Removal of cannabis from Schedule I of the Controlled Substances Act

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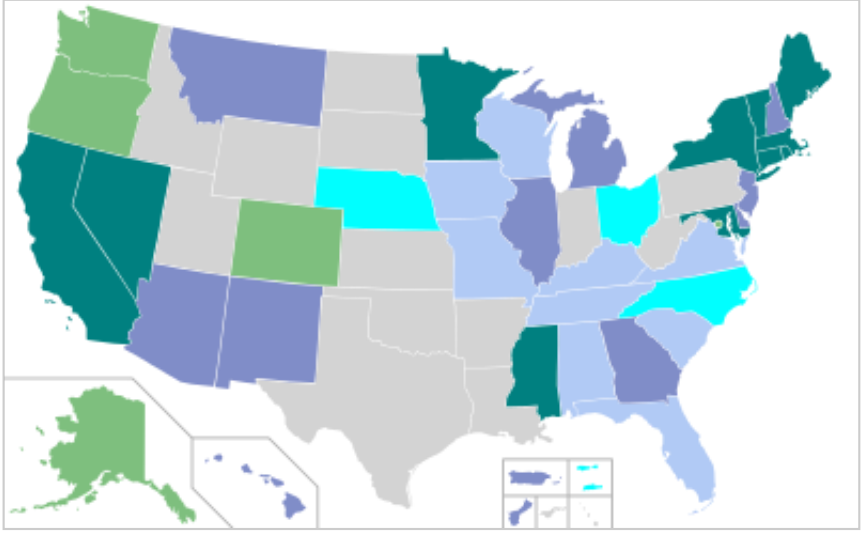
Since 1972, there have been numerous proposals in the United States to **remove cannabis from Schedule I of the Controlled Substances Act**, the most tightly restricted category reserved for drugs which have "no currently accepted medical use". Rescheduling proponents argue that cannabis does not meet the Controlled Substances Act's strict criteria for placement in Schedule I, and therefore the government is required by law either to permit medical use or to remove the drug from federal control altogether. The government, on the other hand, maintains that cannabis is dangerous enough to merit Schedule I status. The dispute is based on differing views on how the Act should be interpreted and what kinds of scientific evidence are most relevant to the rescheduling decision.



Cannabis laws in the United States[1]

- Jurisdiction with legalized cannabis.
- Jurisdiction with both medical and decriminalization laws.[2]
- Jurisdiction with decriminalized cannabis possession laws.
- Jurisdiction with legal psychoactive medical cannabis.
- Jurisdiction with legal non-psychoactive medical cannabis.

The Controlled Substances Act provides a process for rescheduling controlled substances by petitioning the Drug Enforcement Administration. The first petition under this process was filed in 1972 to allow cannabis to be legally prescribed by physicians. The petition was ultimately denied after 22 years of court challenges, although a pill form of cannabis' psychoactive ingredient, THC, was rescheduled

in 1985 to allow prescription under schedule II. In 1999 it was again rescheduled to allow prescription under schedule III. A second petition, based on claims related to clinical studies, was denied in 2001. The most recent rescheduling petition filed by medical cannabis advocates was in 2002, but was denied by the DEA in July 2011. Subsequently, medical cannabis advocacy group Americans for Safe Access filed an appeal in January 2012 with the D.C. Circuit, which was heard on 16 October 2012[1] and denied on 22 January 2013.[2] As of May 2014, 22 states and Washington D.C. have legalized the use of medical marijuana.[3] Currently, the FDA is conducting an analysis, at the request of the DEA, on whether marijuana should be downgraded, said Douglas Throckmorton, Deputy Director for Regulatory Programs at the FDA, at a congressional hearing in June 2014.[4]

Jurisdiction with cannabis prohibition.

[1] Includes laws which have not yet gone into effect.

[2] Mississippi has only legal non-psychoactive medical cannabis.

* Cannabis **remains a Schedule I substance under federal law** as of 2015.
* Some cities and Indian Reservations have legalization policies separate from their surrounding states.

Advocates of marijuana legalization argue that the budgetary impact of removing cannabis from Schedule I of the Controlled Substances Act and legalizing its use in the United States could save billions by reducing government spending for prohibition enforcement in the criminal justice system. Additionally, they argue that billions in annual tax revenues could be generated through proposed taxation and regulation.[5] Patient advocates argue that by reclassifying marijuana, millions of Americans who are currently prevented from using medical marijuana would be able to benefit from its therapeutic value.

