy regarding prescribing opioids has resulted in increased complications, disability, accelerated mortality including suicide. The current hostile regulatory environment has resulted in the marginalization of a large demographic of patients resulting in denial of access to medical care.

Harm reduction would entail protecting patient's access to medical care to effectively treat pain associated with disease and injuries.

Current US Drug Policy has been implemented as prohibition, and as a result, illicit drug use has resulted in skyrocketing overdose deaths, not less.

Opioid Policy: A Platform for Change

By utilizing research, collaborative tools and social media strategy, advocate for changing over-reaching draconian healthcare policy by:

- *encouraging dialogue with policy makers, special interests, and oversight agencies to recognize the negative impact of the CDC guidelines on patients experiencing acute/ chronic/ intractable pain
- *urging policy makers, special interests, and oversight agencies to stop new legislation that restricts prescribing opioids to patients until viable research, treatments and medical modalities for pain have demonstrated reliability through sufficient trials establishing their efficacy in comparison with opioids
- *refuting third-party administrators efforts to further deny coverage to restrict treatment of acute/ chronic/ intractable pain with opioids
- *empowering patients and caregivers to contribute to state/ federal policy discussions impacting medical care for acute and intractable pain patients
- *derailing state/ federal legislation, medical boards, Department of Justice, Drug Enforcement Agency and any other policy guidelines that restrict physician's autonomy to provide individualized care to patients in acute/ chronic/ intractable pain
- *ensuring that information and data obtained from the Prescription Drug Monitoring Program (PDMP) is utilized appropriately, including discouraging unwarranted profiling of patients or physicians, providing an Avenue for patients to dispute inaccurate information and provide efficient follow up on all complaints, if there are errors identified, and preventing mis-use of patient data to profit or be enrolled in research without consent

Public Awareness

By utilizing research, collaborative tools and social media strategy, address raising public awareness about the "opioid crisis" by:

- *informing the public about treatment of acute/ chronic/ intractable pain patients including the "benefits" utilizing opioids for effective analgesia

- *correcting misconceptions about the opioid crisis, including clarifying to the public that the culprit contributing to unintended overdoses is illicit Fentanyl (synthetic analogues), distributed illegally by cartels from China, Mexico and Afghanistan
- *clarifying to the public the influx of “illicit” Fentanyl is not related to over prescribing opioids or pharmaceutical grade Fentanyl by licensed pain management physicians to legitimate patients
- *educating the public that new state legislation, third-party administrators, and special interests are rolling out guidelines that are not well researched, or are based on skewed data
- * Provide greater oversight of special interests, non-profits, foundations who have a vested financial interest and profiteering by impacting the pain population’s access to adequate opioid analgesia by disseminating inaccurate information, including “half truths” about the efficacy of opioids or the culprit of overdoses as related to prescription opioids

Research

By utilizing research, collaborative tools and social media strategy, address raising awareness about current research about opioids by:

- *disputing the use of flawed research and/ or statistics to implement “opioid prohibition” resulting in harm to patients and the medical community
- *disputing flawed research and/ or statistics to justify extreme government overreach that extensively interferes with the patient/ physician/ pharmacist relationship
- *ensuring all future research impacting pain patients include metrics that focus on maintaining “functional ability and quality of life” as successful treatment goals vs. reducing number of prescriptions
- *advocating future research is free of special interest profit motives, and government interference
- *advocating for research for viable treatments that equal opioid analgesia’s effectiveness vs. reducing prescribing of opioids

Individualized Patient Care

By utilizing research, collaborative tools and social media strategy, address protecting individualized patient care by:

- *protecting all patient’s educated healthcare choices made mutually with their physician to implement opioids as part of their treatment plan
- *advocating for individualized medical care, not a “one size fits all approach” to manage pain in the event, other medical modalities are deemed unsuccessful
- *restoring autonomy and latitude to physicians to make healthcare decisions about prescribing opioids with their patients without the burden of fear, threat or harm to their ability to practice medicine, or maintaining their assets
- *restoring the eroded patient-physician-pharmacist relationship from one of suspicion, to a relationship of mutual trust

- *ceasing inappropriate mass diagnosis of chronic\ intractable pain patients with Opiate Use Disorder (OUD) or as having a behavioral disorder merely because opioids are a part of a patient's short or long-term treatment plan
- *providing intractable pain patients with individualized psychosocial support, tailored specifically for the needs of the pain community, which differ significantly from the needs of the mental health community and/ or the needs of an individual coping with addiction
- *supporting pain management physicians to restore their clinical autonomy from physician groups, who implement protocols that are more stringent than mainstream guidelines, to ensure third-party administrators will reimburse them, leaving patients receiving different care from different facilities ultimately, destroying continuity of care
- *challenging government oversight agencies from interfering with pharmacies delivering medications lawfully
- *preventing pharmacists and third party administrators from practicing medicine and/ or profiling physicians/ patients on behalf of oversight agencies by using the Prescription Drug Monitoring Program (PDMP)
- *challenging the prevalence and practice of under-diagnosis of pain, under-medicating symptoms of pain, or over-medicating with patented drugs that are often ineffective or have side effects, over-utilization of injections or invasive but, highly lucrative procedures including spinal cord stimulators, as a viable alternative to offering treatment with opiates, when all other treatment modalities have failed
- *requiring healthcare providers to incorporate continued education addressing "healthcare bias" when treating patients with acute, chronic or intractable pain
- *demanding appropriate diagnosis, treatment, and pain management is delivered to patients within a reasonable time frame, prior to patient's declining, losing their livelihood, experiencing bankruptcy, ultimately being marginalized, and thrust unwillingly into disability or in some cases, accelerated mortality or suicide
- *offering pain management physicians, not addiction specialists and patients with lived experience a seat at the table when drafting policy

Health Equity

"Health equity" is harm reduction as it relates to drug policy and public health policy. Public health drug policy currently is punitive and discriminatory to minorities/ disabled/ women/ poor/ elderly and veterans by systematically denying access to medical care, effective pain management including access to long term opioid therapy (LTOT), further creating a hostile regulatory environment, which is ultimately contributing to preventable deaths. Harm reduction includes providing access to medical care to these patients, not patient abandonment and protecting physicians who treat patients in pain in good faith, by offering resources and guidance, not punitive, restrictive, untested public health drug policy (drafted in secret, by special interests and researchers with a profit motive) based on skewed data, surveillance and incarceration.

Slater, Sandy R. EOP/ONDCP

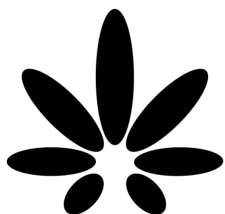
From: Dasheeda Dawson <(b)(6)>
Sent: Saturday, August 7, 2021 12:00 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] CEASE Statement
Attachments: CEASE Statement to ONDC .pdf

Dasheeda D. Dawson, CEO & Author | *The WeedHead™ & Company*
EDUCATION. EMPOWERMENT. E-COMMERCE.



