Policy/Position Statement of the American Cannabis Nurses Association

The Impact of Descheduling and Decriminalizing Cannabis

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Purpose

Cannabis has a long history of being used successfully to treat medical conditions. However, politics and greed have led to its criminalization over the course of the 20th century. The American Cannabis Nurses Association (ACNA) believes the time has come to deschedule and decriminalize cannabis based on the current science.

Overview

The American Cannabis Nurses Association (ACNA) membership is composed of nurses who work directly with patients on medical cannabis therapeutics and who are invested deeply in understanding cannabis, including the current research. Many of these nurses hold advanced degrees, some of which are specifically cannabis-focused. ACNA members are well versed in the current research of cannabis. Cannabis care nurses have many combined years of experience witnessing first-hand the positive outcomes of medical cannabis therapeutics in their patients. A 2019 survey of the ACNA membership reflects this fact. According to the 2019 ACNA survey, ACNA members' support for descheduling cannabis was 67%, and 29% supported at least rescheduling it within the Controlled Substance Act.

The American Cannabis Nurses Association is aligned with the American Nurses Association (ANA) in acknowledging that as long as cannabis remains a Schedule I drug, ongoing research is blocked. This makes it difficult to establish evidence-based guidelines in providing cannabis nurse care to alleviate chronic disease symptoms. The ANA's position for 20 years is that cannabis patients should have access to medication without fear of prosecution (ANA, 2016). The ACNA supports and upholds this same belief!

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We are in alignment with the National Organization for the Reform of Marijuana Laws (NORML), Americans for Safe Access (ASA) and Patients Out of Time (POT). These organizations comprise the largest national member-based organization of patients, medical professionals, scientists, and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research. Both NORML and ASA convey that it is imperative to deschedule and decriminalize cannabis (ASA, 2020; Armentano, 2016). Rescheduling cannabis as a Schedule II drug places it in the same category as cocaine. This scheduling classification option does not remove barriers to access without fear of prosecution, maintains government control over access, and limits research opportunities.

Americans overwhelmingly support the use of medical cannabis. Sixty percent (60%) support recreational use, 91% support medical use, and **fewer than 1 in 10 say cannabis should not be legal for adults** (Pew Research Center, 2021). The American public will continue to use cannabis regardless of its legal status at the federal level. Federal descheduling and decriminalization allows adults to freely choose to incorporate medical cannabis into the management of their conditions, and allows cannabis care nurses and healthcare providers to work openly with patients. This will lead to safer cannabis consumption and reduce harm.

Current State Legislation

Current legislation related to cannabis varies with each state. At the time of this position statement, thirty seven (37) states, the territory Guam, and the District of Columbia have enacted legislation to regulate cannabis for medical use (National Conference of State Legislators, 2022).

Current Federal Legislation

Presently, there have been 117 bills introduced that relate to various aspects of cannabis decriminalization at the federal level in the U.S. House of Representatives and the Senate (United States Congress, 2021a-d). H.B. 3617, the Marijuana Opportunity Reinvestment and Expungement Act of 2021 (MORE Act of 2021), encompasses the key elements of all other bills currently being processed by the U.S. House of Representatives.

The MORE Act of 2021 essentially decriminalizes and deschedules cannabis at the federal level, including removal as a scheduled drug under the Controlled Substance Act and removal of criminal penalties for all aspects of cannabis from manufacturing to possession. The following additional changes are included in

this bill:

- The Department of Labor will begin publishing data on cannabis-related business owners, employees, and the cannabis job market.
- Funding will be made available to help those negatively impacted by the "war on drugs" due to cannabis related offenses.
- Certain cannabis-related conduct or convictions will no longer prevent individuals, including immigrants, from being able to access federal public benefits. Furthermore, immigrants will not be denied immigration protection laws.
- Cannabis will be taxed at the federal level, bringing in the needed funds to help with our ever-growing federal deficit.
- Banks will be able to provide services to cannabis-related businesses. Small businesses loans will be made available to cannabis-related businesses.
- A process will expunge convictions and conduct sentencing review hearings for those prosecuted for federal cannabis offenses.
- The Government Accountability Office will be required to study the impact of cannabis legalization on society.

