



A Wiser Course: Ending Drug Prohibition, Fifteen Years Later

A Statement from the New York City Bar Association's Committee on Drugs and the Law

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Introduction

In 1994, the New York City Bar Association's Committee on Drugs and the Law concluded that the societal costs of drug prohibition are too high to justify it as a policy and called for a national dialogue on alternatives. Fifteen years later, that dialogue has not occurred, we are no closer to a drug-free society, and the problems associated with the illegal drug trade are worse than ever.

The starting point for a critical inquiry into U.S. drug control policy is the Controlled Substances Act of 1970. The legal profession, in partnership with medical professionals and other stakeholders, should study the CSA and propose improvements to it where necessary.

A Call for Dialogue Fifteen Years Ago

On June 10, 1994, the Committee on Drugs and the Law (the "Committee") of the New York City Bar Association released a report (the "Report") entitled "A Wiser Course: Ending Drug Prohibition." It is available at <http://www.nycbar.org/pdf/report/94087WiserCourse.pdf>

The Report argued in detail, *inter alia*, that drug prohibition strains the judicial system with no apparent diminution in drug trade or drug use, fills prisons at great expense to the taxpayers, disproportionately punishes racial minorities, corrupts police and erodes constitutional rights, subsidizes organized crime, drafts poor children into the drug trade, causes violence by engendering competition over the lucrative illegal drug market, fails to decrease demand for drugs, facilitates the spread of disease and impairs the health of drug users, and diverts resources from prevention and treatment to law enforcement.

In short, the Report argued that U.S. drug control policy is the cause of, rather than the solution for, many social problems associated with drugs, and it identified several alternatives to prohibition proposed by members of the federal judiciary (including repeal of all federal laws banning drug sales and possession in favor of state-level drug control, a policy of reduced arrests, and sale of drugs through state stores) without advocating any specific policy. (The Report also stated that any

post-Prohibition regime should leave state and local governments able to apply penal sanctions when drug use results in harm to others, e.g. causing injury while using a motor vehicle under the influence of drugs and to address quality of life issues related to drugs. Report at 81-82.)

The 1994 Report closed with the Committee’s recommendation for “a public dialog regarding new approaches to drug policy, including legalization and regulation.” (Report at 83). Since the Report was issued, there has been a dramatic increase in the influence of drug policy reform advocacy organizations working around the United States on issues such as needle exchange, repeal of mandatory minimums, re-entry of drug law offenders into society, substance abuse treatment, and access to marijuana for medical purposes, but there has been no engaged, systematic evaluation of the rationale of United States drug control policy outside the reform community.

Today the Committee makes a renewed call for a serious discussion of U.S. drug policy through a focus on the medical paradigm and the Controlled Substances Act.

Paradigms

There are, at a minimum, three paradigms of legitimate use of psychoactive substances: sacramental, recreational, and medical.¹ Federal law recognizes certain sacramental uses of peyote and ayahuasca (a substance containing dimethyltryptamine). *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 126 S.Ct. 1211 (2006). Alcohol and tobacco are legal for recreational use and regulated by the Bureau of Alcohol, Tobacco and Firearms.

Historically, federal drug control has been linked to the medical paradigm since drug regulation began with the Harrison Narcotics Act of 1914. The Act limited opiates to what was medically necessary and authorized the Treasury Department to enforce the law. In the late 1960s, the Justice Department replaced the Treasury Department as enforcer.

The Controlled Substances Act of 1970

The starting point for legal analysis of federal drug control is the Controlled Substances Act (the “CSA”), Title II of The Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (Oct. 27, 1970), codified at 21 U.S.C. § 801 et seq, since the CSA is the statute that governs most psychoactive substances (except for three legal and widely used and abused drugs: alcohol, tobacco, and caffeine)².

¹ There is, of course, also the paradigm of destructive use which is well-known to society as “substance abuse” or “addiction”. This statement does not intend to minimize in any way the validity or significance of this fourth paradigm. However, “non-medical use” is currently assumed to be equivalent to “abuse.” The question posed by this statement is whether and in what circumstances the federal law should make that assumption.

² As used in this statement, the term “psychoactive substance” does not refer to alcohol, nicotine, or caffeine.

The essential inquiry of the regulatory system established through the CSA is medical utility. Whether a particular psychoactive substance may ever be used and, if so, under what circumstances is a function of the interplay between three considerations: (a) medical utility, (b) abuse potential, and (c) safety; substances are classified in five different “schedules” based on the interplay between those factors.

Psychoactive substances with (a) a high potential for abuse, (b) no currently accepted medical use in treatment in the United States, and (c) a lack of accepted safety under medical supervision are in Schedule I. 21 U.S.C. § 812(b)(1). Placement in Schedule I means that no physician may ever prescribe the substance for a patient. 21 U.S.C. § 829 (providing for prescription of substances in Schedules II—V). Marijuana and heroin, for example, are in Schedule I, where Congress put them in 1970, along with LSD, psilocybin, peyote, and ibogaine, among others. 21 U.S.C. § 812(c), Schedule I(c).

A substance in Schedule II is one that has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions, even though it also has a high potential for abuse and abuse of the substance may lead to severe psychological or physical dependence. 21 U.S.C. § 812(b)(2). Cocaine and methadone, for example, are in Schedule II, 21 U.S.C. § 812(c), Schedule II(a)(4) and b(4), meaning that they may be dispensed and used under medical supervision in extremely limited circumstances.

Substances in Schedules III-V are those that have a medical use in treatment in the United States, abuse potential that is lower than that of substances in Schedules I and II, and varying degrees of potential for dependence. 21 U.S.C. § 812(b)(3)-(5). For example, amphetamine, Ritalin, certain amounts of codeine, and anabolic steroids are in Schedule III. These substances are available by prescription, subject to regulation by the Department of Justice via the Drug Enforcement Administration.