Contents

Background

Schedule I is the only category of controlled substances that may not be prescribed by a physician. Under *21 U.S.C. § 812 (http://www.law.cornell.edu/uscode/21/812.html)*, drugs must meet three criteria in order to be placed in Schedule I:

1. The drug or other substance has a high potential for abuse.
2. The drug or other substance has no currently accepted medical use in treatment in the United

States.
3. There is a lack of accepted safety for use of the drug or other substance under medical supervision.

In 1970, Congress placed cannabis into Schedule I on the advice of Assistant Secretary of Health Roger O. Egeberg. His letter to Harley O. Staggers, Chairman of the House Committee on Interstate and Foreign Commerce, indicates that the classification was intended to be provisional:

> Dear Mr. Chairman: In a prior communication, comments requested by your committee on the scientific aspects of the drug classification scheme incorporated in H.R. 18583 were provided. This communication is concerned with the proposed classification of marihuana.
>
> It is presently classed in schedule I(C) along with its active constituents, the tetrahydrocannibinols and other psychotropic drugs.
>
> Some question has been raised whether the use of the plant itself produces "severe psychological or physical dependence" as required by a schedule I or even schedule II criterion. Since there is still a considerable void in our knowledge of the plant and effects of the active drug contained in it, our recommendation is that marijuana be retained within schedule I at least until the completion of certain studies now underway to resolve the issue.

In 1972, the National Commission on Marijuana and Drug Abuse released a report favoring decriminalization of cannabis. The Nixon administration took no action to implement the recommendation, however.

Arguments for and against

For rescheduling

Jon Gettman, former director of the National Organization for the Reform of Marijuana Laws, has argued that cannabis does not fit each of the three statutory criteria for Schedule I. Gettman believes that "high potential for abuse" means that a drug has a potential for abuse similar to that of heroin or

cocaine.[6] Gettman argues further that since laboratory animals do not self-administer cannabis, and because cannabis' toxicity is virtually non-existent compared to that of heroin or cocaine, cannabis lacks the high abuse potential required for inclusion in Schedule I or II.

Gettman also states: "The acceptance of cannabis' medical use by eight (now twenty-three and DC) states since 1996 and the experiences of patients, doctors, and state officials in these states establish marijuana's accepted medical use in the United States."[7] Specifically, Alaska, Arizona, California, Colorado, Connecticut, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and Washington DC have enacted legislation allowing the medical use of cannabis by their citizens.[8] A minimum of 35,000 patients are currently using medical cannabis legally in these states, and over 2,500 different physicians have recommended it for use by their patients.[9]

In his petition, Gettman also argues that cannabis is an acceptably safe medication. He notes that a 1999 Institute of Medicine report found that "except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications." He points out that there are a number of delivery routes that were not considered by the Institute, such as transdermal, sublingual, and even rectal administration, in addition to vaporizers, which release cannabis' active ingredients into the air without burning the plant matter.[10]

A study published in the March 1, 1990 issue of the *Proceedings of the National Academy of Sciences* stated that "there are virtually no reports of fatal cannabis overdose in humans" and attributed this safety to the low density of cannabinoid receptors in areas of the brain controlling breathing and the heart.[11][12] Gettman claims that the discovery of the cannabinoid receptor system in the late 1980s revolutionized scientific understanding of cannabis' effects and provided further evidence that it does not belong in Schedule I.

In 2003, the United States government patented cannabinoids, including those in marijuana that cause users to get "high" (such as THC) based on these chemicals' prevention of trauma- and age-related brain damage.[13]

In January 2008, the American College of Physicians called for a review of cannabis's Schedule I classification in its position paper titled "Supporting Research into the Therapeutic Role of Marijuana" It stated therein: "Position 4: ACP urges an evidence-based review of marijuana's status as a Schedule I controlled substance to determine whether it should be reclassified to a different schedule. This review should consider the scientific findings regarding marijuana's safety and efficacy in some clinical conditions as well as evidence on the health risks associated with marijuana consumption, particularly in its crude smoked form." [14]

From 2008 to 2012, the American Patients Rights Association, in cooperation with Medical Marijuana expert Kim Quiggle, lobbied the federal government over what is now known as the "Mary Lou Eimer Criteria" based on a medical study performed by Quiggle on over 10,000 chronically ill and terminally ill patients use of medical marijuana in Southern California. This study provided conclusive evidence that medical marijuana provided a safer and alternative application to many current pharmaceutical products available for patients, especially those with cancer and HIV/AIDS. The 'Mary Lou Eimer Criteria' was instrumental in the issuance of the Cole Memorandum which has set federal guidelines over states with medical marijuana laws; and has urged the federal government to reschedule marijuana to a Class IV or Class V controlled substance based on the results of the Quiggle Study.

