U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

July 25, 2008

The Honorable John Conyers, Jr.
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your letter, dated April 29, 2008, inquiring about the efforts of the Drug Enforcement Administration (DEA) to enforce federal law with respect to marijuana traffickers in California. We appreciate your interest in this issue. As you are aware, there has been a significant amount of misleading information circulating about DEA's activities, and we welcome the opportunity to share with you how the Department of Justice (DOJ) and DEA are meeting our obligations under federal law, and how the unlawful trafficking in marijuana taking place in California under the guise of "medicine" is detrimental to the public health and safety.

As you know, marijuana is a schedule I controlled substance under the Controlled Substances Act (CSA).[1] Marijuana remains in schedule I consistent with the fact that the drug has never been approved by the Food and Drug Administration (FDA) for marketing in the United States because scientific studies have never established that marijuana can be used safely and effectively for the treatment of any disease or condition.[2] Marijuana's placement in schedule I of the CSA results in the following legal consequences: marijuana may not be dispensed for medical use in the United States; it is illegal to manufacture, distribute, or possess marijuana for any purpose (other than Government-approved research); and there is no "medical necessity" defense to the CSA prohibitions relating to marijuana.[3]

Marijuana also is a schedule I controlled substance under California law,[4] but pursuant to a 1996 voter referendum, California decriminalized the cultivation and possession of marijuana by any person who has obtained from a physician a "recommendation" that marijuana would benefit that person's health. Nonetheless, as the Supreme Court's decisions in *United States v. Oakland Cannabis Buyers' Cooperative*

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[1] 21 U.S.C. § 812(c), Schedule I(c)(10).
[2] *See* 66 Fed. Reg. 20038, 20050-52 (2001) (DEA denial of petition to remove marijuana from schedule I based on FDA scientific and medical evaluation), *pet. for review dismissed, Gettman v. DEA*, 290 F.3d 430 (D.C. Cir. 2002).
[3] *United States v. Oakland Cannabis Buyers' Cooperative* 532 U.S. 483, 491, 494 & n.7 (2001).
[4] Ca. Health & Safety Code § 11054.

(*OCBC*)[5] and *Gonzales v. Raich*[6] make clear, regardless of the California marijuana legalization law, it remains illegal under the CSA for any person to cultivate, distribute, or possess marijuana for claimed "medical reasons."

Please also note that the effectiveness of CSA depends on maintaining the integrity of the "closed system" of distribution of controlled substances established by the Act.[7] Through this closed system, the CSA "provides for control of problems related to drug abuse through registration of manufacturers, wholesalers, retailers, and all others in the legitimate distribution chain, and makes transactions outside the legitimate distribution chain illegal."[8] One of the central elements of this closed system is that all transactions in controlled substances undertaken by DEA registrants involve strict record-keeping requirements to ensure proper accounting and prevent diversion.[9] Those who engage in illicit manufacturing and distribution of marijuana (such as the California "cannabis clubs") obviously act wholly outside the closed system mandated by the CSA.

Under federal law, marijuana has been classified as a schedule I substance since Congress enacted the CSA in 1970. However, as with any controlled substance, marijuana may be rescheduled if new evidence so dictates. The CSA provides a statutory procedure that allows any drug to be rescheduled in light of changes in the factors relevant to scheduling, such as new patterns of abuse and increased understanding about the drug's pharmacological effects. Under the CSA, any person who believes that new evidence warrants the rescheduling of a particular drug may petition DEA to initiate rescheduling proceedings. Before initiating such proceedings, DEA must obtain from the FDA a scientific and medical evaluation and scheduling recommendation. If the FDA evaluation and other relevant data constitute substantial evidence that the drug should be rescheduled, DEA must initiate rulemaking proceedings to reschedule the drug accordingly.[10]

To date, there are no data from adequate and well-controlled clinical trials to support any of the claimed therapeutic uses for smoked marijuana. In 2001, DEA published in the Federal Register the agency's response to a petition seeking to initiate rulemaking proceedings to reschedule marijuana.[11] The FDA and DEA thoroughly analyzed the relevant medical, scientific, and abuse data and concluded that marijuana continues to meet the criteria for placement in schedule I. The complete FDA and DEA analyses were published in the Federal Register along with the denial of the petition. With respect to whether marijuana can be used safely and effectively as medicine, the FDA noted that "there have been no studies that have scientifically assessed the efficacy

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[5] 532 U.S. 483 (2001).
[6] 545 U.S. 1 (2005).
[7] H.R. Rep. No. 91-1444 at 6 (1970).
[8] *United States v. Moore*, 423 U.S. 122, 135 (1975) (quoting *id.* at 3).
[9] 21 U.S.C. § 827.
[10] 21 U.S.C. § 811; 21 C.F.R. §1308.43; *see Gettman v. DEA*, 290 F.3d 430, 432 (D.C. Cir. 2002) (explaining CSA rescheduling procedures).
[11] 66 Fed. Reg. 20038 (2001).

of marijuana for any (emphasis added) medical condition" and that "[t]here are no FDA-approved marijuana products." The FDA concluded:

