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NUMBERS NEVER LIE: DOES MARIJUANA HAVE A HIGH POTENTIAL FOR ABUSE?

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I. INTRODUCTION

Over the last twenty-years, public support for legalizing medical and recreational marijuana use has increased substantially,[1] leading to a growing number of states enacting marijuana laws that clash with federal drug law.[2] Increasing opposition to federal marijuana prohibition has become a popular topic of debate across America. An aspect of the marijuana debate of lesser notoriety however, is the multiple failed efforts to change the Schedule I status of marijuana through the drug classification provisions of the Controlled Substances Act (CSA).[3]

This note looks at that process with a narrow focus on the classification scheme for determining the abuse potential of a drug. Part I briefly discusses the CSA's classification of drugs and describes the evidence the DEA relies on for assessing AP of a drug. Part II then presents a more in depth evaluation of this evidence and argues that removal of marijuana from the CSA is proper, as it does not meet the requirements for inclusion in any of the schedules.

II. CSA CLASSIFICATIONS AMBIGUOUS NATURE

Enacted in 1970, the CSA represented a synthesizing of the multitude of existing drug laws into a single comprehensive statue for federal control of all dangerous drugs.[4] It established five schedule of substances providing for varying measures of control that reflect the abuse potential (AP) and medical utility of the drugs within each schedule.[5] "Schedule I drugs are subject to the

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[1] Pew Research Center, *Marijuana in America: Shifting Attitudes, Events and Laws*, Apr. 4th, 2013, http://www.people-press.org/2013/04/04/marijuana-timeline/.

[2] Id.

[3] Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801 et seq.

[4] H.R. No. 91-1444, at 658.

[5] See 21 U.S.C. § 812(b); H.R. No. 91-1444, at 598. Americans for Safe Access v. DEA, 706 F.3d 438, 441 (D.C. Cir. 2013) (citing ACT v. DEA, 15 F.3d at 1133). Due to schedule I drugs lacking any accepted medical uses they can only be lawfully obtained and used by doctors for federally

most severe controls … [as] they are deemed to be the most dangerous substances, possessing no redeeming value as medicines."[6] The initial placement of marijuana in Schedule I was not based on Congresses finding of a high AP, but rather on its view that there was a "considerable void in [its] knowledge [about marijuana] and [its] effects."[7]

Recognizing that a drugs proper schedule may change over time[8] the CSA provided a process for rescheduling or de-scheduling a drug under CSA control.[9] Under the classification provisions of § 811, ultimate authority over the classification of drugs rests with the Attorney General – who delegated this authority to the Drug Enforcement Administration (DEA).[10] This authority includes the ability to remove a drug from the CSA entirely, if the DEA finds the drug "does not meet the requirements for inclusion in any schedule."[11] Drug classification determinations require consideration of eight "[f]actors

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approved research purposes. Id. Schedule II-V substances; on the other hand, can lawfully be prescribed under the conditions of section 829 of the CSA. 21 U.S.C. § 829.

[6] Alliance for Cannabis Therapeutics v. DEA, 930 F.2d 936, 937 (D.C. Cir. 1991). Placement in Schedule I requires that a drug be found to have (1) a high potential for abuse, (2) no accepted medical use, and (3) a lack of safety for use under medical supervision. 21 U.S.C. § 812(b)(1)(A)-(C).

[7] H.R. No. 91-1444, at 605, 653 (noting recommendations of Assistant Secretary for Health and Scientific Affairs, Roger O. Egeberg, M.D. that marijuana remain in Schedule I until review of drug by Shaffer Commission was completed to fill the void in their knowledge).

[8] Nat'l Org. for Reform of Marijuana Laws v. Drug Enforcement Admin., 559 F.2d 735, 737-38 (D.C. Cir. 1977).

[9] 21 U.S.C. § 811 (establishing authority and criteria for classification of substances under the CSA).

[10] 28 C.F.R. § 0.100 (2012). The Administrator of the DEA has subsequently re-delegated this authority to the DEA's Deputy Administrator. 28 C.F.R. § 0.104 (2012).