Since 2012, The American Patients Rights Association (APRA), based in Southern California, has become the strongest advocate for rescheduling medical marijuana to a Schedule V pharmaceutical. APRA's Regulatory Affairs Director, Patrick Rohde, has been highly critical of Colorado's legalization of marijuana, stating that the state government "...has violated patient's rights through its recreational marijuana regulatory scheme" labeling the program "Tax & Jail" in reference to the state's drugged driving laws and high taxes on medical marijuana.

"Regulations regarding 'driving under the influence of 3 micrograms of THC or greater' is pseudoscience and an abuse of regulatory oversight; I could have 3 micrograms of THC in my blood stream from medical marijuana that I medicated with over a month ago. I could have 3 micrograms in my blood even by simply inhaling too much second hand....APRA wishes to see such decisions on public health reserved for physicians and laboratories with professional expertise." - Patrick Rohde [15]

Against rescheduling

In 1992, DEA Administrator Robert Bonner promulgated five criteria, based somewhat on the Controlled Substances Act's legislative history, for determining whether a drug has an accepted medical use.[16] The DEA claims that cannabis has no accepted medical use because it does not meet all of these criteria:[17]

- The drug's chemistry is known and reproducible;
- There are adequate safety studies;
- There are adequate and well-controlled studies proving efficacy;
- The drug is accepted by qualified experts; and
- The scientific evidence is widely available.

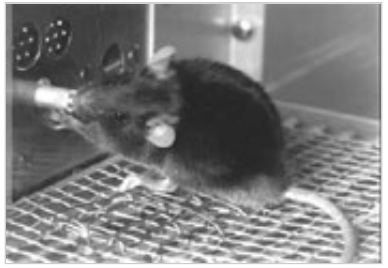
These criteria are not binding; they were created by DEA and may be altered at any time. Judicial deference to agency decisions is what has kept them in effect, despite the difference between these and the statutory criteria. Cannabis is one of several plants with unproven abuse potential and toxicity that Congress placed in Schedule I. The DEA interprets the Controlled Substances Act to mean that if a drug with even a low potential for abuse — say, equivalent to a Schedule V drug — has no accepted medical use, then it must remain in Schedule I:[17]

> When it comes to a drug that is currently listed in Schedule I, if it is undisputed that such drug has no currently accepted medical use in treatment in the United States and a lack of accepted safety for use under medical supervision, and it is further undisputed that the drug has at least some potential for abuse sufficient to warrant control under the CSA, the drug must remain in schedule I. In such circumstances, placement of the drug in schedules II through V would conflict with the CSA since such drug would not meet the criterion of "a currently accepted medical use in treatment in the United States." 21 USC 812(b).
>
> Therefore, even if one were to assume, theoretically, that your assertions about marijuana's potential for abuse were correct (i.e., that marijuana had some potential for abuse but less than the "high potential for abuse" commensurate with schedules I and II), marijuana would not meet the criteria for placement in schedules III through V since it has no currently accepted medical use in treatment in the United States—a determination that is reaffirmed by HHS in the attached medical and scientific evaluation.

This argument silently rejects the concept that if a drug does not meet the criteria for any schedule, it should not be in any schedule.

The Department of Health and Human Services rejects the argument that laboratory animals' failure to self-administer cannabis is conclusive proof of its low potential for abuse:[17]

> The Secretary disagrees with Mr. Gettman's assertion that "[t]he accepted contemporary legal convention for evaluating the abuse potential of a drug or substance is the relative degree of self-administration the drug induces in animal subjects." As discussed above, self-administration tests that identify whether a substance is reinforcing in animals are but one component of the scientific assessment of the abuse potential of a substance. Positive indicators of human abuse liability for a particular substance, whether from laboratory studies or epidemiological data, are given greater weight than animal studies suggesting the same compound has no abuse potential.



The U.S. Government argues that human studies are more relevant than studies showing animals do not self-administer cannabis.