> Marijuana does not have a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions. As discussed earlier, the known risks of marijuana use are not outweighed by any potential benefits. In addition, the agency cannot conclude that marijuana has an acceptable level of safety without assurance of a consistent and predictable potency and without proof that the substance is free of contamination. If marijuana is to be investigated more widely for medical use, information and data regarding the chemistry, manufacturing and specifications of marijuana must be developed. Therefore, FDA concludes that, even under medical supervision, marijuana has not been shown to have an acceptable level of safety.
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> FDA therefore recommends that marijuana be maintained in schedule I of the CSA.[12]

FDA has recently reiterated this determination, stating that "there is currently sound evidence that smoked marijuana is harmful," and "that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use."[13]

As the foregoing indicates, the CSA criteria for determining whether a controlled substance may be transferred out of schedule I overlap substantially with the medical and scientific considerations involved in the FDA drug approval process under the Food, Drug, and Cosmetic Act (FDCA).[14] It is therefore not mere coincidence that all schedule I controlled substances, including marijuana, lack FDA approval. The FDA approval process has protected the public for decades, and serves as the model for all nations. For the United States to remain the safest country in which to purchase medicine, adherence to the rigorous scientific criteria required by the federal drug approval laws must remain mandatory and not be allowed to be superseded or circumvented by state law or referendum.

The impact of marijuana on young persons warrants additional consideration. The Director of the National Institute for Drug Abuse, Nora Volkow, M.D., has stated that, "Although the overall number of young people using marijuana has declined in recent years, there is still reason for great concern, particularly since roughly 60 percent

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[12] 66 Fed. Reg. at 20052.

[13] "Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine." U.S. Food and Drug Administration, April 20, 2006), *available at* http://www.fda.gov/bbs/topics/NEWS/2006/NEW01362.html.

[14] *See* 57 FR 10499 (1992) (setting forth criteria for determining whether a controlled substance has a currently accepted medical use within the meaning of the CSA), *pet. for review dismissed, Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994).

of first-time marijuana users are under 18 years old. During adolescence and into young adulthood, the brain continues to develop and may be vulnerable to marijuana's deleterious effects. Science has shown marijuana can produce adverse physical, mental, emotional and behavioral changes, and . . . it can be addictive."[15]

These conclusions are not unique to the federal government. In 1999, the Institute of Medicine (IOM), a component of the National Academy of Sciences, conducted a review of the scientific evidence regarding the potential health benefits and risks of marijuana and its constituent cannabinoids. The IOM report stated, among other things: "Defined substances, such as purified cannabinoid compounds, are preferable to plant products, which are of variable and uncertain composition. Use of defined cannabinoids permits a more precise evaluation of their effects, whether in combination or alone."[16] With respect to this issue, the IOM reached the following conclusion: "Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances."[17] The report further stated:

> The therapeutic effects of cannabinoids are most well established for THC, which is the primary psychoactive ingredient of marijuana. But it does not follow from this that smoking marijuana is good medicine.
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> Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. In addition, plants contain a variable mixture of biologically active compounds and cannot be expected to provide a precisely defined drug effect. For those reasons there is little future in smoked marijuana as a medically approved medication. If there is any future in cannabinoid drugs, it lies with agents of more certain, not less certain, composition."[18]

Of note, both the IOM and the FDA support research into the possible medical utility of *individual chemical components* of marijuana, as distinguished from research into the medical utility of smoked marijuana. Marijuana contains at least 483 different chemicals, the effects of which are either uncertain or likely to be highly detrimental to humans, as the FDA and the IOM have indicated. While there have been some preliminary clinical trials conducted toward the goal of investigating the possible medical utility of smoked marijuana, preliminary phases of clinical research must be distinguished

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[15] Press Release, Office of National Drug Control Policy, Study Finds Highest Levels of THC in U.S. Marijuana To Date: 20 Year Analysis of Marijuana Seizures Reveals a Doubling In Pot Potency Since Mid-80's (April 25, 2007), *available at* http://www.whitehousedrugpolicy.gov/news/press07/042507_2.html.
[16] Institute of Medicine, Marijuana and Medicine: Assessing the Science Base 4 (J. Janet E. Joy et al. eds. 1999).
[17] *Id.*
[18] *Id.* at 177-178.

from later phases of research.[19] Preliminary scientific trials are not designed to – and cannot, as a scientific fact – demonstrate that a drug can be used safely and effectively as medicine.

Many medical organizations have issued statements regarding marijuana that are consistent with the federal government's position. A few of these notable organizations include:

- **The American Medical Association,** which rejected pleas to endorse marijuana as medicine and instead urged that it remain a prohibited, schedule I controlled substance, at least until more research is done.[20]

- **The American Cancer Society,** which "does not advocate inhaling smoke, nor the legalization of marijuana, although the organization does support carefully controlled clinical studies for alternative delivery methods, specifically a THC patch."[21]

- **The American Academy of Pediatrics,** which expressed the view that any change in the legal status of marijuana, even if limited to adults, could affect the prevalence of use among adolescents, and while it supports scientific research on the possible medical use of cannabinoids as opposed to smoke marijuana, it opposes the legalization of marijuana.[22]

- **The National Multiple Sclerosis Society,** which stated that it could not recommend that medical marijuana be made widely available for people with multiple sclerosis (MS) for symptom management, explaining: "This decision was not only based on existing legal barriers to its use but, even more importantly, because studies to date do not demonstrate a clear benefit compared to existing symptomatic therapies and because issues of side effects, systemic effects, and long-term effects are not yet clear,"[23] and

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[19] Clinical trials generally proceed in three phases involving successively larger groups of patients: 20 to 80 subjects in phase I; no more than several hundred subjects in phase II; and several hundred to several thousand subjects in phase III. 21 CFR 312.21. After completing the clinical trials, the sponsor files a new drug application containing, among other things, "full reports of investigations" showing whether the "drug is safe for use and ... effective"; the drug's composition; a description of the drug's manufacturing, processing, and packaging; and the proposed labeling for the drug. 21 U.S.C. § 355(b)(1).