Ph: (b)(6) | E: (b)(6)
F: @theweedhead | IG/TW: @DasheedaDawson

Pick up the latest edition of our top-selling workbook, [How to Succeed in the Cannabis Industry](#)



c. e. d. s. e.

CANNABIS EDUCATION ADVOCACY SYMPOSIUM & EXPO

Executive Office of President
Office of National Drug Control Policy
Docket No: ONDCP FRDOC 0001-0008
Document Citation 86 FR 35828
Document No. 2021-14365
OGC@ondcp.eop.gov

This statement is submitted on behalf of **Cannabis Education Advocacy Symposium & Expo (CEASE)** concerning the Application of Equity in U.S. National Drug Control Policy RFI submitted on July 7, 2021.

Founded in 2017, CEASE is a 501c3 nonprofit organization with a mission to promote inclusion, equity and justice in the cannabis community by increasing awareness and educating consumers, particularly those marginalized by racially-biased prohibition, about the history, health and economic impact of the cannabis decriminalization movement, empowering them to seek expanded access to the globally developing legal industry. A coalition leader within the Cannabis Health Equity Movement (CHEM), the organization looks to cease misconceptions about the plant and to enhance cannabis competency through community enrichment and public education rooted in scientific fact.

A few noteworthy examples include:

- In 2018, the organization hosted the state of Oklahoma's first ever cannabis industry conference, and is proud that the state has had the most successful medical cannabis roll-out for any state to-date, capturing over 350,000 patients or almost 10% of the state's population after just opening the medical market in 2019.¹
- Capitalizing on the legalization of hemp through the Agricultural Improvement Act of 2018, CEASE also created a Hemp Symposium in Wisconsin in partnership with St. Croix Chippewa Native American tribe. With over 50,000 potential uses, we were able to share the industrial, agricultural, medical and nutritional potential of the plant.

Since inception, CEASE has also been educating legislators and law enforcement at the federal, state and local municipal levels across the country, most recently at the 2021 NY State Black, Hispanic & Asian Caucus. Our efforts ensure that fear-based regulations and draconian

¹ Marijuana Policy Project (MPP):
<https://www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/>

policies are reformed with equity-centered intention to repair communities that were targeted through racially-biased enforcement of cannabis prohibition. Our training has helped policymakers understand the nature of cannabis as medicine, first and always. Moreover, we have demonstrated how even good policies can be implemented in ways that are detrimental to vulnerable communities because of canna-phobic biases and systemic racism.

CANNABIS CRIMINALIZATION

Despite holding a patent for the neuroprotectant and antioxidant benefits of cannabinoids, the United States government continues to harm its constituents by keeping cannabis, specifically marijuana or high Delta-9-THC strains, at a Schedule I designation. Consequently, America continues to fall behind in the full understanding of the Endocannabinoid System (ECS) and how cannabis can be leveraged as a solution for countless ailments through modulation of the ECS. Additionally, this federal status continues to prolong the stigma of cannabis use and prevents millions of people from accessing the best consultation from health professionals who are also ignorant to the inherent medicinal value of the cannabis plant.

Decades of aggressive and excessive cannabis criminalization has prevented access to patients, impacting our most vulnerable, historically excluded populations more exponentially. This includes Black, Indigenous and other people of color, disabled individuals and/or those living with debilitating diseases, military veterans and women.

Drug offenses account for the majority of all arrests in the country, which has led to 1 in 5 individuals incarcerated for a drug offense². For decades, cannabis (marijuana specifically) has represented the largest percentage of all drug arrests and this trend continues despite over 30 states having a government-run medical cannabis program.

By reforming the federal drug control policy on cannabis, the ONDCP has an opportunity to dismantle a longstanding construct of racism still persistent in the United States. The war on drugs, predominantly waged against Black, Indigenous and communities of color, has long been a tool of racial oppression. Marijuana possession and sale, whether perceived or real, has provided an excuse for over policing, state violence, and law enforcement interactions that far too often end in death for people of color. According to the 2020 ACLU report, “A Tale of Two Countries: Racially Targeted Arrests in the Era of Marijuana Reform”, cannabis prohibition has led to Black people being 3.64 times more likely to be arrested for possession relative to White counterparts and remains one of the top reasons for deadly police interactions in Black and Brown communities³. These disparities have contributed to mass incarceration, multi-generational marginalization and disinvestment in the wellbeing of Black and Brown people, impacting every single determinant of health in communities of color including

² Drug Policy Alliance (DPA): <https://drugpolicy.org/issues/drug-war-statistics>

³ *A Tale of Two Countries: Racially Targeted Arrests in the Era of Marijuana Reform*, 2020 American Civil Liberties Union (ACLU) Report

unemployment⁴, median household income⁵, access to housing, health disparities⁶, and overall mortality rates⁷.

These negative impacts must be remediated in every aspect of cannabis legalization and reform.

Formal consultations for the National Drug Control Strategy often involve direct relationships between ONDCP and the consulting group, organization, or subject matter expert. What are recommendations on how the agency can broaden its formal consultations to gain broader perspectives earlier in the policy development process?

From our work on the ground, CEASE knows firsthand that many state and municipal governments are increasingly making the commitment to not only responsibly license and regulate commercial cannabis activity, but to also pioneer and collaborate on the development of innovative government programs that seek to acknowledge and address the harms of the racially-biased enforcement of cannabis prohibition, also known as the War on Drugs. Over the last several years, and certainly in the last twelve months, legal states have made significant progress in elevating the need to center equity in cannabis policy reform. This is evidenced through recent state and local efforts to decriminalize and legalize cannabis, and the establishment of cannabis equity programs, community reinvestment initiatives and the development of strategies specifically addressing racial inequities in policy reform.

With this in mind, we strongly encourage ONDCP to reach out to the [Cannabis Regulators of Color Coalition \(CRCC\)](#), a coalition of government officials appointed and/or selected to lead, manage and oversee the regulatory and policy implementation for legal cannabis markets across the United States. The organization offers support and real-time insights to educate all stakeholders and to help local, state and federal lawmakers, law enforcers, and policy leaders implement evidence-based, equitable cannabis regulations.

Additionally, one of the biggest mistakes in the legalization movement thus far has been the exclusion of health professionals in the conversation. Cannabis is inherently medicinal by way of its interaction on the Endocannabinoid System, the largest system of receptors in the human

⁴ Source: Federal Reserve Economic Data, "Unemployment Rate: Black or African American," 2019

⁵ Source: U.S. Census Bureau, Current Population Survey, 1968 to 2018 Annual Social and Economic Supplements.