The Food and Drug Administration elaborates on this, arguing that the widespread use of cannabis, and the existence of some heavy users, is evidence of its "high potential for abuse," despite the drug's lack of physiological addictiveness:[17]

> [P]hysical dependence and toxicity are not the only factors to consider in determining a substance's abuse potential. The large number of individuals using marijuana on a regular basis and the vast amount of marijuana that is available for illicit use are indicative of widespread use. In addition, there is evidence that marijuana use can result in psychological dependence in a certain proportion of the population.

The Department of Justice also considers the fact that people are willing to risk scholastic, career, and legal problems to use cannabis to be evidence of its high potential for abuse:[17]

> Throughout his petition, Mr. Gettman argues that while many people "use" cannabis, few "abuse" it. He appears to equate abuse with the level of physical dependence and toxicity resulting from cannabis use. Thus, he appears to be arguing that a substance that causes only low levels of physical dependence and toxicity must be considered to have a low potential for abuse. The Secretary does not agree with this argument. Physical dependence and toxicity are not the only factors that are considered in determining a substance's abuse potential. The actual use and frequency of use of a substance, especially when that use may result in harmful consequences such as failure to fulfill major obligations at work or school, physical risk-taking, or even substance-related legal problems, are indicative of a substance's abuse potential. The same and much worse can also be said about the clear abuse of alcohol by many Americans.

Process

Cannabis could be rescheduled either legislatively, through Congress, or through the executive branch. Congress has so far rejected all bills to reschedule cannabis. However, it is not unheard of for Congress to intervene in the drug scheduling process; in February 2000, for instance, the 105th Congress, in its second official session, passed *Public Law 106-172*, also known as the *Hillory J. Farias and Samantha Reed Date-Rape Drug Prohibition Act of 2000*,[18] adding GHB to Schedule I.[19] On June 23, 2011, Rep. Barney Frank and Rep. Ron Paul introduced H.R. 2306 (https://www.congress.gov/bill/112th-congress/house-bill/2306),[20] legislation that would completely remove cannabis from the federal schedules, limiting the federal government's role to policing cross-border or interstate transfers into states where it remains illegal.

The Controlled Substances Act also provides for a rulemaking process by which the United States Attorney General can reschedule cannabis administratively. These proceedings represent the only means of legalizing medical cannabis without an act of Congress. Rescheduling supporters have often

cited the lengthy petition review process as a reason why cannabis is still illegal.[6] The first petition took 22 years to review, the second took 7 years, the third was denied 9 years later. A 2013 petition by two state governors is still pending.

Rulemaking proceedings

The United States Code, under Section 811 of Title 21,[21] sets out a process by which cannabis could be administratively transferred to a less-restrictive category or removed from Controlled Substances Act regulation altogether. The Drug Enforcement Administration (DEA) evaluates petitions to reschedule cannabis. However, the Controlled Substances Act gives the Department of Health and Human Services (HHS), as successor agency of the Department of Health, Education, and Welfare, great power over rescheduling decisions.

After the DEA accepts the filing of a petition, the agency must request from the HHS Secretary "a scientific and medical evaluation, and his recommendations, as to whether such drug or other substance should be so controlled or removed as a controlled substance." The Secretary's findings on scientific and medical issues are binding on the DEA.[22] The HHS Secretary can even unilaterally legalize cannabis: "[I]f the Secretary recommends that a drug or other substance not be controlled, the Attorney General shall not control the drug or other substance." *21 U.S.C. § 811(b) (http://www.law.cornell.edu/uscode/21/811(b).html)*.

Factors

Unless an international treaty requires controlling a substance, the Attorney General must, in finding whether the drug meets the three criteria for placement in a particular schedule, consider the following factors:

- The drug's actual or relative potential for abuse.
- Scientific evidence of its pharmacological effect, if known.
- The state of current scientific knowledge regarding the drug or other substance.
- Its history and current pattern of abuse.
- The scope, duration, and significance of abuse.
- What, if any, risk there is to the public health.

- Its psychological or physiological dependence liability.
- Whether the substance is an immediate precursor of a controlled substance.