[20] "Policy H-95.952 'Medical marijuana." American Medical Association.

[21] "Experts: Pot Smoking Is Not Best Choice to Treat Chemo Side-Effects." American Cancer Society. May 22, 2001, *available at* http://www.cancer.org/docroot/NWS/content/update/NWS_1_1xU_Experts_Pot_Smoking_Is_Not_Best_Choice_to_Treat_Chemo_Side_Effects.asp.

[22] Committee on Substance Abuse and Committee on Adolescence. "Legalization of Marijuana: Potential Impact on youth." Pediatrics Vol. 113, No. 6 (June 6, 2004): 1825-1826. See also, Joffe, Alain, MD, MPH, and Yancy, Samuel, MD. "Legalization of Marijuana: Potential Impact on Youth." *Pediatrics* Vol. 113, No.6 (June 6, 2004): e632-e638h. Recommendations Regarding the Use of Cannabis in Multiple Sclerosis

[23] *Recommendations Regarding the Use of Cannabis in Multiple Sclerosis,* National Clinical Advisory Board of the National Multiple Sclerosis Society, April 2, 2008.

- **The British Medical Association,** which voiced extreme concern that downgrading the criminal status of marijuana would mislead the public into believing that the drug is safe.[24]

Unfortunately, the British Government did not heed their Medical Association's warning and downgraded cannabis from Class B to a Class C drug in 2004. This resulted in an increase of crime and various health problems, which later prompted a reversal, according to United Kingdom's Home Office.[25] As a result, on May 8, 2008, the Home Office announced that cannabis will be reclassified as a Class B drug.[26] Home Secretary Jacqui Smith addressed the need to update their public policies to match recent scientific evidence about the serious harms of marijuana use when she said, "The enforcement response must reflect the danger that the drug poses to individuals, and in turn to communities."[27]

The United States has also signed various international treaties to control illegal drug activity.[28] The International Narcotics Control Board (INCB) of the United Nations is charged with monitoring compliance with the drug control treaties. In its 1998 annual report, the INCB pointed out that the state marijuana initiatives recently passed in the United States are contrary to United States federal law. The report called on the United States to "vigorously enforce its federal law" in the face of these initiatives. The report further stated: "The decision of whether a substance should be authorized for medical use has always been taken, and should continue to be taken, in all countries by the bodies designated to regulate and register medicines [which, in the United States, are the FDA and DEA]. Such decisions should have a sound medical and scientific basis and should not be made in accordance with referendums organized by interest groups."[29]

The recitation of the forgoing information should not be interpreted as implying that DOJ or DEA opposes efforts to conduct research into the possible therapeutic effects of marijuana or its cannabinoid constituents. To the contrary, the CSA provides for, and DEA supports, all bona fide research involving schedule I controlled substances (including marijuana) conducted by researchers who have submitted research protocols that have been deemed scientifically meritorious by the Department of Health and Human

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[24] *Doctors' Fears at Cannabis Change*, BBC News, January 21, 2004, *available at* http://news.bbc.co.uk/1/hi/health/3414285.stm.

[25] Press Release, UK Home Office, Government crackdown on cannabis (May 7 2008), *available at* http://press.homeoffice.gov.uk/press-releases/government-crackdown-cannabis.

[26] *Id.*

[27] *Id.*

[28] The main drug control treaties currently in force to which the United States is a party are: the Single Convention on Narcotic Drugs, 1961, 18 U.S.T. 1407; the Convention on Psychotropic Substances, 1971, 32 U.S.T. 543; and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, 28 I.LM. 493. Among the United States obligations pursuant to these treaties are: (i) to enact and carry out legislation disallowing the use of schedule I drugs outside of authorized research; (ii) to make it a criminal offense, subject to imprisonment, to traffic in illicit drugs or to aid and abet such trafficking; and (iii) to prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal Government.

[29] U.N. International Narcotics Control Board, United Nations. *Report 1998* at par. 259, U.N. Sales No. E.99.XI.1, *available at* http://www.incb.org/incb/en/annual_report_1998.html.

Services (HHS).[30] As of June 2008, there were over one hundred researchers registered with DEA to perform studies with marijuana, marijuana extracts, and non-tetrahydrocannabinol marijuana derivatives that exist in the plant, such as cannabidiol and cannabinol. Studies include evaluation of abuse potential, physical/psychological effects, adverse effects, therapeutic potential, and detection. DEA has registered all researchers of marijuana whose research protocols have been approved by HHS. Nineteen of the researchers were approved to conduct research with smoked marijuana on human subjects.