[11] The DEA may initiate classification determinations on its own, at the Secretary of HHS's request, or on petition by any interested party. § 811(a)(2). However, the DEA's authority to remove drugs from the CSA is limited somewhat by subsection (d) of § 811. "If control is required by United States obligations under international treaties … in effect on [the effective date of this part], the Attorney General shall issue an order controlling such drug under the schedule he deems most appropriate … without regard to the findings required by … § 812(b)…" § 811(d)(1). Although an interesting topic, consideration of international diplomacy issues is outside the scope of this note. Discussions on the effect of international treaties – namely the Single Convention of 1961 – on the debate over legalization of recreational and/or medicinal marijuana will be important as the debate progresses. See generally N.Y. City Bar, The International Drug Control Treaties: How Important Are They to US Drug Reform?, Committee on Drugs & The Law (Aug. 2012), available at http://www2.nycbar.org/pdf/report/uploads/3_20072283-InternationalDrugControlTreaties.pdf (detailing the many aspects of international drug treaties on drug policies and drug law reform in the United States and discussing the possible effect of Bolivia being the first country to make a hard challenge to UN drug control and international treaties); Nicolas Eyle, Heather J. Haase and Joshua R. Schrimpf, 50% of Americans Want Marijuana Legal, 70% Want Medicinal Pot – Are International Treaties Standing in the Way of Legalization?, AlterNet, July 5, 2012, http://www.alternet.org/story/156191/50_of_americans_want_marijuana_legal%2C_70_want_medicinal_pot_--_are_international_treaties_standing_in_the_way_of_legalization (discussing effect of international drug treaties on the United States policies on marijuana); and Eric Sterling, International Treaties vs. Marijuana Legalization, July 18, 2012, http://justiceanddrugs.blogspot.com/2012/07/international-treaties-vs-marijuana.html (discussing effect of the Single Convention on the votes in Washington and Colorado to legalize recreational use of marijuana).

determinative of control [under] or removal from [CSA] schedules" that focus on scientific, medical and abuse aspects of a drug.[12]

Since 1970, the DEA has denied three petitions to reschedule marijuana concluding in each that marijuana continues to satisfy CSA criteria for Schedule I drugs.[13] Facilitating these conclusions and the continued Schedule I status of marijuana is three flaws that result from the CSA's ambiguity. First, the CSA fails define "abuse potential,"[14] which is a requirement for placement in any CSA schedule.[15] Second, the CSA's statutory framework bases its schedules on a comparative AP scale, with high potential as the baseline, without clearly establishing what constitutes "high potential for abuse."[16] Third, the CSA provides only minimal guidance for determining the level of AP a drug possesses.[17] Essentially, the CSA's vagueness gives the DEA immense interpretational authority in determining what constitutes a "high potential for abuse,"[18] which allows them "to control, almost at will, any drugs it want[s]."[19]

III. DETERMINING THE ABUSE POTENTIAL OF MARIJUANA

A primary focus of the DEA's abuse potential evaluation in previous classification assessments of marijuana are national surveys and databases on

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[12] § 811(b)-(c). The eight factors for evaluating a drug are: "(1) Its actual or relative potential for abuse; (2) Scientific evidence of its pharmacological effect, if known; (3) The state of current scientific knowledge regarding the drug or other substance; (4) Its history and current pattern of abuse; (5) The scope, duration, and significance of abuse; (6) What, if any, risk there is to the public health; (7) Its psychic or physiological dependence liability; and (8) Whether the substance is an immediate precursor of a substance already controlled under this [title]." § 811(c)(1)-(8).

[13] Denial of National Organization for Reform of Marijuana Laws (NORML) Petition to Reschedule Marijuana, 54 Fed. Reg. 53767 (Dec. 29, 1989) (hereinafter Denial of NORML Petition); Notice of Denial of Petition of Jon Gettman to Reschedule Marijuana, 66 Fed. Reg. 20038 (Apr. 18, 2001) (hereinafter Denial of Gettman Petition); Denial of Coalition for Rescheduling Cannabis Petition to Reschedule Marijuana, 76 Fed. Reg. 40552, 40570 (July 8, 2011) (hereinafter Denial of CRC Petition).

[14] Final Brief for Respondent, Americans for Safe Access v. DEA, No. 11-1265, at 13, 48 (D.C. Cir. May 29, 2012).

[15] *See generally* §§ 812(b)(1)(A), (2)(A), (3)(A), (4)(A), (5)(A) (stating findings about abuse required for placement in each schedule, schedules I-II require high potential for abuse). By declining to define potential for abuse, the CSA effectively gives the DEA immense authority "to control, almost at will, any drugs it want[s]."

[16] The CSA's abuse potential scale starts with high potential for abuse for Schedule I and II drugs and then decreases to "a potential for abuse less than the drugs … in schedules I and II" for Schedule III drugs. *Compare* 21 U.S.C. § 812(b)(1)(A), *with* § 812(b)(2)(A). Continuing to decrease only "a low potential for abuse relative to the drugs … in schedule III" is required for Schedule IV drugs and merely "a low potential for abuse relative to the drugs … in schedule IV" for Schedule V drugs. §§ 812(b)(3)(A),(4)(A),(5)(A).

[17] Interestingly, this is not a uniquely American problem. While many countries "have drug classification systems that purport to be structured according to the relative risks and dangers of illicit drugs … the process by which harms are determined is often undisclosed, and when made public can be ill-defined, opaque, and seemingly arbitrary." David Nutt et al., *Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse*, 369 LANCET 1047 (2007).

