International Journal of Drug Policy 42 (2017) 109–114

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

Observations of the role of science in the United States medical cannabis state policies: Lessons learnt

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ARTICLE INFO

Article history:
Received 29 June 2016
Received in revised form 4 December 2016
Accepted 21 December 2016

Keywords:
Medical cannabis
Medical cannabis policy
United States
Role of science

ABSTRACT

Background: Clinical trials have shown cannabis to be effective in the treatment of some medical conditions and there is mounting public and political pressure to enact laws enabling the use of cannabis for medicinal purposes. To date, 28 United States (U.S.) states and the District of Columbia have enacted medical cannabis laws. This study sought to identify the main issues pertaining to the development of medical cannabis laws in the U.S, including the role of scientific evidence.
Methods: Data were collected from three groups of participants: government officials, lobbyists and medical professionals involved in the medical cannabis debate in five selected states in the U.S.; researchers from the same five states conducting funded research in the alcohol and other drugs field; and members of the International Society for the Study of Drug Policy. The data were analysed using thematic analysis.
Results: Six major themes emerged in relation to the factors influencing policy: scientific evidence plays a limited role in the development of policy; the available research is limited and mixed; there is a need for clearer communication and active dissemination of evidence to policy makers; researchers need to consider what research is likely to impact on policy; scientific evidence is not a major factor in policy development; and there is a need to consider evidence within a political context.
Conclusion: Researchers need to be aware of the political context in which medical cannabis laws are or are not enacted and consider ways in which research findings can achieve a higher profile within this context.

Introduction

Prior to 1914, any restrictions on use and distribution of drugs in the United States (U.S.) were at the state or local level, with federal control over drug use and prescription practices by medical professions thought of as unconstitutional (McBride, Terry-McElrath, Harwood, Inciardi, & Leukefeld, 2009; Musto, 1999). Drugs such as heroin, morphine, and cannabis were readily available and sold as medicines. Cannabis remained legal under federal law until the Controlled Substances Act (CSA) of 1970 (U.S. Food and Drug Administration, 2009; Eddy, 2010). The act classified all drugs into schedules, and cannabis was placed in the most restrictive, Schedule I category, which implied that it had no accepted medical use, had a high potential for abuse, and could not be used safely even under medical supervision (U.S. Food and Drug Administration, 2009).

Since cannabis' Schedule I classification there has been mounting public and political pressure to enact laws enabling the use of cannabis for medicinal purposes, with suggestions that if cannabis were moved to Schedule II to allow for its medical use, the federal government would be able to better regulate it (Belackova et al., 2015; Clark, 2000; Grinspoon, 2001; Pacula & Sevigny, 2014). The ongoing controversy over cannabis being a medicine and its adverse effects as well as the conflict between scientific evidence and political ideology have been impeding progress in the area of medical cannabis (Mather, Rauwendaal, Moxham-Hall, & Wodak, 2013; Pacula & Sevigny, 2014).

Medical cannabis advocates note that cannabis will most likely not be rescheduled until there is sufficient scientific evidence for its effectiveness and have turned to state and local governments to pass medical cannabis laws (Marshall, 2005). To date 28 states and the District of Columbia have enacted medical cannabis laws and eight states and the District of Columbia have passed laws allowing for the personal possession and consumption of cannabis by adults (National Organization for the Reform of Marijuana Laws, 2017; ProCon.org., 2017). While the state medical cannabis laws apply at

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http://dx.doi.org/10.1016/j.drugpo.2016.12.019
0955-3959/

the state level, the laws put the states in violation of federal law because cannabis is a Schedule I substance according to the CSA (Eddy, 2010; Marijuana Policy Project, 2013).

As medical cannabis measures have created a conflict between the federal prohibition on medical cannabis and state legalisation, patients, their caregivers, and cannabis providers are at risk of being arrested and prosecuted under federal law (Ferraiolo, 2008; Hall & Degenhardt, 2003; Pickerill & Chen, 2008). In August 2016 the Drug Enforcement Administration (DEA) announced that it had denied two petitions to reschedule cannabis under the CSA, maintaining that cannabis has a high potential for abuse, has no currently accepted medical use in treatment in the US and lacks accepted safety for use under medical supervision (Denial of petition to initiate proceedings to reschedule marijuana, 2016). However, the DEA also announced a policy change designed to expand the number of DEA registered cannabis manufacturers (U.S. Drug Enforcement Administration, 2016). The University of Mississippi is currently the only entity authorised to supply cannabis for research (U.S. Drug Enforcement Administration, 2016). In his paper on the drug policy governance in the United Kingdom (UK) and the classification of cannabis in the UK Misuse of Drugs Act, Monaghan (2014) pointed out that "the issue of cannabis classification gained prominence because it was linked to an increasing preoccupation amongst academics, policy makers and the public over the way that evidence is used, misused or unused in policy making" (p. 1026).