In addition, beginning in 1999, HHS instituted new procedures to make research-grade marijuana more readily available to privately funded researchers. Pursuant to this new program, the California Center for Medical Cannabis Research has sponsored at least seventeen pre-clinical or clinical studies of marijuana, all of which were deemed meritorious by HHS and granted DEA registrations to conduct the research. In sum, DEA's position on marijuana is not based on a lack of compassion for those who are seriously ill, but on the fundamental principles that science must dictate whether we allow drugs to be sold to the American people as medicine and that FDA regulations must be adhered to when conducting clinical research involving marijuana to protect the safety of the human subjects.

As you are well aware, DEA was established to be the lead federal drug enforcement agency when it was created in 1973. Since its creation, the DEA has had primary responsibility for the enforcement of the CSA. The DEA is therefore the agency responsible for fulfilling the Executive Branch's constitutional obligation to "take care that the laws be faithfully executed" with respect to the CSA.

It is the mission of the DEA to enforce all the controlled substance laws and regulations of the United States and bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the trafficking of controlled substances appearing in, or destined for, the United States. It is also the agency's responsibility to recommend and support nonenforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. It would it be detrimental to the public health and welfare for DEA to abandon these responsibilities when it comes to marijuana.

The authority of the DEA to investigate those growing, selling, and possessing marijuana, irrespective of state law has been reaffirmed by recent rulings by the Supreme Court. In rejecting the notion marijuana activities purportedly taking place in compliance with California law and supposedly on a "wholly intrastate" basis are beyond the reach of Congress' commerce clause authority, the Supreme Court stated in *Raich*:

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[30] *See* 21 U.S.C. § 823(f) (providing that DEA may only issue a registration for research involving a schedule I controlled substance where HHS has found the researcher to be qualified and the research protocol meritorious).

> The CSA designates marijuana as contraband for *any* purpose; in fact, by characterizing marijuana as a Schedule I drug, Congress expressly found that the drug has no acceptable medical uses. Moreover, the CSA is a comprehensive regulatory regime specifically designed to regulate which controlled substances can be utilized for medicinal purposes, and in what manner. . . . Thus, even if respondents are correct that marijuana does have accepted medical uses and thus should be re-designated as a lesser schedule drug, the CSA would still impose controls beyond what is required by California law. The CSA requires manufacturers, physicians, pharmacies, and other handlers of controlled substances to comply with statutory and regulatory provisions mandating registration with the DEA, compliance with specific production quotas, security controls to guard against diversion, recordkeeping and reporting obligations, and prescription requirements. *See* 21 U.S.C. §§ 821-830; 21 C.F.R. § 1301 *et seq.* (2004). Furthermore, the dispensing of new drugs, even when doctors approve their use, must await federal approval.[31]

The Court also provided the following explanation for rejecting the marijuana trafficker's commerce clause argument in *Raich*:

> Given the enforcement difficulties that attend distinguishing between marijuana cultivated locally and marijuana grown elsewhere, 21 U.S.C. § 801(5), and concerns about diversion into illicit channels, we have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole in the CSA.[32]

In addition, as noted above, the Supreme Court's decision in *OCBC* makes clear that the marijuana activities of a California "cannabis club" are illegal under the CSA. In sum, the Supreme Court rulings indicate unequivocally that the CSA prohibitions on manufacturing, distributing, and possessing marijuana apply regardless of whether the person engaging in such activity claims to have a "medical necessity," claims to be acting in accordance with state law, or claims to be acting in a wholly intrastate manner. Thus, the DEA is constitutionally obligated to enforce the CSA in all circumstances. Accordingly, DEA is obligated to take all appropriate law enforcement actions, using all of the tools at our disposal, and to investigate any organization, including marijuana distribution facilities (sometimes referred to by their operators as "cannabis clubs") that are engaged in the unlawful manufacture and distribution of controlled substances.

DEA investigations of cannabis clubs are typically initiated as a result of one or several of the following factors: a community complaint made to DEA or other law enforcement agency;[33] a request for assistance from local law enforcement and/or city

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[31] 545 U.S. at 27-28.

[32] 545 U.S. at 22 (footnote omitted).

[33] Occasional news articles have reported on community complaints about the presence of cannabis clubs, which are very similar to the complaints made to the DEA. An example of such articles include: Eric

government(s);[34] or a tip that was generated as a result of its association with a collateral drug trafficking/money laundering investigation. DEA does not investigate or target individual "patients" who use cannabis, but instead the Drug Trafficking Organizations (DTOs) involved in marijuana trafficking. A sample list of the complaints that DEA has received include:

- people smoking marijuana outside the distribution facility,
- an increase in pedestrian and automobile traffic clogging the streets,
- illegal parking,
- public safety concerns,
- loss of customers and business in a once quiet neighborhood,
- an influx of criminal elements into the neighborhoods,
- noise, litter, loitering, property damage,
- the pungent smell of marijuana seeping into neighboring businesses,
- the smell of marijuana making people ill,
- secondary smoking risks,
- public urination,
- threats and harassment,
- display of firearms by owners or customers,
- verbal altercations,
- selling items that look like candy that small children could confuse and ingest,
- violations of residential zoning laws,
- marijuana distributors operating in school zones or close to schools or parks,
- marijuana distributors operating in or near buildings that house drug treatment facilities,
- fire hazards from makeshift electrical systems for indoor grows,
- a decrease in business and revenue for legitimate neighborhood stores,
- a decrease in tourist revenues and tourist traffic,
- a decrease in property values,
- juveniles under the age of 18 are able to purchase marijuana from cannabis clubs under the guise of parental consent,
- the majority of the customers seen in these clubs are young and do not appear to have any illness, and
- adults have been buying marijuana from the cannabis clubs and re-selling marijuana to juveniles.