⁶ Source: Center for Disease Control, Summary Health Statistics: National Health Interview Survey, 2018

⁷ Source: "Deaths: Final Data for 2017" National Vital Statistics Reports Volume 68, Number 9 June 24, 2019, Center for Disease Control and Prevention

body. This system controls nearly every aspect of our health and wellbeing as it works to achieve homeostasis. For that reason, it is impossible to continue creating policies and regulations without inclusion of cannabis competent health professionals. Therefore, we highly encourage ONDCP to consult with the [Association for Cannabis Health Equity and Medicine \(ACHEM\)](#), a professional medical association for BIPOC healthcare professionals and students active or interested in cannabinoid medicine and health equity.

Provide recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of National drug control policy. What would be your recommendations for short-term and long-term goals that ONDCP should take into account to measure progress towards equity in drug policy?

Many of the advocates in the cannabis industry are also patients/consumers. We encourage ONDCP to reach out to our organization to gain more access to cannabis patients. We also believe there's an opportunity to gain insights from the 30+ medical cannabis programs throughout the country.

Please feel free to contact us at:

(b)(6)

www.ceaseconference.org

Slater, Sandy R. EOP/ONDCP

From: Katree Saunders <(b)(6)>
Sent: Saturday, August 7, 2021 1:37 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Application of Equity in U.S. National Drug Control Policy

I looked over and would like to include the disparities in Specifically The Nevada Cannabis Market. My name is Katree Darriel Saunders. As a Patient and Advocate. In 2011 I was indicted under Operation Chronic Problem in Las Vegas, NV after I met President Obama and he said he wasn't Prosecuting Medical Cannabis Patients. For the past decade. I have had to deal with the repercussions of this Failed War on Drugs. Then I helped build a Industry. Made millions for the State of Nevada and local Business owners. Only to be systemically barred from working in the industry that I helped build, protected over 800 people when I got indicted. Assisted in Opening Multiple Dispensaries building white generational wealth. Then have the laws changed to help further benefit White Privilege. There needs to be accountability and oversight. Moving forward it is vital that The White House has proper guidance from those who have been adversely affected by this Failed War on Drugs. That there be a committee oversight with People like myself can make the proper recommendations to begin to repair the harms sustained. Listed below is a study showing the gap of Ownership when it pertains to those most affected by the War on Drugs. Over 40,000 people are still incarcerated for this nonviolent crime. People Like Edwin Rubis and Parker Coleman deserve to be Free along with so many others. It is high time we begin to Educate rather than punish people for this plant.

We as Americans Deserve safe access to this plant. Our bodies have a Endocannabinoid System that is to be nourished by the Cannabinoids found in the Cannabis Plant. End the Stigma and give us Safe Access for Research and Development. I stand with ASA as a member and a Constituent with Last Prisoner Project. Thank you for your time.

Sincerely,

Katree Darriel Saunders

<https://hightimes.com/news/most-affected-how-federal-pot-charges-impact/?fbclid=IwAR1a7k8ru40SMT6Ra0NYbXY1xFD IX7xm329K EOJBirscXYIHMboM4ImaYc>

https://medium.com/@jeff_59566/marshawn-lynchs-dodi-blunts-teams-up-with-last-prisoner-project-to-launch-apprenticeship-program-195385ec93fb

<https://www.vegascannabismag.com/home-featured/operation-chronic-problem-you-are-the-problem/>

[FINAL-012921-CCB-Demographic-Study.pdf \(nv.gov\)](#)

Nevada's first official [demographic survey](#) of cannabis businesses shows that women and minorities account for a smaller percentage of the local marijuana industry versus their overall representation in the state – especially when it comes to ownership and management.

According to the U.S. Census Bureau, women account for almost 50% of Nevada's residents, but the state-mandated survey found that only 38% of cannabis professionals identified as female.

This disparity increases when considering ownership and board membership. Representation on company boards was 81% male, with 72% of owners/managers also identifying as male.

Women found more opportunities as employees or consultants, accounting for 40% of those positions.

The pattern was similar when considering race.

Employees and consultants tended to be more diverse, while owners and executives mostly identified as white.

Non-white ownership, according to the survey, was 35%, which is lower than the state's overall non-white population.

Nevada is almost 50% non-white, according to the latest census numbers. Its population is 48% white, 29% Hispanic, 9% Black and 8% Asian.

Nevada's current cannabis regulations are limited when it comes [to promoting diversity](#) among business owners, and while there has been discussion about how to improve social equity, significant barriers must be overcome to foster inclusion.

For example, recreational cannabis licenses are limited and expensive in Nevada, with applicants needing to prove they possess at least \$250,000 in liquid assets to score higher for a permit. (People Who have been affected by the War on Drugs do not have this kind of liquid assets to start a Cannabis Business) this was done by design by Nevada State Legislature. Also when they went from Medical to retail they changed the law to exclude felons. Justice Impacted individuals deserve Ownership and a pathway to lending to accomplish it.

The Nevada Cannabis Compliance Board conducted and released the survey report, now an annual requirement after the passage of [Assembly Bill 533](#) at the end of the 2019 legislative session.

While the compliance board, which was created by the same law and [began functioning](#) summer, hasn't had any open licensing rounds, it has indicated it will consider applicant diversity and veteran status when issuing future permits.

The survey asked people issued agent cards as of January 2020 – including those working in cultivation, production, testing, retail and distribution – about their gender, race, age and education.

Of the 9,890 potential respondents, almost 50% returned the survey within the two-week response period.

That said, nearly 100% of industry executives responded.

When combining owners, board directors, officers, employees and consultants, the survey found:

- 58% identified as male versus 38% identifying as female.
- 53% identified as white versus 10% identifying as Black.
- 24% identified as Hispanic, Latino or Spanish origin.
- 44% said they were 25-34 years old.

Of the total respondents:

- 49% were in retail.
- 42% were in cultivation.
- 28% were in production.
- 12% were affiliated with a cannabis distribution facility.
- 7% were in testing.
- 8% were some other type of employee.

The compliance board said it will refine the survey process but hopes the initial data will provide a baseline moving forward.

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Kannabis Kouture

Slater, Sandy R. EOP/ONDCP

From: Faye Coleman <(b)(6)>
Sent: Sunday, August 8, 2021 3:42 PM
To: MBX ONDCP OGC
Cc: Adrina Walker
Subject: [EXTERNAL] Office of National Drug Control Policy - Pure Genesis Testimony 8.6.21
Attachments: PG Testimony to NJ Bill - Adult Use Legalization 8.6.21.pdf

The Executive Office of The President
Office of National Drug Control Policy
Docket No: ONDCP FRDOC 0001-0008
Document Citation 86 FR 35828
Document No. 2021-14365
OGC@ondcp.eop.gov



Pure Genesis, LLC Testimony presented on Drug Policy Impact

The Executive Office of The President
Office of National Drug Control Policy
Docket No: ONDCP FRDOC 0001-0008
Document Citation 86 FR 35828
Document No. 2021-14365

Presented on August 6, 2021

By: Faye Coleman
Co-founder & CEO
Pure Genesis, LLC

As a citizen of the state of New Jersey for more than 20 years, my company, Pure Genesis, LLC (PG), a Minority & Women-Owned Business Enterprise (MWBE), is a multi-state hemp operator and has served as educators of cannabis throughout the state of New Jersey and nationally. Our goal is to operate a full vertical medical cannabis ecosystem as a cannabis operator and consultant offering safe, quality driven, and efficacious products and services, with a community first and business-centric engagement.