International treaty

If an international treaty, ratified by the U.S., mandates that a drug be controlled, the Attorney General is required to "issue an order controlling such drug under the schedule he deems most appropriate to carry out such obligations" without regard to scientific or medical findings.[23] Under the Single Convention on Narcotic Drugs, cannabis and cannabis resin are classified under Schedule IV, that treaty's most strictly controlled category of drugs.[24] However, *Article 4(c)* of the Single Convention specifically excludes medicinal drug use from prohibition, requiring only that Parties "limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs".[24] On the other hand, *Article 2(5)(b)* states that for Schedule IV drugs:

> *A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.*[25]

The Single Convention on Narcotic Drugs requires governments to regulate cannabis cultivation, but does not ban medical use.

The clause "...in its opinion..." refers to a judgment that each nation makes for itself. The official Commentary on the treaty indicates that Parties are required to make the judgment in good faith. Thus, if in the opinion of the United States, limiting cannabis use solely to research purposes would be "the most appropriate means of protecting the public health and welfare," the U.S. would be required to do that. Presumably, this would greatly restrict the possibilities for medical use.

Jon Gettman, in *Science and the End of Marijuana Prohibition*, claims that "if prohibition ends in the U.S. it must also end world-wide because U.S. law requires that we amend international drug control treaties to correspond with our own findings on scientific and medical issues".[6] This is at least partially correct; *21 U.S.C. § 811(d)(2)(B)* of the Controlled Substances Act states that if the United Nations Commission on Narcotic Drugs proposes rescheduling a drug, the HHS Secretary "shall evaluate the proposal and furnish a recommendation to the Secretary of State which shall be binding on the representative of the United States in discussions and negotiations relating to the proposal".[21] As the major financial contributor to the United Nations Office on Drugs and Crime and related agencies, the U.S. has a great deal of influence over international drug policy.[26] However, former United Nations Drug Control Programme Chief of Demand Reduction Cindy Fazey points out in *The UN Drug Policies and the Prospect for Change* that since cannabis restrictions are embedded in the text of the Single Convention,[25] complete legalization would require denunciation of the Single Convention,[27] amendment of the treaty,[28] or a reinterpretation of its provisions that would likely be opposed by the International Narcotics Control Board.[29]

History

1972 petition

In 1972 the National Organization for the Reform of Marijuana Laws (NORML) petitioned the Bureau of Narcotics and Dangerous Drugs (BNDD) (now the Drug Enforcement Administration (DEA)) to transfer cannabis to Schedule II so that it could be legally prescribed by physicians. The BNDD declined to initiate proceedings on the basis of their interpretation of U.S. treaty commitments.

In 1974, the United States Court of Appeals for the District of Columbia Circuit ruled against the government and ordered them to process the petition (*NORML v. Ingersoll* 497 F.2d 654). The government continued to rely on treaty commitments in their interpretation of scheduling-related issues concerning the NORML petition. In 1977, the Court issued a decision clarifying that the Controlled Substances Act requires a full scientific and medical evaluation and the fulfillment of the rescheduling process before treaty commitments can be evaluated (*NORML v. DEA 559 F.2d 735*). On October 16, 1980, the Court ordered the government to start the scientific and medical evaluations required by the NORML petition (*NORML v. DEA Unpublished Disposition, U.S. App. LEXIS 13100*).

Meanwhile, some members of Congress were taking action to reschedule the drug legislatively. In 1981, the late Rep. Stuart McKinney introduced a bill to transfer cannabis to Schedule II.[30] It was co-sponsored by a bipartisan coalition of 84 House members, including prominent Republicans Newt Gingrich (GA), Bill McCollum (FL), John Porter (IL), and Frank Wolf (VA).[31] After the bill died in committee, Rep. Barney Frank began annually introducing nearly identical legislation.[32] All of Frank's bills have suffered the same fate, though, without attracting more than a handful of co-sponsors.

On October 18, 1985, the DEA issued a Notice of Proposed Rulemaking to transfer "Synthetic Dronabinol in Sesame Oil and Encapsulated in Soft Gelatin Capsules" — a pill form of Δ^9-tetrahydrocannabinol, the main psychoactive component of cannabis, sold under the brand name Marinol — from Schedule I to Schedule II (*DEA 50 FR 42186-87*). The government issued its final rule rescheduling the drug on July 13, 1986 (*DEA 51 FR 17476-78*). The disparate treatment of cannabis and the expensive, patentable Marinol prompted reformers to question the DEA's consistency.[33][34]