DEA has always focused its attention on those cannabis club operators who are major drug traffickers. Again, the agency does not target individual users who are engaged in "simple possession" of the drug – even though they too are violating federal

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Bailey, "Reefer Sadness and Untended Consequences," *Los Angeles Times*, December 27, 2006; Paul Payne, "Pot Club Triggers Furor in Forestville" *The Press Democrat*, November 9, 2005; and Phillip Matier and Andrew Ross, "Pot Clubs May be Taking Root Near Your Own Backyard," *San Francisco Chronicle*, December 1, 2004.

[34] For an example of such a request, please see an October 2006 letter from the California Police Chiefs Association, Inc., to former DEA Administrator Karen Tandy. A copy is provided as Attachment 2.

law and entitled to no immunity.[35] In fact, DEA has not charged anyone associated with a cannabis club with simple possession, including anyone encountered in the 106 enforcement actions listed in the attachment to your letter.[36] Rather, the DEA has targeted drug dealers and suppliers.

For example, since 2004, DEA has initiated over 87 investigations involving cannabis clubs. In the 130 enforcement actions taken to date as part of these investigations, 365 people were arrested on both federal and state charges. None of those arrested were charged with simple possession, nor were any of the individuals arrested simply customers of the cannabis clubs. An overall breakdown of arrests during these cases is as follows:

- 28% of the arrests were of retail dealers,
- 15% of the arrests were of lab (marijuana grow) operators,
- 9% of the arrests were of domestic suppliers,
- 11% of the arrests were of facilitators,
- 13% of the arrests were of organization lieutenants,
- 8% of the arrests were of organizational heads,
- 1% of the arrests were of transporters,
- 1% of the arrests were of couriers,
- 1% of the arrests were for money laundering , and
- 11% of the arrests were for other related charges (e.g., conspiracy to cultivate marijuana, weapons offenses).[37]

In addition, there were a wide variety of state charges also filed by state prosecutors as a result of these enforcement actions, showing that in addition to violating federal law, these marijuana traffickers often are in violation of state law as well.

Moreover, the amassed profits and assets attributed to these marijuana traffickers who DEA have investigated show the true nature of these criminal organizations. These organizations also take steps to hide their profits. DEA investigations have shown that many of these individuals use bank accounts to launder their illegal proceeds and structure transactions (in violation of state and federal law) to attempt to avoid detection of the source of the funds. In addition, they use proceeds from the illegal sales and cultivation of marijuana to buy and lease conveyances (vehicles), investments and personal property, and pay expenses. For example, in a recent investigation, DEA found that Larry Kristich, the owner of several dispensaries in the Los Angeles area, purchased several luxury and exotic vehicles, including a new Land Rover, Ferrari F-430 sports car and a Bentley, and owned a $3 million estate. On January 31, 2008, Kristich pled guilty to one count of maintaining drug-involved premises and one count of money laundering. Kristich admitted he was responsible for distributing over 15,000 pounds of marijuana,

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[35] Unlawful possession of a controlled substance, as set forth in 21 U.S.C. § 844 (sometimes referred to as "simple possession"), is a misdemeanor. In contrast, possession of a controlled substance with intent to manufacture, distribute, or dispense is a felony, as set forth in 21 U.S.C. § 841.

[36] Please see Attachment 1 for additional information on these enforcement actions.

[37] Percentages are approximate due to rounding.

sold $95 million worth of marijuana and THC-laced products, and laundered over $50 million in marijuana proceeds. As part of his plea, Kristich also agreed to the forfeiture of over $1.2 million. In 2004, there were approximately ten marijuana distribution clubs in the Los Angeles area. But by 2007, that number had escalated to over 400.

Given that marijuana remains illegal under federal and state law, it is not surprising that there is no regulatory oversight whatsoever – federal or state – of the quality of marijuana products sold at these facilities. There are no warning labels, standard dosages, or reporting requirements for those who sell marijuana products – whether those products are intended to be smoked or eaten. Cannabis clubs take advantage of this by marketing marijuana as food products, including baked goods, candy, soda, liquids, peanut butter, cereal, soup, and ice cream.[38] The food products are typically labeled, "3X," "6X," "9X" and "10X," which describes the potency of THC in the food product, although there is no standard against which this can be measured. Again, there are no standards at all for these products; they are not inspected by anyone prior to selling them; there are no expiration dates; no list of ingredients; and no danger warnings on the packaging. Some of the marijuana food and beverage products have been packaged in wrappers and labels made to purposely resemble legitimate food items.[39]