The CSA does not account for any non-medical use of scheduled drugs in the way that there is non-medical use of alcohol, tobacco, and caffeine.³ There is medical use, which is legitimate, and non-medical use, i.e., abuse, which is illegitimate and must be prohibited.

This provides the context for the “medical marijuana” controversy in states that have enacted laws permitting use of marijuana for medical purposes. Beginning with California in 1996, 13 states have legalized the medical use of marijuana⁴ – in defiance of the federal government. Because federal law does not recognize marijuana as a medicine, no one may legally dispense or use marijuana as a medicine without the prospect of facing criminal penalties.⁵

³ A different articulation of the idea is that they are available to adults without a prescription.

⁴ Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington. Website of the National Organization for the Reform of Marijuana Laws at “Active State Medical Marijuana Programs.”

http://norml.org/index.cfm?Group_ID=3391 (accessed February 22, 2009)

⁵ The United States Attorney General, Eric Holder, Jr., recently announced an end to federal raids of marijuana dispensaries. While this change in policy is welcome, it is still an exception; it does

Charting a wiser course forward: Specific proposals

1. Evaluate the Utility of Schedule I

The basic structure of the Controlled Substances Act has the odd effect of placing drug control in a medical paradigm controlled not by medical experts but by law enforcement agents.

Section 812(b)(1)(b) states that a substance may never be used as a medicine if it has “no currently accepted medical use in treatment in the United States.”⁶ Since the description is passive – “*accepted* medical use” – the unanswered question is “accepted by whom”? By a policeman or a physician? By a physician or a patient? By a judge or a defendant?

It is because of this fatal ambiguity in language – leaving open a power struggle over who defines what constitutes medicine, or, more broadly, healing—that Congress should reexamine the CSA’s basic definitions and scheduling criteria. The fatal ambiguity is the essence of prohibitionist drug control: the authority of police to second-guess physicians in medical matters, in particular here in determining whether a given substance can have a medical use for a given patient.

The more pertinent question perhaps is why there should even be a Schedule I, i.e., why is there a category of substances that no physician may ever prescribe for any purpose under criminal penalty? On what basis does Congress legislate that there are no currently accepted medical uses of a substance? What constitutes a currently accepted medical use of a substance? If an individual physician determines that a particular substance benefits an individual patient, why is that determination nullified by Congress’ determination in 1970 that the substance had no “accepted medical use in treatment”?

2. Congressional Action to Move Marijuana out of Schedule I

Congress put marijuana into Schedule I in 1970. Even if Schedule I classification made sense then, it no longer does. Today, it is inexplicable that cocaine, fentanyl, methadone, and morphine are in Schedule II and thus available by prescription but marijuana is not. There is no credible evidence that marijuana is so dangerous that it cannot be used safely under medical supervision, and Congress should work to spare the federal and state judiciaries further piecemeal litigation over the proper classification of marijuana.

A minimum first step is for Congress to identify what additional evidence it would require to move marijuana out of Schedule I. Leaving aside for a moment the question of whether adults should be subject to criminal penalties for buying, selling, possessing, eating, drinking, or smoking marijuana other than for medical purposes, the continued placement of marijuana in Schedule I means that no

not indicate any permanent change since it does not purport to be grounded in a more rational overall federal policy with regard to marijuana.

⁶ A concept not defined in the CSA.

physician may prescribe it for a patient notwithstanding the physician's medical judgment and the patient's preference for a course of treatment using marijuana. Congress cannot, any more than law-enforcement agents, credibly disregard the claims that marijuana has health benefits, such as analgesia and anti-emetic effects. If it has questions as to the validity of those claims, Congress should take testimony to evaluate them.

If Congress continues to question whether marijuana has a "currently accepted medical use in treatment in the United States," then it should authorize funds to conduct double-blind randomized clinical trials of marijuana as a treatment for the various conditions for which patients claim it is effective.

3. Re-evaluate Scheduling Criteria and Regulatory Agency

Congress could provide statutory definitions for the placement criteria in the Schedules. Congress could provide that the Secretary of Health and Human Services re-evaluate the scheduling criteria at regular intervals to determine whether they are in accordance with the best practices of the respective professional disciplines with relevant expertise. Indeed, Congress should consider overall what aspects of drug regulation should be transferred from the Justice Department to agencies in the Department of Health and Human Services.

4. Abolish Bureaucratic Distinctions Between Substances

Finally, Congress could decide to abolish the bureaucratic distinctions between substances that pick out certain psychoactive substances and subject them to a special statute entrusted to particular federal agencies. Congress could decide to limit federal regulation of substances to accurate labeling on packaging—including false claims about medical efficacy and safety—and leave to the states the task of regulating intrastate trade in the substances, subject to federal protection of fundamental Constitutional rights. The states will be free to impose their own criminal penalties upon and permit civil tort liability against persons who breach duties of care in the manufacture or distribution of psychoactive substances.

Conclusion

Fifteen years ago, the New York City Bar Association's Committee on Drugs and the Law called for dialogue about fundamental change in drug control policy. The Committee renews the call for dialogue, and focuses on the Controlled Substances Act. The results of failed U.S. drug policies are all around us, from international drug cartels and crises to overburdened prison systems to broken families. Drug control policy consists of laws, the root of which are criminal laws limiting the use of psychoactive substances based on conclusions about their medical utility. It is incumbent upon the legal profession, the medical profession, citizens and their representatives, without further delay, to begin an earnest and sustained dialogue about our drug control laws and the assumptions upon which they rest.