[18] Adding to the DEA's interpretational leeway is the use of the arbitrary and capricious standard to review final classification determinations of the DEA. See Americans for Safe Access v. DEA, 706 F.3d 438, 440 (D.C. Cir. 2013) ("The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency.") (quoting Motor Vehicle Mfrs. Ass'n of the U.S., Inc., v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).

[19] Hogan, at 39, n.35.

drug use and abuse in the United States. Three of these databases are particularly useful in assessing the abuse potential of marijuana the National Survey on Drug Use and Health (NSDUH), the Drug Abuse Warning Network (DAWN), and the Treatment Episode Data Set (TEDS). These databases "provide quantitative data on many factors related to abuse of a particular substance."[20]

A thorough evaluation of these databases not only allows for the assessment of the (AP) of marijuana, but also is useful in comparing its (AP) with that of drugs with an established "high potential for abuse." However, because the structure of the CSA allows for unfettered interpretation in making classification determinations, the DEA often restricts its analysis to the evidence that supports a finding of a high (AP).[21]

A full evaluation of all the relevant NSDUH data – which provides estimates of illicit drug use, abuse, and dependence[22] - contributes useful information for determining the abuse potential of marijuana. While the DEA considered NSDUH data in its most recent classification evaluation of marijuana, it appears to restrict unnecessarily its analysis.[23] Examining only the overall user and dependence/abuse totals for marijuana, without considering how the numbers for marijuana correlate to each other and to other illicit drugs, leaves the DEA's evaluation open to valid criticisms.[24]

Such a limited evaluation of NSDUH's quantitative data to assess abuse potential is irrational[25]; only vaguely revealing the relevant abuse potential of marijuana.[26] A reliable assessment of how NSDUH data reflects abuse potential

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[20] 76 Fed. Reg. 40552, 40570.

[21] *See generally* Petitioners' Opening Brief, Americans for Safe Access v. DEA, No. 11-1265, at 37-48 (D.C. Cir. Jan. 26, 2012) (arguing DEA's evaluation of marijuana was arbitrary and capricious in failing to perform a full and proper evaluation of all the evidence) (hereinafter Petitioners Opening Brief).

[22] SAMHSA, *National Survey on Drug Use and Health: About the Survey*, http://www.samhsa.gov/data/population-data-nsduh/about (last visited July 18, 2013) (noting NSDUH is a nationwide survey administered annually that provides estimates of licit and illicit drug use, abuse, and dependence in the United States at the national and state levels).

[23] 76 Fed. Reg. at 40570 (citing 2009 NSDUH data showing marijuana as illicit drug of most common use and dependence/abuse). HHS concluded that "[t]he large number of individuals using marijuana on a regular basis [and] its widespread use … are indicative of the high abuse potential for marijuana." Id. at 40562. Similarly, the DEA also cites marijuana's widespread use in its conclusion of a high abuse potential for marijuana. Id. 40584.

[24] In its appeal of the DEA's classification determination for marijuana, Americans for Safe Access argue that the DEA erroneously uses the NSDUH data to equate widespread use with abuse. *See* Petitioners' Opening Brief, *supra* note 21, at 43-46 (arguing that claim of widespread use equating to widespread abuse was implicitly rejected by Congress with its exemption of the more popular drugs of alcohol and tobacco from CSA control). "Indeed, if use alone could justify Schedule I treatment, extremely popular substances, such as caffeine and aspirin, which are not statutorily exempt, would have to joint marijuana in Schedule I." Id. at 45. But see Respondents Opening Brief at 51 (claiming exclusion of tobacco and alcohol from CSA does not make its consideration of the number of users unreasonable).

[25] *See* H.R. 91-1444, at 615, 625 (noting classification determinations should involve *full consideration* of *all the factors*, *all the information available*, and *all other relevant data*) (emphasis added). *See also* Petitioners' Opening Brief, *supra* note 21, at 37-42 (arguing the CSA requires a comparison by the DEA of a substance with other substances in the CSA to determine the substances proper schedule).

[26] *See* Rulemaking Petition to Reclassify Cannabis for Medical Use from a Schedule I controlled Substance to a Schedule II, at 26 (Nov. 30, 2011).

for a drug, such as marijuana, should take all of the relevant data into account.[27] Looking at NSDUH totals for marijuana, as the DEA did, a finding of a high abuse potential seems reasonable, given the over 29 million marijuana users[28] and the classification of 4.5 million individuals with marijuana abuse/dependence in 2010.[29] Nevertheless, this is only one part of a relevant consideration of the NSDUH data.[30]