The illegal activity generated by these cannabis clubs is not limited to selling marijuana. According to a complaint filed with the DEA in Los Angeles in August 2006, a high school coach provided his "medical marijuana" recommendation to high school students to enable them to purchase marijuana for recreational use. The 16 and 17 year olds then went to a dispensary in Sherman Oaks, California and purchased marijuana. In a separate case, a Van Nuys area patrol officer was dispatched to Grant High School to investigate an assault. While walking across campus, the officer observed a card placed on several vehicles in the school parking lot that advertised medical marijuana recommendations at JT Medical Group, Inc., in North Hollywood (approximately ½ mile from the school). The card stated, "Yes, in the state of California, it is still legal to own, grow, and smoke medical marijuana as long as you do it properly. Qualifying is simple and our experienced physicians are more than happy to help you." The card also stated, "If you do not qualify for a recommendation your visit is free."[40]

In addition, there have been many recorded incidents of violence and property crimes at or near dispensaries around the state. These violent crimes have included robberies, burglaries, aggravated assaults, and burglary from autos. For example, the Los Angeles Police Department (LAPD) reported a 200% increase in robberies, 52.2% increase in burglaries, 57.1% rise in aggravated assaults, and 130.8% rise in burglaries from autos near cannabis clubs in Los Angeles.

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[38] Please see Attachment 3 for photographs of such products.
[39] In addition to violating the CSA and FDCA, marketing products in such a manner raises potential trademark infringement issues.
[40] Please see Attachment 4 for a copy of this flyer.

Similarly, an analysis of one-year's data provided by the San Francisco Police Department (SFPD) of the crimes committed at or near 23 of the city's 29 cannabis clubs in the city of San Francisco between January 1, 2006, and February 1, 2007, shows a significant concentration of violent crimes and property crimes. Violent crimes include: murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. Violent crimes that occurred at, or in close proximity to, San Francisco's cannabis clubs during the last year included:

- 98 aggravated assaults,
- 144 incidents of battery,
- 7 incidents of battery of a police officer,
- 1 attempted rape – bodily force,
- 1 forcible rape – bodily force,
- 3 sexual batteries,
- 2 attempted homicides,
- 3 homicides with a gun,
- 21 deaths (causes unknown),
- 6 possession of a loaded firearm,
- 1 exhibiting deadly weapon,
- 27 attempted robberies, and
- 57 robberies.

Property crimes include burglary, larceny-theft, and motor vehicle theft. Property crimes that occurred at, or in close proximity to, San Francisco's cannabis clubs during the last year included:

- 20 attempted thefts,
- 294 grand thefts,
- 23 credit card thefts,
- 139 petty thefts,
- 2 attempted burglaries, and
- 198 burglaries.

These reports from individual police departments are supported by a July 2006 report by the California Police Chiefs Association (CPCA) on the secondary effects of marijuana distribution clubs. This report compiled data from state and local law enforcement agencies and media coverage, showed that between 2005 and 2006 there were at least 5 homicides, 35 robberies, and several fires at cannabis clubs. These are just a small sample of the crimes. Often crimes involving dispensaries are underreported, if reported at all, due to the fear of arrest and prosecution.[41]

Investigations have shown that individuals operating dispensaries consider themselves to be a "covert industry" trusting no one. There is no requirement for

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[41] "Medical Marijuana Dispensaries and Associated Issues Presented to the California Chiefs of Police Association." El Cerrito, CA Police Department, September to December 2007. See: www.californiapolicechiefs.org/nav_files/marijuana_files/Oct_Dec_07_final_report.pdf,.

background verifications of persons who open, operate, or work at dispensaries. Operators and owners include convicted drug traffickers, persons on probation for serious crimes, and street gang members. Many of the owners/operators and employees of the marijuana dispensaries have extensive criminal histories. In January 2007, DEA executed 11 search warrants and identified 17 owners and/or operators in the Los Angeles area. Of these 17 owners and/or operators, 14 had prior criminal histories, seven had weapons charges, eight had prior drug charges, and two had murder/attempted murder charges.

As with all medicines containing controlled substances, and approved by the FDA, only those who are registered with DEA and licensed in accordance with state laws can legally manufacture, possess, or dispense these substances. In addition to this registration process, registrants are required to maintain certain records, report theft and losses of these substances, and report suspicious transactions involving these substances. All of these requirements are circumvented in cases involving cannabis clubs. Furthermore, individuals operating these clubs do not have necessary training commensurate with that of a pharmacist. For example, pharmacists, through their training and experience, help identify and prevent situations where taking one drug in combination with another, wittingly or unwittingly, may cause harm to the patient. These protections are clearly nonexistent with the dispensation of marijuana at these cannabis clubs.

Your letter also asked how DEA uses the legal authorities and resources that we have been provided to enforce the CSA. In particular, your letter questioned DEA's "use of civil forfeiture" as a tactic when conducting marijuana trafficking investigations in California. DEA's use of civil asset forfeiture stems from the authorities granted to law enforcement by the Civil Asset Forfeiture Reform Act of 2000 (CAFRA).[42]

CAFRA requires that all real property be forfeited pursuant to a federal judicial action. Any search warrant, seizure warrant or Complaint for Forfeiture *In Rem*, involving real property, must be presented to the United States Attorney's Office in the applicable judicial district for review. Only a federal court proceeding may authorize a seizure warrant, search warrant, or the forfeiture of real property.