A letter of intent regarding cannabis legalization was submitted by Senator Chuck Schumer (D-NY) to House Speaker Nancy Pelosi (D-CA). At the end of January 2022, Senator Schumer announced that he intended to invite fellow senators from both parties to collaborate in creating a bill to address federal cannabis legalization with a goal of submission to the U.S. Senate in April 2022. He is calling this bill the Cannabis Administration and Opportunity Act (CAOA). Information released to date indicates the CAOA will include similar key components to the MORE Act (United States Congress, 2022).

In November 2021, H.R. 5977, U.S. Representative Nancy Mace (R-SC) introduced The States Reform Act to the U.S. House of Representatives. This bill, if enacted, would remove cannabis from the Schedule I Controlled Substance Act and place regulations under the U.S. Food and Drug Administration and U.S. Department of Agriculture. It includes provisions for federal taxation and commerce, both domestic and international. It has a provision for expungement of criminal records for non-violent domestic cannabis-related charges, excluding driving under the influence charges. The bill does not provide for reparation to individuals or communities impacted by the war on drugs. The bill does not correct the misuse of the words

marijuana and marihuana in current government documents. Instead, it intermixes these terms with cannabis, lending to further confusion. This bill has not attracted the public's attention nor does it share the same level of co-sponsors as the MORE Act (United States Congress, 2021c).

Medical Cannabis and Research

Medical cannabis is a natural botanical medicinal derived from the cannabis plant. Current limited research has demonstrated potential efficacy to treat a variety of medical conditions without addiction or side effects when used as medicine. Only 9% of those who try cannabis develop an addiction called *cannabis use disorder* (Centers for Disease Control and Prevention [CDC], 2020). Some therapeutic properties of cannabis established through rigorous scientific research include:

- Pain modulation.
- Potent anti-inflammatory.
- Anti-convulsant.
- Improve sleep.
- Improve appetite.
- Anti-tumor.
- Nausea and chemotherapy/cancer care side effect relief.
- Bronchodilator.
- Antibiotic properties.
- Antianxiety.
- Neuroprotectant properties.
- Memory disruption (application for post-traumatic stress disorder [PTSD], substance abuse).

Tetrahydrocannabinol (THC) was identified in 1964 by Dr. Raphael Mechoulam and colleagues at the Hebrew University of Israel. Dr. Allyn Howlett and colleagues at St. Louis University discovered the cannabinoid receptor in 1988 (Goldstein, 2016). Further research in the 1990s gave rise to the discovery of the endocannabinoid system (ECS), cannabinoid receptors CB1 and CB2, and endocannabinoids (Konieczny & Wilson, 2018). The endocannabinoid system is "an extensive network of neurons, neural pathways, receptors, cells, molecules, and enzymes that work tirelessly throughout the body to maintain a state of homeostasis" (Konieczny & Wilson, 2018).

These landmark discoveries led to further research exploring the potential uses of cannabis and its various cannabinoids in the treatment of diseases. Since that time, peer-reviewed journals have been publishing research that demonstrates the clear medical benefits of cannabis in treating the conditions listed above. Research has demonstrated that the rate of deaths due to opioid overdose has dropped an average of 25% in states that have legalized medical cannabis (ASA, 2020). IN 2018, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a "landmark comprehensive study culling together and reviewing research findings dating back to 1999 related to the recreational and medical use of cannabis" (Clark, 2021). The report concluded there is evidence to support medical cannabis use for the treatment of chronic pain, symptoms of multiple sclerosis, and chemotherapy-induced nausea and vomiting.

The current status of cannabis as a Schedule I controlled substance "has impeded the advancement of research in the United States, leaving providers with little evidence-based information to educate their patients and has resulted in limited evidence for its safety and efficacy (Ryan et al., 2021). The NASEM (2017) states that current federal restrictions on cannabis pose a public health risk by preventing the study of the potential health effects of cannabis and cannabinoids.

The demand for cannabis for research purposes has increased by 40% over the past two years; however, the U.S. Drug Enforcement Agency (DEA, 2019) currently controls all sources of cannabis used for research. This control eliminates researchers from exploring the effects of cannabis with different cannabinoid and terpene profiles. Today, the classification of cannabis as a Schedule I drug requires researchers who want to examine both the therapeutic and adverse effects of cannabis to obtain approval from the National Institute of Drug Abuse (NIDA) and the DEA. The researcher must then obtain a Schedule I license and request cannabis from the University of Mississippi, the only DEA-licensed cannabis cultivator in the United States (Ryan et al., 2021). Federal descheduling would remove the hurdles researchers have to navigate to obtain the proper authorizations and allow access to a wider variety of cannabis for the purpose of studying the impact of cannabis on patients and the public.