It is important to determine the role scientific evidence plays in public health policymaking and identify factors it contends with in the sometimes arduous policymaking process (Birkland, 2005; Ritter, 2009). In the current study, we explored the role scientific evidence played in medical cannabis policymaking from the perspective of the individuals directly or indirectly involved in the drug policy field.

Method

Participants

We studied a convenience sample of three groups of participants directly or indirectly involved in the drug policy field. Group One participants were all from the U.S. and were identified through a review of publicly available literature including government publications, newspaper articles, court documents, and press releases as actively or previously involved in the medical cannabis debate in at least one of five states chosen for their contrasting roles in the medical cannabis legalisation process. The states chosen for the review were Michigan, New Mexico, Illinois, Kentucky and Louisiana (Grbic, 2015). Michigan was chosen as a representative state for medical cannabis laws passed by ballot initiative, while New Mexico was chosen as a representative state for medical cannabis laws passed by the legislative process. The states were chosen because they were the most recent states to pass a medical cannabis law at the time the broader study from which this paper is drawn was conducted in 2011 and 2012. Illinois was chosen as a state which is considering medical cannabis laws, but had not passed one at the time (Illinois became the 20th state in the U.S. to legalise medical cannabis in July 2013). Kentucky was chosen as a state which had no medical cannabis laws and had not considered one, while Louisiana was a state which had not considered passing a medical cannabis law, but had an ineffective, symbolic, medical cannabis law on its books.

Group One participants included government officials, lobbyists, and medical professionals. A total of 172 individuals were invited to participate; 31 (18%) completed our questionnaire online or via mail. State representation ranged from 10 respondents from Illinois to 1 from Kentucky.

Group Two comprised researchers in one of the five target states who were conducting research funded by either the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, or the Substance Abuse and Mental Health Service Administration; 209 participants were contacted via email and invited to complete the questionnaire online, and 23 (11%) did so. Target state representation ranged from 11 Illinois-based researchers to 1 researcher each from Louisiana and New Mexico. The majority of Group Two researchers (78%) indicated that they were at least somewhat aware of the medical cannabis debate in their state.

Group Three participants, all members of the International Society for the Study of Drug Policy, were selected to further explore the themes developed through the responses to the Group One and Two questionnaire and the review of the medical cannabis debate in the five target states, and obtain a general overview of the factors influencing medical cannabis and other drug policies. The participants were interviewed in the order they responded to the invitation to participate and until data saturation was reached (i.e., when no new or relevant information emerges from the data and the information obtained from participants becomes repetitive) (Liamputtong & Ezzy, 2005; Mason, 2010). Ten Group Three participants were interviewed. All had research experience in drug policy.

Measures and procedure

Prior to beginning the study, approval was obtained from the Edith Cowan University Human Research Ethics Committee. The data collection period for Groups One and Two spanned from mid-October 2010 to mid-January 2011.

Themes emerging from a review of journal articles, newspaper articles, legislative proceedings, and court documents relating to medical cannabis policies in five target states were used to develop a questionnaire which was sent to Groups One and Two. The first section of the questionnaire covered participants' opinions on medical cannabis, scientific evidence, and the importance of factors such as advocacy groups, politicians, and money in determining whether medical cannabis legislation is enacted or not. Participants were also asked to rate factors identified through the state by state review in terms of their level of influence on medical cannabis legislation. Closed-ended items covered participants' opinions about a variety of factors and are discussed elsewhere (Grbic, 2015). The second part of the questionnaire involved open-ended questions relating to the medical cannabis debate and both general and state-specific factors influencing medical cannabis legislation are discussed in Results (below). Examples of questions included "In your opinion, which factors influenced the passing or failure to pass medical cannabis legislation in your state?" and "Does scientific evidence play a role in the medical cannabis debate in your state? If so, what role does it play?" The participants were identified by their group number followed by the individual number (assigned by order of completion).

Group Three data collection period spanned from mid-February to late April 2011 and involved semi-structured telephone interviews incorporating nine open-ended questions. The questions helped guide the interaction between the participants and the researcher (J. G.), while still allowing participants an opportunity to raise and discuss pertinent issues (Liamputtong & Ezzy, 2005). Examples of questions included "What role do you think scientific evidence generally plays in policy-making?" and "In your opinion, which factors influenced the passing of medical cannabis legislation in 15 U. S. states (such as Michigan, and New Mexico) since 1998?" (At the time of interview, only 15 U.S. states had enacted medical cannabis laws). The questions were based on themes derived from the state reviews and Group One and Two results.