As we look at the impact that drugs have had on black, indigenous and people of color (BIPOC), it is clear that we have been disproportionately impacted in a way that has led in part, to the negative economic, environmental, social and health equity of families. To move forward and commit to righting this wrong, there must be a focus on providing opportunity for these communities of color to enter into this industry that systematically disenfranchised us. PG believes that while it is the goal of the newly appointed cannabis regulatory commission to reduce the disparity of opportunity within this industry as it relates to licensing opportunities within New Jersey, there are several challenges that may prevent this goal from being realized. PG wants to speak on a few areas of focus that we believe, with collaborative input from minority and women ancillary leaders and operators (within the industry), PG will have the necessary support to start, run and grow a successful medical cannabis operation.

In an industry that has been legal in many states for at least 10 years, nationally only 4% of African Americans own a cannabis business and only 1% are African American women-owned. If the goal is to create a robust cannabis market that drives revenue for the state, the communities, and equally important, the cannabis businesses, we have to change the state of play to create a path towards success for all.



- Let's consider revenue generation for the state. For example, Oklahoma, where they currently have 10,000 licenses and at a fee of \$2500 per year that is \$22M annually (fees only). Now let's look at Colorado which brought in \$1.75B in sales in 2019 and received \$302M in tax revenue. With New Jersey projected to be a \$2B market (mature), the state will be poised to bring in approximately \$345M in tax revenue.
- The communities will be impacted comprehensively through job creation as witnessed by Colorado's 40k cannabis specific jobs. However, the benefits are far beyond job creation. Tax revenue has been directed towards youth consumption prevention programs, investment in public school construction, health care, health education, substance abuse prevention and treatment programs, and law enforcement.
- Businesses aspiring to be operators, specifically those who are socially and economically disadvantaged, must be provided with a different approach that does not include "winning" a license. This current process requires businesses to spend hundreds of thousands of dollars to compete for a chance at a license - with a 90% failure rate. This has led to a significant number of socially and economically disadvantaged businesses to suffer financial hardship and thus prevented from the opportunity to continue to apply due to a process that was developed for businesses with significant financial support. This strategy has led the state to provide 6 licenses in 3 years with minimal diversity impact. As a solution, is it possible to follow in the footsteps of most industries (e.g. legal, pharmacy...) where applicants are to meet specific requirements set by the state and local governments and by meeting those requirements are able to acquire a license? The free-market approach in Oklahoma also has proven successful where of the 10,000 license holders, 60% in operation, approximately \$800M in revenue is projected for 2020.

Another solution that has been successfully adopted in several states are social equity programs. As a result, not only do those socially and economically disadvantaged businesses benefit, but the communities by which they reside benefit and therefore the states benefit. Let's take for example the impact of Black Lives Matter (BLM) and George Floyd – For the longest time, cannabis regulators with social equity goals have been trying to salvage poorly designed policies and frameworks purposely intended to keep previous marijuana offenders, a large majority Black, Indigenous or Hispanic, from participating in a legal cannabis market. However, in the wake of George Floyd's murder and subsequent protests in all 50 states, there has been a huge momentum shift in the policy conversations across the country with regards to cannabis equity. Legislative leaders have a strong motivation to find ways to support, build and reinvest in Black lives. Now, after nearly 5 years of debating the need for a social equity program in Colorado, the state passed HB 20-1424 establishing social equity licenses in the adult-use cannabis program within **20 days** of being introduced as new legislation in June 2020. Similarly, in the same month, Portland's city council divested \$2.3M of cannabis tax revenue that was originally allocated to go to the police bureau. A portion of that was added to the city's Social Equity & Educational Development (SEED) Initiatives to provide \$1M in ongoing annual funding to communities most



impacted by cannabis prohibition. These examples not only set precedent for other states, but they also demonstrate how quickly the government can move if properly educated and motivated. This is exciting to see, and I believe New Jersey is equipped to follow a similar path.

Now, PG has shared how we can remove barriers to entry to gain access to licenses. Next, we want to address the barriers that we believe will significantly limit future license holders from effectively competing.

- Note, current license holders (all non diverse) have the opportunity to expand without merit with 2 additional licenses. If the goal is to create a robust cannabis market that drives revenue for the state, communities, and cannabis operators, it must be competitive. Those that secure licenses post 2020 may find it a challenge to compete and remain viable because current license holders will set price that will greatly reduce revenue and ultimately profit margins. This is a common business practice. PG realizes that New Jersey wants the cannabis industry to be successful and is looking at catalysts that will spur such growth. However, we are asking that the Commission have confidence in those yet to secure a license. Specifically, those Minority, Women-Owned and Veterans-Owned businesses who are not only primed to compete but are prepared with the necessary resources. It is critical that we understand that we need the Commission to provide equitable access to business and allow the fair and competitive market to take shape and drive revenue where all productive businesses have an opportunity to win.
- This winning strategy can be further extended by removing the barriers of licensing caps. The thought may be that with the licensing cap more businesses will be able to apply. If that is the intent, then first a cap must be placed on the current license holders to ensure a competitive market. Second, socially and economically disadvantaged businesses will not be able to survive with licensing caps due to a lack of control of their ecosystem. For example, a minority business owns a dispensary and sales spike. If the dispensary must rely on an outside grower, they may not receive product during that spike which dilutes sales, reduces profit margins, and makes it challenging to remain operational. If socially and economically disadvantaged businesses had no licensing caps they could pursue their own full vertical ecosystem and compete on equal footing.

PG is excited that New Jersey citizens, businesses and government are all aligned on the medicinal and financial value of cannabis within the state. We share our thoughts to convey the importance of social equity as an integral part of legislation. We want to believe that the possibility of being an operator within the state exists for Minority, Women-Owned and Veterans-Owned businesses. The language has been included in our current policies. It is our hope that execution of awarding licenses is fair and appropriate. Our cannabis regulatory commission is the most diverse commission in the US so we are on the right path. That coupled with an inclusive bill that fundamentally supports inclusion through a new process for license acquisition, a comprehensive social equity program, as well as elimination of licensing caps and license expansion of current license holders is the solution needed.