In the summer of 1986, the DEA administrator initiated public hearings on cannabis rescheduling. The hearings lasted two years, involving many witnesses and thousands of pages of documentation. On September 6, 1988, DEA Chief Administrative Law Judge Francis L. Young ruled that cannabis did not meet the legal criteria of a Schedule I prohibited drug and should be reclassified. He declared that cannabis in its natural form is "one of the safest therapeutically active substances known to man. (T)he provisions of the (Controlled Substances) Act permit and require the transfer of marijuana from Schedule I to Schedule II".[35]

Then-DEA Administrator John Lawn overruled Young's determination. Lawn said he decided against re-scheduling cannabis based on testimony and comments from numerous medical doctors who had conducted detailed research and were widely considered experts in their respective fields. Later Administrators agreed. "Those who insist that marijuana has medical uses would serve society better by promoting or sponsoring more legitimate research," former DEA Administrator Robert Bonner opined in 1992. This statement was quoted by the Multidisciplinary Association for Psychedelic Studies (MAPS) in its membership drives.[36]

In 1994, the D.C. Court of Appeals finally affirmed the DEA Administrator's power to overrule Judge Young's decision (*Alliance for Cannabis Therapeutics v. DEA. 15 F.3d 1131*). The petition was officially dead. "Each of the doctors testifying on behalf of NORML claimed that his opinion was based on

scientific studies, yet with one exception, none could identify, under oath, the scientific studies they relied on," DEA Administrator Thomas A. Constantine remarked in 1995.[37]

1995 petition

On July 10, 1995, Jon Gettman and *High Times* Magazine filed another rescheduling petition with the DEA. This time, instead of focusing on cannabis' medical uses, the petitioners claimed that cannabis did not have the "high potential for abuse" required for Schedule I or Schedule II status. They based their claims on studies of the brain's cannabinoid receptor system conducted by the National Institute of Mental Health (NIMH) between 1988 and 1994. In particular, they claim that a 1992 study by M. Herkenham et al.,[38] "using a lesion-technique, established that there are no cannabinoid receptors in the dopamine-producing areas of the brain".[12] Other studies, summarized in Gettman's 1997 report *Dopamine and the Dependence Liability of Marijuana*, showed that cannabis has only an indirect effect on dopamine transmission.[12] This suggested that cannabis' psychoactive effects are produced by a different mechanism than addictive drugs such as amphetamine, cocaine, ethanol, nicotine, and opiates. The National Institute on Drug Abuse, however, continued to publish literature denying this finding. For instance, NIDA claims the following in its youth publication *The Science Behind Drug Abuse*:[39]

> *A chemical in marijuana, THC, triggers brain cells to release the chemical dopamine. Dopamine creates good feelings — for a short time. Here's the thing: Once dopamine starts flowing, a user feels the urge to smoke marijuana again, and then again, and then again. Repeated use could lead to addiction, and addiction is a brain disease.*

In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine (IOM) to conduct a review of the scientific evidence to assess the potential health benefits and risks of cannabis and its constituent cannabinoids.[40] In 1999, the IOM recommended that medical cannabis use be allowed for certain patients in the short term, and that preparations of isolated cannabinoids be developed as a safer alternative to smoked cannabis. The IOM also found that the gateway drug theory was "beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids."

Both sides claimed that the IOM report supported their position. The DEA publication *Exposing the Myth of Smoked Medical Marijuana* interpreted the IOM's statement, "While we see a future in the development of chemically defined cannabinoid drugs, we see little future in smoked marijuana as a medicine," as meaning that smoking cannabis is not recommended for the treatment of any disease condition.[41] Cannabis advocates pointed out that the IOM did not study vaporizers, devices which, by heating cannabis to 185 °C, release therapeutic cannabinoids while reducing or eliminating ingestion of various carcinogens.[42]

On July 2, 1999, Marinol was again rescheduled, this time from Schedule II to the even less-restrictive Schedule III, while cannabis remained in Schedule I (*64 FR 35928*).[43] The petitioners argued that the distinction between the two drugs was arbitrary, and that cannabis should be rescheduled as well. The DEA, however, continued to support Marinol as a method of THC ingestion without harmful smoke inhalation.

The DEA published a final denial of Gettman's petition on April 18, 2001.[44] The U.S. Court of Appeals for the D.C. Circuit upheld the agency's decision on May 24, 2002, ruling that the petitioners were not sufficiently injured to have standing to challenge DEA's determinations in federal court (*290 F.3d 430*).[45] Since the appeal was dismissed on a technicality, it is unknown what position the Court would have taken on the merits of the case.