These protections and judicial review assist in ensuring that the use of asset forfeiture remains a valuable law enforcement tool. Civil asset forfeiture is provided for in the CSA. Specifically, 21 U.S.C. § 881(a) provides that certain property "shall be subject to forfeiture to the United States and no property right shall exist in them." This includes "[a]ll real property, including any right, title and interest (including any

[42] *See* 18 U.S.C. § 983 *et. seq.* The CAFRA legislation increased protections for property owners, while respecting the interests of law enforcement. Among other provisions, the bill placed the burden of proof in civil forfeiture cases on the government throughout the proceeding; placed reasonable time limits on the government in civil forfeiture actions; awards attorney fees and costs to property owners who prevail against the government in civil forfeiture cases; authorizes the court to release property pending trial in appropriate circumstances; eliminates the cost bond; and provides a uniform innocent owner defense to all federal civil forfeitures affected by the bill.

leasehold interest) in the whole of any lot or tract of land ... which is used, or intended to be used, in any manner or part, to commit, or to facilitate the commission of, a violation of this subchapter punishable by more than one year's imprisonment."[43] CAFRA governs how these authorities can be exercised, and struck an important balance between law enforcement objectives and the rights of innocent owners by codifying a uniform innocent owner defense.[44]

In addition, it is important to keep in mind that CAFRA also codifies that real property may not be seized – except in exigent circumstances – without prior notice and an opportunity to be heard. In particular, sections § 983(d) and § 985 detail how an individual could protect themselves against forfeiture by acting as a "reasonable person." DEA's use of any civil forfeiture action must, and does, comply with this law. In addition, civil asset forfeiture serves as a valuable deterrent for individuals who need financial consequences to understand the costs of breaking the law.

You also asked about DEA's allocation of resources to investigate marijuana dispensaries in California. DEA appreciates the Committee's concern that we may not have adequate resources to work against the drug cartels in Mexico, Colombia, and elsewhere. Accordingly, we want to reassure you that DEA routinely assesses the drug threat and drug-related crimes when we are making allocation decisions. To address the changes in the drug threat, or drug flow, DEA regularly conducts workload analyses and 'right sizing' reviews to ensure that the most urgent needs are being met with the limited resources we have available. Other factors that are taken into consideration include information on drug-related crimes from state, local, and federal entities; statistical data from drug use surveys, such as the Monitoring the Future study or the National Survey on Drug Use and Health; current investigative information about significant drug traffickers and organizations; agent investigative work hours; and the advice of DEA Special Agents in Charge. Working with the resources we have, DEA believes our current deployment is well-balanced to confront all of the threats we face. DEA personnel and resources are well-positioned to accomplish the tasks and responsibilities of this agency in fulfilling our mission.

You also raised a concern about whether the loss of state tax revenue was a consideration in DEA's decision to enforce the CSA. You may know that this is a question that some jurisdictions in California have raised directly with the Department of Justice, and to which the Department has responded. In summary, we have explained that income derived from the sale of marijuana, whether in California or not, represents proceeds of illegal drug trafficking, and as such is forfeitable under federal law. The State of California is neither an innocent owner nor a lien holder in regards to collecting illegal drug proceeds.[45] All right, title, and interest in property subject to forfeiture under the CSA – including all money and other proceeds of illegal drug sales – shall vest in the United States upon commission of the illegal act giving rise to the forfeiture.[46] Under the

[43] See 21 U.S.C. §881 (a)(7).
[44] See 18 U.S. C. § 983 (d).
[45] *See* 21 U.S.C. § 881.
[46] 21 U.S.C. § 811(h).

supremacy clause of the United States Constitution, a state may not impose a sales tax, or any other tax, on the property of the United States.[47]

Nonetheless, if a state entity wishes to assert a legal claim to any seized funds, CAFRA provides a mechanism for it to do so, which begins by submitting a claim in a timely manner and in the appropriate legal proceeding. In evaluating whether to maintain a legal claim please consider that general creditors lack standing to contest the federal forfeiture of property.[48] Thus, if a state or local entity asserts that it is a general creditor based upon unreported and/or unpaid sales taxes, it might look to those entities whose property was seized, rather than the federal government, for relief.

If, instead, the state or local entity claims some specific interest in the seized funds – funds which were derived from the distribution of a schedule I controlled substance – then such an interest would have to be evaluated according to principles of federal forfeiture law.[49] To date, no state or local entity has made such claims.

With respect to what the research to date has demonstrated regarding the potential therapeutic value of marijuana, and what role scientific data plays in DEA actions, please note the following. As indicated above, scientific data is of paramount consideration under both the CSA scheduling process and the FDA approval process. In particular, "[t]here must be adequate, well-controlled, well-designed, well-conducted and well-documented studies, including clinical investigations, by experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, on the basis of which it could fairly and responsibly be concluded by such experts that the substance will have the intended effect in treating a specific, recognized disorder."[50] It is therefore crucial to bear in mind that the FDA, the Substance Abuse and Mental Health Services (SAMHSA), and the National Institute for Drug Abuse (NIDA) have all "concluded that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use."[51] Absent a scientific basis for concluding that marijuana should be removed from schedule I, there is no legal basis for DOJ to treat it as anything other than a schedule I controlled substance.