On behalf of Pure Genesis, LLC, thank you so much for allowing me the time to convey thoughts regarding the impact that drug policies have had on our communities, but more important how we can in part remedy today through our now legal (by state) cannabis industry. The time for action is now.

Faye

Faye E. Coleman

Co-founder & CEO, Pure Genesis, LLC

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Slater, Sandy R. EOP/ONDCP

From: Dipesh Chauhan M.A. C.A.M.S. <(b)(6)>
Sent: Monday, August 9, 2021 10:52 AM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Drug Policy Priorities



Good Morning,

I am late in my response, but I wanted to make sure I briefly relayed my opinion. I am happy to elaborate if needed.


1. When we mention EBP treatment, I would encourage the administration to look at EBP techniques. I believe specific skills are much more trainable, executable in larger areas, and are cost-efficient. Some EBP treatment programs take months, if not a year, to implement. They are effective, but universal skill development for the community, treatment providers, and students can be a much more effective tool: i.e. family engagement tools, CBT strategies.
2. Social Determinants....we need to be addressing social determinants in all things substance abuse. Practical strategies will have a limited impact if we do not begin the conversation with this. Social determinants and EBP should be hand in hand.

Thank you for allowing me to provide feedback!

Regards,
Dipesh B. Chauhan
Dipesh Chauhan M.A. C.A.M.S.
Director of Program Development
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Slater, Sandy R. EOP/ONDCP

From: Dustin McDonald <(b)(6)>
Sent: Monday, August 9, 2021 5:22 PM
To: MBX ONDCP OGC
Subject: [EXTERNAL] Re: Americans for Safe Access Comments on FR: 2021-14365
Attachments: ASA Comment Ltr-FR2021-14365.pdf

Hello. I am writing to resubmit the attached comment letter from Americans for Safe Access (ASA) to ONDCP's comment period opened on July 7 for FR 2021-14365-Application of Equity in U.S. National Drug Control Policy. The original letter submitted on August 6 contained a reference to LA County, but should have referenced the City of LA. Thanks, -Dustin

On Fri, Aug 6, 2021 at 12:15 PM Dustin McDonald <(b)(6)> wrote:
To Whom It May Concern:

I am writing on behalf of Americans for Safe Access(ASA) to submit comments to the Office of National Drug Control Policy in response to *FR 2021-14365-Application of Equity in U.S. National Drug Control Policy*. ASA is the nation's oldest and largest 501(c)(3) member-based medical cannabis advocacy organization with a mission to advance access to cannabis for therapeutic use and research, and we look forward to collaborating more deeply to help the administration navigate this challenging policy area.

Please do not hesitate to contact me if you have any questions or would like to discuss any details included in our comment letter. Thanks, -Dustin

--

Dustin McDonald | Interim Policy Director
Americans for Safe Access

1629 K Street NW | Suite 300 | Washington, DC 20006
Phone: (b)(6) | Toll Free: (b)(6)

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Dustin McDonald | Interim Policy Director
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August 6, 2021

Kemp Chester, Acting Director
Office of National Drug Control Policy
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

RE: FR 2021-14365-Application of Equity in U.S. National Drug Control Policy

Americans for Safe Access (ASA) thanks the Office of National Drug Control Policy for organizing this request for comment on such an important issue, and respectfully submits these comments for consideration in response to Federal Register Notice 2021-14365. ASA is the nation's oldest and largest 501(c)(3) member-based medical cannabis advocacy organization with a mission to advance access to cannabis for therapeutic use and research, and we look forward to collaborating more deeply to help the administration navigate this challenging policy area.

Specifically, ASA is eager to work with ONDCP to address cannabis equity issues that patients using cannabis to treat their health face daily, ranging from social justice, patient rights and civil protections to safe, legal and affordable access to medicine. Despite a supermajority of U.S. states approving medical use of cannabis and authorizing physicians to work with patients to effectively apply cannabis medicine, patients of all races and genders – mothers, fathers, children, seniors, veterans and our families and colleagues – continue to face discrimination and a lesser standard of care under today's multi-state medical cannabis policy framework.

This discrimination is supported by the federal government's classification of cannabis as a Schedule I drug under the Controlled Substances Act (CSA), a designation that carries with it the false notion that cannabis is a drug with no medical value and a high propensity for abuse. Millions of patients living under this classification across 37 states with medical laws are at risk of employment, housing and family law discrimination for participating in state-sponsored health programs, and for using cannabis medicine where Food & Drug Administration (FDA)-approved prescription and over-the-counter remedies have failed to effectively treat their health conditions.

1. Jurisdictions at the State, local, Tribal, and territorial levels have implemented equity assessment tools to inform their policymaking or budgetary processes. What are the lessons these jurisdictions have learned from implementing or interacting with those tools?

ASA has a long and successful track record of collaborating with state and local governments, licensed cannabis businesses and community organizations to develop functional cannabis



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ASA is the largest national nonprofit organization of patients, medical cannabis providers, medical professionals, scientists and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research with over 100,000 advocates in all 50 states.

policy, and train licensed cannabis businesses to meet state health and safety requirements. Related to equity specifically, ASA participated in the equity process through City of Los Angeles in California, and was selected to provide Patient Focused Certification (PFC) services¹ to social equity licensing recipients across the city. Unfortunately, the rollout of the city's equity program is consistent with that of many other state and local governments across the country who have attempted to develop similar measures, in that the program experienced organizational challenges, and frequently subjected applicants to long delays. These delays can dramatically increase project costs for equity operators, and even force applicants to abandon the process of joining the legal market.

Given the critical nature of ensuring that Los Angeles cannabis businesses receive training to appropriately serve patients and meet critical state and local product safety and operational requirements, it is important that these processes are improved. To date it has taken over one and a half years for the city to approve ASA's training application and award the contract, and over six months to get final documents reviewed. At the time of submission of this comment letter these documents are still pending review. While the public is accustomed to the slow pace of government operations, policy and licensing approaches must be amended to improve outcomes for equity cannabis business operators and their employees across 37 states, and the patients in their communities who desperately need the services of these businesses for their health treatment.

Regarding state cannabis equity policy, states are making strides to address equity issues² pertaining to business licensing and ownership, granting resources to support business organization, and even funding criminal records expungement for past low-level cannabis offenses. However, much like the Los Angeles example, most of these state policies have been slow to develop, organize and implement, even when adopted early. As a result, many equity cannabis business operators and employees from these communities were not able to participate in the formation of the legal cannabis marketplaces authorized by states. On the related issue of health equity, none of the original state medical reform models contemplated the specific health challenges of equity communities, or sought to address them through application of cannabis medicine to their unique health challenges. ONDCP coordination with federal and state health departments to focus on solutions in this arena would be welcome.