Education of Healthcare Professionals

In 2018, the National Council of State Boards of Nursing (NCSBN) published *The NCSBN National Nursing Guidelines for Medical Marijuana*. This guide outlines the six principles of essential knowledge related to cannabis therapeutics. Unfortunately, the guidelines are still not being taught in the vast majority of nursing programs. In their published study, Clark and Parmelee (2021) reported only 7% of nursing students had received formal cannabis education in their nursing program, and most of their knowledge came from media sources.

A 2017 survey by Carlini and colleagues conducted among primarily internal medicine physicians reported that respondents had low knowledge and comfort level related to medical cannabis. Respondents rated medical cannabis knowledge as important and supported medical cannabis training in the medical/health provider curriculum (Carlini et al., 2017). According to a report conducted in 2017, only 9% of medical schools have added it to their curriculum (Evanhoff, et al., 2017). In a 2016 survey conducted among oncologists, only 30% reported they were sufficiently informed on the medical use of cannabis, although 65% felt it was equally or more effective than traditional treatments for some symptoms associated with cancer (Braun et al., 2018).

Universities and medical schools have avoided adding content on the endocannabinoid system and medical cannabis for a variety of reasons, one being its Schedule I status. Descheduling cannabis on a federal level will allow institutions of higher education to maintain their federal source of funding.

Federal illegalization of cannabis means institutions of higher education must monitor, enforce, and sanction any student or faculty that violates the 1989 Drug-Free Schools and Campuses Act. This regulation requires that schools teach students and faculty of the dangers associated with illegal drugs. Since cannabis is considered illegal at the federal level, teaching that it can be used as a primary treatment or adjunct to other medical therapies would be illegal. Doing so could cause that institution to have all forms of financial assistance terminated by the U.S. Secretary of Education (eFCR, 2022).

Descheduling cannabis may encourage educational institutions to add much needed content to their programs. Medical and nursing schools would be liberated to provide content that educates students regarding the positive aspects of using cannabis as primary treatment or as adjunct therapy. Nurses would

be able to provide appropriate nursing interventions related to cannabis use regardless of purpose (recreational or medical). In turn, having professionals educated in the use of cannabis allows for appropriate nursing interventions and open dialog with nurses' patients.

Social Justice and Equity

Disparities in legalization status from state to state and between states and the federal government have created severe health and social inequities due to limitations on access and from criminal prosecutions (Ryan et al., 2021). The primary social justice and equity tenets of cannabis prohibition include lack of access, cost, a disproportionate impact on minorities, and the unfair impact of criminalization.

The Drug Enforcement Agency's *Cannabis Eradication Program* spent over $67 million between 2012 and 2016 (DEA, 2016). They have not published more recent figures nor released figures regarding spending from the time of inception of the program (1979 to 2012), but they continue to operate this program (DEA, 2021). The average cost of incarceration for one inmate was over $36,000 in 2018 (U.S. Bureau of Prisons, 2018). The U.S. Bureau of Justice reports it costs taxpayers $80 billion annually to incarcerate nearly 2.3 million prisoners. Total state spending on correctional institutions was approximately $42.1 billion in 2016 (Wilson & Lemoine, 2021). According to the American Civil Liberties Union, 43% of all drug arrests were for cannabis, and 89% of those were for possession only in 2018. Blacks are 3.64 times more likely to be arrested for possession than whites even though the rates of use are the same, even in states that have legalized cannabis (Edwards et al., 2020). Any legislation passed must address the inequities prohibition created.

According to a 2019 survey completed by the ASA (2020), 70% of patients on medical cannabis therapeutics believed their medicine was unaffordable, and nearly one-quarter stated it is so cost-prohibitive, they must go without their treatment. Additionally, many reported the high costs associated with enrolling in a state's program to be prohibitive. The fee to enroll in a state's program ranges from $1.00 in Washington to $350.00 in Arizona. This is in addition to the cost of the healthcare provider appointment. Federal descheduling could reduce the cost of medical cannabis for the over 4 million patients enrolled in medical programs throughout the United States (ASA, 2020).

Decriminalization would make the Cannabis Eradication Program unnecessary. Expungement of criminal

records would allow those who have served time for minor cannabis-related crimes equity in their ability to obtain housing and employment. The cost of incarceration would also be greatly reduced by decriminalization.