Nonetheless, we are aware that some supporters of the marijuana legalization laws continue to contend that persons suffering from terminal illnesses should be allowed to use whatever substances they believe will help them, regardless of whether such substances have been proven to be safe and effective. Such a contention was once made with respect to the drug Laetrile, which many touted in the 1970s as a cure for cancer. Laetrile was sold in Mexico but was banned in the United States due to its lack of FDA

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[47] *See McCullough v. Maryland*, 17 U.S. 316 (1819); *see also U.S. v. California State Bd. of Equalization*, 650 F.2d 1127 (9th Cir. 1981), *aff'd.* 456 U.S. 901 (1982), *reh'g denied*, 456 U.S. 985 (1982).
[48] *See, e g., United States v. $20,193.39 U.S. Currency*, 16 F.3d 344, 346 (9th Cir. 1994).
[49] *See, e.g.*, 18 U.S.C. § 983(d)(3) and 21 U.S.C. § 853(n)(6)(B).
[50] 57 FR at 10505.
[51] Press Release, FDA, Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine (April 20, 2006) (available at http://fda.gov/bbs/topics/NEWS/2006/NEW01362.html).

approval. Several terminally ill cancer patients who believed they needed the drug to survive sued the United States to stop the FDA from enforcing the Food, Drug, and Cosmetic Act (FDCA) with respect to their use of Laetrile. The case was decided by the United States Supreme Court in *United States v. Rutherford*.[52] The Supreme Court ruled that the FDCA drug approval process must be followed – even in the case of terminally ill patients. Writing for a unanimous Court, Justice Thurgood Marshall emphasized the dangers of abandoning the FDCA approval process:

> To accept the proposition that the safety and efficacy standards of the [FDCA] have no relevance for terminal patients is to deny the [FDA] Commissioner's authority over all drugs, however toxic or ineffectual, for such individuals. If history is any guide, this new market would not be long overlooked. Since the turn of the century, resourceful entrepreneurs have advertised a wide variety of purportedly simple and painless cures for cancer, including liniments of turpentine, mustard, oil, eggs, and ammonia; peat moss; arrangements of colored floodlamps; pastes made from glycerin and limburger cheese; mineral tablets; and "Fountain of Youth" mixtures of spices, oil, and suet. In citing these examples, we do not, of course, intend to deprecate the sincerity of Laetrile's current proponents, or to imply any opinion on whether that drug may ultimately prove safe and effective for cancer treatment. But this historical experience does suggest why Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self-styled panaceas that inventive minds can devise.[53]

State actions that circumvent these protections by permitting the manufacturing, possession, distribution, and use of a schedule I controlled substance undermine the effectiveness of the CSA. DEA's efforts to enforce federal law with respect to trafficking in, and possession of, marijuana have been hampered by the passage of laws in several states which inhibit state and local law enforcement from acting against individuals and organizations selling marijuana under the guise of "medicine".

In these states, law enforcement has seen a growing list of ailments used by dealers, patients and physicians to justify smoking marijuana. That list includes attention deficit disorder, headaches, arthritis, premenstrual syndrome, irritable bowel syndrome hepatitis, renal failure, hypertension, anxiety, depression, post-traumatic stress disorder, insomnia, paranoia, bipolar affective disorder, alcoholism, cocaine and amphetamine addiction, epilepsy, bronchitis, emphysema, osteoporosis, degenerative disc disease, polio, ulcers, stuttering, seizures, color blindness and various types of pain. It has become so exhaustive that anyone could claim "a medical need," and such claims far outstrip any scientific evidence about the therapeutic value of marijuana.

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[52] 442 U.S. 544 (1979).
[53] 442 U.S. at 557-558.

This proliferation of excuses used by marijuana smokers hiding behind state laws goes even beyond what was envisioned by some of the most ardent supporters of the original proposition, California's Proposition 215. Scott Imler, who co-wrote Proposition 215, stated, "Nothing in Prop. 215 allows for the sale of marijuana to anyone. We created Prop. 215 so that patients would not have to deal with black market profiteers. But today its all about the money. Most of the dispensaries operating in California are little more than dope dealers with store fronts."[54]

DEA is charged with enforcing the entire CSA, not portions of it. Thus, when individuals possess, distribute, or use *any* controlled substance outside the scope of the closed-system of distribution, the DEA must investigate and enforce the laws that protect the public health and safety.

Finally, your letter also included a list of law enforcement actions against marijuana suppliers throughout California.[55] To the extent that we are able, you should find the requested information included in the enclosed spreadsheet. We trust this information is of value to your policy and oversight efforts.

We hope this information is helpful. Please do not hesitate to contact this office if we can be of assistance in other matters.

Sincerely,

Keith B. Nelson
Principal Deputy Assistant Attorney General

Enclosures

[54] Jerry Wade, "A Comparison of Medical Marijuana Programs in California and Oregon", *Alternatives Magazine* Fall, 2006 Issue 39.
[55] Please see Attachment 1.