With state and local equity programs expanding in number, size and scope, it is important to focus on metrics to measure the utility of these programs in serving the intended beneficiaries, and identify areas of improvement to increase program performance. These tools should measure the effectiveness of programs in serving targeted populations, and track any negative externalities that may result from the policy on targeted and ancillary populations. The Small Business Administration's suite of loan and grant programs may have useful metrics for ONDCP to consider utilizing to measure the effectiveness of these programs.

ONDCP leadership is also needed in assisting states address medical cannabis policy challenges ranging from health equity, patient rights and civil protections to accessibility, cost, consistency and safety of cannabis medicine. As states pivot from limited medical cannabis frameworks to authorization of adult-use access, many patient issues remain outstanding such as employment protections, subsidies to support the cost of medicine and appropriate product testing and labeling standards to keep patients safe.³ ONDCP can help state and local governments improve policy

¹ <https://patientfocusedcertification.org/>

² <https://www.cannabisbusinesstimes.com/article/grant-funding-for-california-social-equity-program/>

³ https://www.safeaccessnow.org/adult_use_blog

and address federal barriers such as the CSA Schedule I classification of cannabis that hampers the performance of state and local policy reforms in serving patients.

Common challenges to the creation and functionality of state and local cannabis equity programs include:

- Determining state and local cannabis business licensing and employment eligibility criteria and related factors for potential business owners and employees, to include addressing challenges related to those with past cannabis-related criminal convictions, and geographically defining eligible participation zones.⁴ A related issue for state and local governments is addressing expungement of criminal records for past low-level cannabis offenses.
- Addressing state constitutional issues such as anti-affirmative action laws or related state supreme court rulings that present obstacles to forming any state or local programs designed to extend benefit to a particular class.⁵
- Extension of resources to assist equity business operators and employees is also an issue that states and local governments are exploring, and ASA encourages ONDCP to partner with the Department of Commerce and the Department of Labor, and national associations such as the Cannabis Regulators Association, National Governors Association, Council of State Governments, National Association of Counties, U.S. Conference of Mayors, National League of Cities, as well as policy experts in this arena such as the Minority Cannabis Business Association, Illinois Senior Advisor to Governor Pritzker for Cannabis Control Toi Hutchinson and Pennsylvania State Representative Chris Rabb to secure their counsel on approaches. Together this group of advisors can help ONDCP explore modifications to existing federal programs, as well as new partnerships in order to help state and local governments and equity cannabis business operators with training resources for business operation, state and local cannabis compliance, and capital support such as low or zero-interest loans to assist equity businesses with the high costs of doing business in the cannabis space.⁶
- Addressing the affordability and availability of legal cannabis medicine. The federal CSA Schedule I classification of cannabis has discouraged individual insurance providers and the Department of Veterans Affairs from providing any subsidy to help cannabis patients cover the cost of their medicine. As state and local regulatory models impose high compliance, licensing and tax costs on cannabis businesses, many of these costs are passed onto consumers to include equity patients.

Though states have developed programs to shield patients from state and local tax payments, the price of legal cannabis medicine is still too expensive for most equity patients.⁷ The availability of legal medical cannabis also continues to challenge equity communities, as most local governments in cannabis reform states have not licensed medical cannabis retailers, or have failed to license them in sufficient volume to meet the demand of patients.⁸ The high cost of legal cannabis, lack of private insurance subsidy and limited availability of legal medical retailers drives a large population of equity patients

⁴ <https://mjbizdaily.com/los-angeles-and-oakland-took-disparate-approaches-to-cannabis-social-equity/>

⁵ <https://willamette.edu/law/resources/journals/sjelj/publications/pdf/3-1/6.-brown.pdf>

⁶ <https://www.cnn.com/2021/07/01/in-billion-dollar-cannabis-market-racial-inequality-persists-despite-legalization.html>

⁷ <https://www.nbcnews.com/news/us-news/ridiculous-price-medical-marijuana-leaves-patients-scrambling-n1274085>

⁸ http://www.cahcc.com/Portals/0/ADE%20Cannabis%20Report%20_8-6-20.pdf?ver=2020-08-11-125659-360×tamp=1597175841928

to purchase medicine from illegal market providers, where patient and product safety are not guaranteed.

As ONDCP initiates work on federal cannabis reform, ASA strongly recommends leadership to improve coordination between state and local governments, and community and patient organizations on equity policy to capture and address specific issues faced by patients who require cannabis for health treatment, as well as improve program functionality. Without such coordination, well-intentioned state programs meant to promote success for equity business operators and their staff may fall short due to lack of policy proficiency and engagement at the local level of government.

The State of California and the City of San Jose provide an excellent example of this phenomenon. While the state maintains a large grant program to extend support to local governments to help cannabis equity businesses, the city is considering a ban on the use of cannabis in multi-unit housing facilities that would most significantly affect equity tenants who rely on cannabis to treat their health conditions, and affordable housing in these facilities to meet their housing needs.⁹ The city's policy proposal fails to provide scientific evidence to support the notion that a patient using medical cannabis in a housing unit has, or can have, harmful effects on another tenant in a separate unit within the same facility. Paradoxically while state and local resources may be lent to licensing cannabis equity business owners in the city, the city is simultaneously proposing to force patients relying on the medicine cultivated, manufactured and sold by these operators to choose between maintaining their health or their housing security. People should not have to choose between maintaining their health or maintaining housing.

2. Formal consultations for the National Drug Control Strategy often involve direct relationships between ONDCP and the consulting group, organization, or subject matter expert. What are recommendations on how the agency can broaden its formal consultations to gain broader perspectives earlier in the policy development process?

Americans for Safe Access understands the need to establish relationships with key stakeholder groups, organizations, and subject matter experts as we are an information provider to patients, caregivers, healthcare professionals, regulators, lawmakers, scientists, researchers and licensed cannabis businesses. As such, the information that we provide must be accurate and presented in a manner that is understandable. As the Office considers elements of federal cannabis reform, ASA encourages it to establish relationships with organizations like ASA, the American Medical Association Cannabis Task Force, the Society of Cannabis Clinicians, Doctors for Cannabis Regulation, the Cannabis Nurses Network, Cannabis Nurses of Color, the Cannabis Nurses Network, the Association for Cannabis Health Equity and Medicine, Janice Knox, M.D., and AMVETS Chief Medical Officer Cherissa Jackson, who are working to support cannabis health access and related equity issues, and who present only information that is scientifically accurate and valid.