Federal decriminalization would address the social inequity faced by individuals in non-legal states who are unable to readily access medical cannabis and if caught in possession face criminal prosecution. Those who live in states in which legalization has been established face several barriers based on individual state laws.

State laws have placed limitations regarding the amount that can be legally possessed, grown for personal use, or purchased. The legal ratio of cannabinoids, primarily tetrahydrocannabinol to cannabidiol, also varies from state to state. The legal process for obtaining a medical cannabis (marijuana) card varies from state to state. Insurance does not pay for this process nor covers the cost of medical cannabis products.

Employees as Patients Taking Medical Cannabis

Cannabis is a Schedule I substance, placing it the category of drugs that have no currently accepted medical use and a high potential for abuse. Despite this federal scheduling of cannabis, an estimated 3 million Americans are currently using cannabis to treat one or more medical conditions (ASA, 2020).

Currently, employers are at liberty to deny employment and fire employees who have a positive cannabis drug test, including healthcare workers. Descheduling cannabis would allow employees who use cannabis medically to be in a position of health equity; this includes nurses and other healthcare workers.

Safety and Quality

Descheduling cannabis federally, while allowing for best practices, will leave in place a patchwork of different state laws. Legislation that deschedules cannabis needs to protect existing cannabis businesses. States, along with federal regulations, need to identify best practices for the interstate commerce of cannabis. Several conflicts exist between state and federal laws, potentially creating confusion, which will lead to logistical and ethical problems (Ryan et al., 2021).

The greatest concern is the Dormant Commerce Clause found in Article IV of the Constitution. It places

limits on state sovereignty in having laws to protect the interests of its citizens as it relates to interstate commerce (Title & Kline, 2021). Ambiguity raises concern that passage of any federal cannabis legalization will automatically nullify state regulatory laws for the quality and safety of products being shipped into their state for consumer use. Editorial and commentaries have been written voicing this concern (Lawrence, 2021; Tobin & Kline, 2022). The Dormant Commerce Clause will have an impact on state laws, potentially leaving consumers at risk.

Descheduling on a federal level will allow current standards of manufacturing to be a safety net for the consumer. Good Manufacturing Processes (GMP) is mandatory for producers of pharmaceuticals, medical devices, food and beverage, dietary supplements, and cosmetics (Code of Federal Regulations, 2022). GMP documents all steps and materials used in production. Adding cannabis to this manufacturing process will improve safety; currently, GMP covers all aspects of production to assure a safe product in the end.

The conflict between state and federal laws creates healthcare disparities and increases the risk of discrimination and prosecution because medical cannabis laws vary by state. For example, one medical condition approved in one state may not be approved in another. States have placed limits on everything from the amount of medical cannabis a patient can grow or have in their possession, the amount they can purchase, to the level of THC their cannabis may contain. In some states, patients are required to have an extensive mental health examination, while in others, the requirements are much more lenient (ASA, 2020).

Currently, there are only six states that have anti-discrimination laws to protect medical patients. Patients taking medical cannabis and living in any other state face discrimination related to access, employment, and housing. Furthermore, all patients taking medical cannabis face potential prosecution. “However, simply moving marijuana to a less restrictive Schedule would not protect existing state medical marijuana programs or change federal penalties for possessing, cultivating and distributing marijuana. It would not prevent people from being arrested and punished for using marijuana” (Drug Policy Alliance, 2019).

Descheduling could provide the much needed safety net related to best dosing practices and administration methods. A 2021 study reported that 64% of medical patients initiated cannabis use without discussing it with their primary care physician. Reasons cited for not communicating medical cannabis use included fear

of legal trouble and the stigma associated with its use (Boehnke et al., 2021).

Recommendations

Our understanding of both the human endocannabinoid system and how cannabis can positively influence health conditions has expanded. We now know that cannabinoids can be effective in the treatment of several medical conditions as demonstrated through recent research. We also know it is not highly addictive and does not result in death, deprivation, or increased crime as previous claims purported.

The American Cannabis Nurses Association supports descheduling and decriminalizing cannabis based on the current science. Furthermore, we support the establishment of a federal regulatory process to protect the consumer from dangerous, low-quality cannabis products; inclusion of cannabis therapeutics in the curricula of all students enrolled in healthcare education programs of study; and provision of reparation to individuals and communities negatively impacted by the prohibition of cannabis.

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ACNA Mission Statement

To advance excellence in cannabis nursing practice through advocacy, collaboration, education, research, and policy development.

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