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VIA EMAIL

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Dear Oregon Board of Pharmacy,

I am writing to submit my comments regarding the proposed rescheduling of marijuana (*Cannabis sativa*) in the state of Oregon. It is my understanding that three criterion are considered when determining how a substance should be scheduled, these being: (1) whether there is an accepted medical use; (2) the degree of abuse potential; and (3) the risk of physical and/or psychological dependence.

As the state of Oregon, under the Oregon Medical Marijuana Program, recognizes certain medicinal applications of marijuana it would be inappropriate for marijuana to remain in Schedule I under Oregon's regulatory system. This leaves us with the task of determining which of the remaining 4 schedules is most appropriate.

Under Schedule II, a substance must have a "high potential for abuse" and must have the potential of leading to "severe psychological or physical dependence." As a substance abuse counselor it is my experience that marijuana has a significant potential for abuse among individuals entering into drug treatment, however, marijuana is generally not the primary substance of abuse among these individuals. I feel that this particular criterion is very subjective since a "high potential for abuse" does not provide any clear indication of what the resulting impact of a particular substance on society may be. Upon reviewing the minutes of your August meeting last year, it appears that several individuals in law enforcement and various district attorneys' offices suggested that marijuana use contributes to increasing crime and violence. Apparently there was also testimony to the effect that marijuana is the number one illegal drug for DUII. This makes sense when one considers that marijuana is the most widely available illicit drug, but this statistic is misleading due to the information that it leaves out. This information provides no comparison between the proportion of DUII connected with alcohol or with prescription drugs. Out of the 200+ individuals court mandated into treatment for DUII that I have worked with I had only one client mandated into treatment for DUII based on marijuana alone. In this particular case the client was in possession of marijuana in his vehicle but was never shown to be intoxicated. Information like this that is presented in a slanted way is not only unhelpful, but

unprofessional and I feel harmful to maintaining a clear and objective process. The other allegations made in this testimony do not discuss whether marijuana is a secondary or primary contributor to addiction and/or criminal behavior, nor do they really address the question at hand: whether marijuana has a “high potential for abuse.”

I feel that the most important criteria in the scheduling process are determining the level of physical and psychological dependence that is brought about by marijuana use. There are studies that have found some symptoms of physical withdrawal associated with heavy marijuana use, although the symptoms seem to be limited to sleep disturbance (ie: insomnia and night sweats). I have not come across any studies or materials that suggest any severe symptoms associated with marijuana withdrawal that might lead to physical harm or anti-social behavior. Also, the results of these studies were limited to heavy users. Unfortunately, I do not have the information at my fingertips as to what qualified as a heavy user.

The real addiction potential with marijuana appears to be limited to psychological addiction. Psychological addiction is a tricky phenomenon that can be triggered by drug and non-drug activities alike, such as gambling, shopping and over-eating. Compulsive behaviors have less to do with the chemistry of any particular substance than they do with the chemical and physiological make-up of the individual, although the euphoric effects of drugs ultimately contribute to the continuation of such behaviors. Although psychological addiction is a risk with marijuana, there is limited information on the severity of the impact that psychological addiction to marijuana poses to the user.

The degree to which marijuana has a potential for abuse is debatable. Physical addiction to marijuana is a possibility in heavy users, though withdrawal symptoms tend to be minor. Psychological addiction is a very real risk with marijuana, but it remains difficult to qualify what the impact of psychological addiction is on the user. Given the above information I do not believe that marijuana is appropriate for Schedule I or II. Schedule III requires a moderate to low possibility of physical dependence with a high risk of psychological dependence. Marijuana poses a low risk for physical dependence and poses a risk for psychological dependence as well, though I would not qualify it as a high risk. Of course, this could be up for debate. The only complimenting factor for determining a classification of Schedule III might be the placement of Marinol in Schedule III at the federal level.

It is my opinion that a placement in Schedule IV or V would be the most appropriate. The criterion for these schedules requires that marijuana’s abuse and addiction potential be compared to the substances in the Schedule immediately preceding. Schedule III, among other substances, includes hydrocodone, codeine and buprenorphine. These substances are known to produce moderate physical dependence at low levels of use, whereas marijuana has a low potential for producing physical dependence. This I think bodes in favor of placing marijuana in Schedule VI or V as marijuana has a lower abuse potential than these drugs and the potential for dependence with marijuana is more limited than with the above medications.

I hope that you will consider all the evidence and testimony that has been presented and balance this information according to the appropriate criteria. I am sure that you are aware that testimony will be

biased depending on the source of the testimony. This should not prevent you from objectively examining the facts and information presented and coming to a fair and appropriate conclusion.

Thank you,

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