It is important for ONDCP to engage with ASA as Congress and the administration consider steps to reform our national cannabis laws, as the Office has traditionally approached cannabis with a view consistent with the incorrect CSA Schedule I status of cannabis, which asserts that the drug

⁹ <https://www.sanjoseca.gov/home/showpublisheddocument/75513/637625516285330000>

has a high propensity for abuse and no medicinal value. As such, many of the stakeholders the Office has traditionally consulted with share this false perception of cannabis, which is at odds with the position of 37 states, the District of Columbia, four U.S. territories, 47 countries across the globe, the United Nations and the World Health Organization. With physicians in a supermajority of states now working directly with patients to apply cannabis medicine to health conditions ranging from cancer, epilepsy or neurodegenerative disorders to chronic pain, we encourage ONDCP to expand its relationships to include organizations like those mentioned above. These are stakeholders who continue to lead efforts to educate lawmakers and regulators at all levels of government on the utility of cannabis medicine, as well as help governments navigate challenges associated with authorization of cannabis medicine.

ASA has organized an advisory committee of leading physicians, researchers, cannabis testing laboratory operators, veterans' organization leaders, health condition advocacy groups and state-licensed medical cannabis businesses to help the administration and Congress understand and address the challenges of pivoting from a patchwork of diverse and poorly-functioning state medical cannabis programs to a system of functional federally-sanctioned cannabis medicine that works for patients. The committee's work is also being correlated with the American Medical Association's Cannabis Task Force. ASA would very much like to offer this committee as a resource to ONDCP as the Office considers approaches to federal cannabis policy reforms.

3. How might research examine equity in the context of law enforcement actions against drug trafficking or transnational criminal organizations? Are there existing applicable research frameworks that might be applied to ONDCP's Grant Administration Programs or other multi-jurisdictional task forces?

Like all federal departments and agencies, ONDCP currently lacks sufficient expertise to approach federal medical cannabis policy reform, or address associated equity challenges affecting patients relying on cannabis medicine. The Office's programs also do not support such efforts, as the mission of federal departments and agencies pertaining to cannabis is predicated on the falsehood that cannabis has no medicinal value and a high propensity for abuse. The impact of this classification on equity patients relying on cannabis for treatment is immense, forcing many to choose between using the medicine they need to treat their health condition and maintaining housing and employment.

Acknowledging that there are 37 states, the District of Columbia, and four U.S. territories that have reformed their laws to establish medical cannabis programs in which patients in consultation with their physicians are utilizing cannabis medicine to treat their health conditions, and 18 states, the District of Columbia and two territories who have reformed their laws to permit adults 21 years or older to possess and use cannabis, ASA encourages ONDCP to consider a new approach.

Specifically, ASA encourages ONDCP to form a commission comprised of patients, caregivers, and senior physician, health and research professionals from key fields such as neurology, psychology, palliative medicine, addiction and emergency medicine, who also possess experience in treating patients with cannabis and equity patient populations. Such a commission would provide a comprehensive review of the scope of domestic and international research conducted on the application of cannabis to health conditions, as well as associated domestic and international policy reforms of countries and world organizations. The commission could also assess the status of cannabis under the Controlled Substances Act and existing jurisdictional roles and responsibilities of federal departments and agencies related to cannabis. Finally, this commission could provide recommendations to Congress and the administration on reassignment of department and agency jurisdictions and responsibilities to facilitate federally-sanctioned

cannabis medicine and research, and address associated equity issues. ONDCP can initiate this work by revisiting interagency coordination related to cannabis research that began in 2016 under the Obama Administration.

- 4. What nationally representative private health, drug or crime databases or systems might be leveraged to provide information about equitable application of U.S. drug policy and how might access to such databases improve equitable responses? Please provide specific contact information for follow-up with those in a position to authorize dataset access.**

- 5. Provide recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of National drug control policy.**

ONDCP has traditionally approached cannabis with a view consistent with the CSA Schedule I status of cannabis – that the drug has a high propensity for abuse but no medical value. This position is at odds with the position of 37 states, the District of Columbia, four U.S. territories, 47 countries across the globe, the United Nations and the World Health Organization. With physicians in 37 states now working directly with patients to apply cannabis medicine to health conditions ranging from cancer, epilepsy or neurodegenerative disorders to chronic pain, ONDCP should consider making a distinction between patients who are using cannabis for medicinal and adult-use purposes versus people who are abusing other legal or illegal substances whom the Office has traditionally defined as “people who use drugs”. Referring to patients that use cannabis for therapeutic purposes as “drug users” implies misuse, abuse and/or addiction similar to known drugs of abuse, such as illicit use of methamphetamine or heroin, and perpetuates stigmas around cannabis use despite 37 states having implemented medical cannabis laws and much scientific research supporting cannabis as a legitimate medical therapy.

As part of ASA’s annual State of the States Report¹⁰, which identifies gaps in state medical cannabis policies and provides state regulators with recommendations to improve their programs, medical patients are surveyed about their medical cannabis usage and access. ASA welcomes the opportunity to discuss survey options with ONDCP and, as the nation’s largest patient-based cannabis advocacy organization, our members are eager to provide answers to questions that help advance medical cannabis policies related to equity and access.

- 6. What would be your recommendations for short-term and long-term goals that ONDCP should take into account to measure progress towards equity in drug policy?**

There are many steps that ONDCP can take to help in both the short and long-term to reach and measure progress on equity in federal drug policy that ASA supports. First and foremost, non-violent cannabis offenders currently serving sentences should be released and their criminal records expunged. The rate of incarceration for non-violent offenders who are charged with cannabis-related crimes is significantly higher for equity communities, which has led to the disproportionate impact of cannabis-related criminal justice on these communities. With 37 states acknowledging the medical utility and safety of cannabis and significant scientific evidence supporting the efficacy and safety of cannabis medicine, it is not appropriate, nor has it ever been, to continue incarcerating people for possessing or using medical cannabis to treat their health.

¹⁰ <https://www.safeaccessnow.org/sos>

ONDCP should also begin working internally with federal departments and agencies to lead a comprehensive review of federal cannabis policies as they exist currently, how those policies affect the health of equity communities, and how changes to the federal scheduling of cannabis under the CSA and corollary reassignments of departments and agencies would improve health outcomes for equity populations. From the Office of Personnel Management and the Department of Housing and Urban development to the Department of Veterans Affairs, Health & Human Services and the Department of Commerce, reforms must be made to facilitate a pathway to federally-sanctioned cannabis medicine and address federal policies that are disproportionately impacting the health equity communities. For example, ONDCP can work with the Office of Personnel Management to ensure that federal hiring laws no longer disqualify qualified applicants for cannabis use, or impose punitive actions against employees for use of cannabis.

If the federal government wants smart, capable and dedicated staff to carry forward the important work of the American people, it must acknowledge that many of these potential employees and contractors hail from one of 37 states with medical cannabis policies firmly in place. Qualified cannabis patients applying for federal work are like any other federal employee relying on some form of federally-sanctioned medicine to treat their health conditions, with the only exception being that this administration is choosing to discriminate against them in hiring. How can an administration so focused on removing systemic equity fail so monumentally in extending employment equity to qualified applicants based on the type of medicine they are using to treat their health?