2002 petition

On October 9, 2002, the Coalition for Rescheduling Cannabis filed another petition.[46] The new organization consisted of medical cannabis patients and other petitioners who would be more directly affected by the DEA's decision. On April 3, 2003, the DEA accepted the filing of that petition. According to Jon Gettman, "In accepting the petition the DEA has acknowledged that the Coalition has established a legally significant argument in support of the recognition of the accepted medical use of cannabis in the United States."

In a footnote to the majority decision in *Gonzales v. Raich*, Justice John Paul Stevens said that if the scientific evidence offered by medical cannabis supporters is true, it would "cast serious doubt" on the Schedule I classification.[47]

On May 23, 2011, the Coalition for Rescheduling Cannabis filed suit in the District of Columbia Circuit Court of Appeals to compel the DEA to formally respond to its 2002 petition to have marijuana rescheduled under the provisions of the Controlled Substances Act (CSA). The writ of mandamus filed alleged that the lack of decision by DEA, "presents a paradigmatic example of unreasonable delay under *Telecommunications Research & Action Ctr. v. FCC*."[48] In response to the suit, the DEA issued a Final Determination on the Petition for Rescheduling on July 8, 2011.[49][50] The Petition for Writ of Mandamus was subsequently dismissed by the D.C. Circuit Court of Appeals as moot on October 14, 2011.[51]

In response to the petition's denial, medical cannabis advocacy group Americans for Safe Access appealed to the D.C. Circuit on January 23, 2012.[52] Oral arguments in the case *Americans for Safe Access v. DEA* were heard on October 16, 2012.[53] On the same day the case was heard, the court ordered the plaintiffs (ASA) to clarify their arguments on standing.[54] In response, ASA filed a supplemental brief on October 22, 2012, detailing how plaintiff Michael Krawitz was harmed by the federal government's policy on medical marijuana due to being denied treatment by the Department of Veterans Affairs.[55] A ruling in the case is expected sometime in 2013.

2011 petition

On November 30, 2011, Washington State Governor Christine Gregoire announced the filing of a petition [56][57] with the U.S. Drug Enforcement Administration asking the agency to reclassify marijuana as a Schedule 2 drug, which will allow its use for treatment – prescribed by doctors and filled by pharmacists. Gov. Lincoln Chafee (I-Rhode Island) also signed the petition.

2012 Bill

On November 20, 2012, after voters in the states of CO and WA voted to legalize recreational use of marijuana, Rep. Diana DeGette (D-CO) introduced a bill referred to as the 'Respect States and Citizens Rights Act' which aims to amend the Controlled Substances act to exclude any state that has legalized marijuana (for medical OR recreational use) from marijuana provisions of the CSA, effectively giving state law precedence over federal law in cases where an individual (or commercial enterprise) is acting within the letter of state law regarding marijuana/cannabis.

State level reclassification

In addition to the federal government's classification, each state maintains a similar classification list and it is possible for these lists to conflict.

California

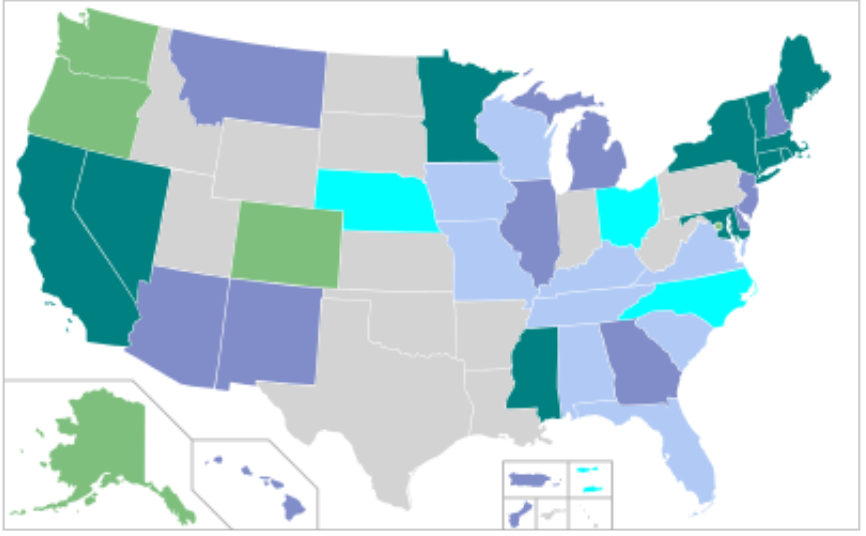
Proposition 19 of California's 2010 election would allow for the production, distribution, use, and taxation of cannabis products. It was a response to cannabis' enormous economy, and the budget gap that needs to be filled. This ballot initiative failed in the November 2, 2010, General Election by a margin of 7%.

Colorado

On Nov. 6, 2012: After passing Amendment 64, Colorado became one of the first two states to legalize the recreational use of marijuana for individuals over the age of 21.[58]

Florida

On January 27, 2014, the Florida Supreme Court approved the ballot language for a proposed constitutional amendment allowing the medical use of marijuana, following a successful petition drive.[59] The amendment proposal appeared on Florida's November 2014 general election ballot



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and received 58% of the vote, below the 60% requirement for adoption. The campaign was notable for opposition funding by casino magnate and Republican Party donor Sheldon Adelson.[59] United for Care, the pro-medical cannabis organization responsible for the initial petition, wrote an updated version for the 2016 general election.[60]

cannabis.

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Iowa

On Feb. 17, 2010, after reviewing testimony from four public hearings and reading through more than 10,000 pages of submitted material, members of the Iowa Board of Pharmacy unanimously voted to recommend that the Iowa legislature remove marijuana from Schedule I of the Iowa Controlled Substances Act.[61]

Minnesota

On March 16, 2011, Kurtis W. Hanna and Ed Engelmann petitioned the Minnesota Board of Pharmacy to initiate rule making to remove Cannabis from the list of Schedule I substance in Minnesota's version of the Uniform Controlled Substances Act.[62][63] The Board was informed when they denied the petition at their meeting on May 11, 2011 by Kurtis Hanna that he planned on filing for judicial review of the agency's decision. In response, the Board voted to petition the State Legislature to remove the Board's authority to remove substances from Schedule I. At a Conference Committee for Omnibus Drug Bill HF57 on May 18, 2011, the following sentence was added to the bill, "The Board of Pharmacy may not delete or reschedule a drug that is in Schedule I" and the following sentence of statute was deleted, "the state Board of Pharmacy [...] shall annually, on or before May 1 of each year, conduct a review of the placement of controlled substances in the various schedules."[64] The bill was signed into law by Governor Dayton on May 24, 2011.[65] Kurtis Hanna never filed a lawsuit against the Board of Pharmacy due to the belief that it would be moot.

Oregon

In June 2010, the Oregon Board of Pharmacy reclassified marijuana from a Schedule I drug to a Schedule II drug.[66] News reports noted that this reclassification makes Oregon the "first state in the nation to make marijuana anything less serious than a Schedule I drug."[67]

Washington

On Nov. 6, 2012: After passing Initiative 502, Washington is one of the first two states to legalize the recreational use of marijuana for individuals over the age of 21.[68]

Wisconsin

Gary Storck sent a letter to the Controlled Substances board in August 2011 requesting procedures to file a petition, which is discussed at the September 2011 Controlled Substances Board Meeting.[69] The Wisconsin Controlled Substances board has authority to reschedule cannabis pursuant to the rule-making procedures of ch. 227.[70] Drafters plan to submit a petition to the Controlled Substances Board in early 2012.

See also

- Adult lifetime cannabis use by country
- Annual cannabis use by country
- Cannabis rescheduling around the world
- Decriminalization of non-medical marijuana in the United States
- Health issues and the effects of cannabis
- Legal and medical status of cannabis
- Legal history of marijuana in the United States
- Legal issues of cannabis
- Legality of cannabis by country
- Marijuana Policy Project
- Medical cannabis
- NORML
- Prohibition in the United States

- Single Convention on Narcotic Drugs

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External links

Federal government:

- Department of Health and Human Services (http://www.dhhs.gov/)
- Drug Enforcement Administration (http://www.usdoj.gov/dea/)
- Food and Drug Administration (http://www.fda.gov/)

Advocacy groups:

- Drug Policy Alliance (http://www.drugpolicyalliance.com/)
- *High Times* (http://www.hightimes.com/ht/home/)
- National Organization for the Reform of Marijuana Laws (http://www.norml.org/)
- Marijuana Policy Project (http://www.mpp.org/)

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