Similarly, ONDCP can work closely with the National Institutes of Standards and Technology to reconcile the diversity of state approaches to medical cannabis product testing and labeling standards.¹¹ These varying standards coupled with federal prohibitions on cannabis patients traveling across state lines with their medicine challenge the safety and consistency of medicine, as well as increase medical expenses.¹²

Another key federal department with whom ONDCP should begin working to address equity issues associated with federal cannabis policy is the Department of Housing and Urban Development (HUD). HUDs mission to extend housing support to equity communities is compromised by the CSA Schedule I nature of cannabis. And with millions facing the loss of housing security and economic instability stemming from the COVID pandemic, it is critical that HUD work to remove discriminatory policies pertaining to cannabis and housing.

According to U.S. census data, there are nearly 4.6 million Americans who rely on federal support for housing. However, because federal law still classifies cannabis as a Schedule I substance under the CSA, any of the 4.6 million Americans who rely on federal support for housing, and who are also medical cannabis patients, are at risk of eviction even if they live in one of the 37 states where medical cannabis is legal. As a result, many of our nation's medical cannabis patients must choose daily between meeting their health and housing needs.

Currently, the largest population receiving federal housing support are seniors. A 2020 JAMA Internal Medicine research letter revealed that senior medical cannabis use doubled between 2015 and 2018, making seniors the fastest growing demographic of medical cannabis patients. Acknowledging this trend, the American Association of Retired Persons (AARP) publicly

¹¹ www.the-scientist.com/bio-business/the-wild-west-of-cannabis-testing-67175

¹² www.safeaccessnow.org/americans_for_safe_access_unveils_medical_cannabis_patient_s_guide_for_u_s_travel

expressed support in 2019 for the group's 38 million members to be able to use medical cannabis in consultation with their doctors if they live in states with legal medical cannabis access.¹³

While many seniors who live in federally-subsidized housing experience health challenges that benefit from medical cannabis treatment, such as chronic pain, insomnia, neuropathy and anxiety, current federal law places these seniors at risk of loss of housing if they legally possess or use medical cannabis where they live. No one should have to choose between using the medicine they need to treat their health and housing security.

Veterans living in one of 37 medical cannabis reform states also desperately need the leadership of ONDCP in working with the Department of Veterans Affairs (VA), as they face a confusing system of federal and state laws related to physician engagement and affordable access. For example, veterans who rely on the VA as their primary healthcare provider are unable to receive medical cannabis recommendations from their doctors, even if they live in a state with a medical cannabis program. And, veterans who use medical cannabis to treat their condition must also pay for this medication out-of-pocket with no financial support or subsidy from the VA.

20 million veterans living in the U.S. experience chronic pain, traumatic brain injuries and post-traumatic stress disorder at a higher rate than the general population,¹⁴ and typical treatment offered for these conditions relies on opioids. Two decades of a continually increasing opioid epidemic have illustrated the addictive and devastating effects of this illusory remedy, and 2021 saw the highest annual increase in opioid overdose deaths ever recorded.¹⁵ According to a 2019 National Institutes of Health (NIH) study veterans are twice as likely to die from an opioid overdose.¹⁶

Meanwhile, research continues to demonstrate the value of cannabis as a medicine in treating neurological challenges and physical pain issues. The results of the first FDA-regulated study on cannabis treatment for veteran post-traumatic stress disorder (PTSD) conducted by the Multidisciplinary Association for Psychedelic Studies (MAPS) were released in March of this year, revealing the effectiveness of cannabis in treating this condition without many of the harmful side effects of opioid use.¹⁷

Beyond advancements in research, there is also wide support among veterans for federally-sanctioned access to cannabis and education of VA physicians on cannabis as a medicine. Results of a 2017 American Legion study revealed that over 90 percent of veterans support medical cannabis research, with 80 percent surveyed also supporting allowing VA doctors to prescribe cannabis to veterans.¹⁸ In this same survey, 22 percent of veterans said that they were already using medical cannabis to treat chronic pain, PTSD, spasticity, agitation and to improve sleep quality.

In addition to VA physician consultations on cannabis from cannabis-educated physicians, the Veterans Administration must also tackle the issue of affordability of medicine. The high price of cannabis continues to be one of the greatest barriers to access reported by patients across the country. Like all medical cannabis patients, veterans who use medical cannabis to treat their condition must also pay for this medication out-of-pocket with no financial support or subsidy from

¹³ www.forbes.com/sites/abbierosner/2019/09/05/aarp-takes-medical-marijuana-mainstream/?sh=6027b244312c

¹⁴ www.radio.com/connectingvets/articles/veterans-could-use-medical-marijuana-va-help-bill

¹⁵ www.commonwealthfund.org/blog/2021/spike-drug-overdose-deaths-during-covid-19-pandemic-and-policy-options-move-forward

¹⁶ pubmed.ncbi.nlm.nih.gov/21407033/

¹⁷ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0246990>

¹⁸ www.legion.org/veteranshealthcare/239814/survey-shows-veteran-households-support-research-medical-cannabis

the VA. The cost of medicine can vary wildly depending on the state and city in which the patient lives, with monthly costs ranging from hundreds to thousands of dollars. With promising research advancing, abundant legal state access available, and 1 in 5 military veterans making the choice to use cannabis for treatment, it is time for ONDCP to help the VA, HUD, OPM and all other federal departments and agencies amend their approaches to cannabis medicine. The patients who rely on and come into contact with federal departments and agencies should not receive discriminatory treatment or punishment because they need cannabis to treat their health.

Conclusion

ASA is encouraged by this request for comment that ONDCP is prepared to lead federal cannabis policy reforms that addresses the failures of the War on Drugs and its impact on equity communities. As the Office embarks on this ambitious agenda ASA encourages partnership with our association and partners referenced in this comment letter to also ensure that federal policies that are imposing harm on cannabis patients are reformed. From patients right and civil protections affecting employment, housing, child custody, pediatric access and affordability, consistency and safety of cannabis medicine policies across federal departments and agencies must be updated. Until these policies are uniformly reconciled with state and local governments across the country, equity communities and cannabis patients will be negatively and disproportionately affected by them at a substantial cost to taxpayers.¹⁹

Sincerely,



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Americans for Safe Access

¹⁹ https://drugpolicy.org/issues/drug-war-statistics?ms=5B1_22GoogleSEM&utm_source=GoogleSEM&utm_medium=cpc&utm_campaign=SEM&cid=7011K000001SFcBQAW&gclid=CjwKCAjwmK6lBhBqEiwAocMc8haF-D5GCVwhTOxZvSgzDJ2VnnUzAQhHapVEkcYQ516fK1Vz9dbbshoCLdAQAvD_BwE