Also relevant to assessing abuse potential is a determination of the probability of use of a drug resulting in abuse or dependence. According to NSDUH data, the probability of marijuana abuse or dependence was 15 percent in 2010.[31] On its face, this would appear to offer at least some additional evidence of a high abuse potential. However, given that CSA scheduling uses a sliding scale of abuse potential, from high to low, a proper determination of abuse potential necessarily requires comparison of a drug with other scheduled drugs.[32] A comparison of marijuana to cocaine and heroin actually lends more support to the argument that marijuana does not have a high abuse potential, as the probability of abuse/dependence for cocaine and heroin is 23 percent and 58 percent, respectively.[33]

Accordingly, in terms of the NSDUH data the abuse potential for marijuana is considerably lower than for cocaine, a Schedule II drug. Furthermore, it is substantially lower than the Schedule I drug heroin, which is noteworthy given the CSA's legislative history states that "[i]n evaluating

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[27] Id. at 625.

[28] According to NSDUH 29,739,000, individuals used marijuana in 2010. SAMHSA, 2011 Tables: Illicit Drug Use, Table 1.1A, available at http://www.samhsa.gov/data/NSDUH/2011SummNatFindDetTables/NSDUH-DetTabsPDFWHTML2011/2k11DetailedTabs/Web/HTML/NSDUH-DetTabsSect1peTabs1to46-2011.htm#Tab1.1A (listing the number of past year users of drugs in the thousands).

[29] SAMHSA, 2011 Tables: Dependence, Abuse, and Treatment, Table 5.2A, available at http://www.samhsa.gov/data/NSDUH/2011SummNatFindDetTables/NSDUH-DetTabsPDFWHTML2011/2k11DetailedTabs/Web/HTML/NSDUH-DetTabsSect5peTabs1to56-2011.htm#Tab5.1A (charting the number of individuals dependent on or abusers of illicit drugs and estimating 4,505,000, with marijuana dependence or abuse).

[30] For instance, it is also relevant to consider that the larger number of marijuana users undeniably results in large part from marijuana being one of - if not the – safest of all illicit drugs. *See* David Nutt et al., *Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse*, 369 LANCET 1047, 1050 (2007) (ranking drugs by harm the cause and placing cannabis at (11) behind heroin (1), cocaine (2), alcohol (5), amphetamines (8), and tobacco (9)); David J. Nutt et al., *Drug Harms in the UK: A Multicriteria Decision Analysis*, 376 LANCET 1558, 1561 (2010) (ranking alcohol as the most harmful drug in front of heroin (2), crack cocaine (3), methamphetamine (4), cocaine (5), tobacco (6), and cannabis (8)); Mark Taylor et al., *Quantifying the RR of Harm to Self and Others from Substance Misuse: Results From a Survey of Clinical Experts Across Scotland*, BMJ OPEN, July 2012, at 1, 5 (ranking cannabis as least harmful drug at (19) behind heroin (1), crack (2), crystal meth (3), alcohol (4), cocaine (5) and tobacco (7)).

[31] Taking the 4,505,000, individuals with abuse/dependence on marijuana, divided by the 29,739,000, marijuana users equals 15 percent. See 2011 Tables: Illicit Drug Use, Table 1.1A, supra note 56; and 2011 Tables: Dependence, Abuse, and Treatment, Table 5.2A, supra note 57.

[32] Under the CSA, Schedule I and II drugs require a finding of a "high" potential for abuse. 21 U.S.C. § 812(b)(1)(A), (2)(A). Schedule III, IV, and V drugs require findings of a potential for abuse, less than Schedule I and II drugs, low abuse potential relative to Schedule III drugs, and low abuse potential relative to Schedule IV drugs, respectively. § 812(b)(3)(A), (4)(A), (5)(A).

[33] *See id*., table 5.2A (estimating 1,012,000, for cocaine abuse/dependence and 361,000, for heroin abuse/dependence); id., table 1.1A (estimating 4,482,000, cocaine users and 620,000, heroin users in 2010).

existing abuse [it is important to] know … whether the abuse … is a significant chronic abuse problem like heroin addiction."[34]

A major reason for a government exerting control over a drug is the level of harm associated with a drug.[35] One such harm is the tendency of a drug to cause physical harm to a user.[36] Accordingly, estimates from DAWN, which compiles data on emergency department (ED) visits involving the implication of recent drug use, is useful in assessing the abuse potential and danger of a drug.[37] Although helpful, DAWN data unfortunately does have some important limitations. Notably, ED visits frequently involve the use of multiple drugs and DAWN records such a visit multiple times.[38] Additionally, DAWN notes that "[s]ince marijuana[] is frequently used in combination with other drugs, the reason for the ED contact may be more relevant to the other drug(s) involved in the episode."[39] Therefore, an ED visit involving marijuana and cocaine will appear in DAWN twice, once for each drug, even if the visit results primarily from the use of cocaine. Furthermore, "DAWN does not assess the medical reasons for the visit, and it cannot be assumed that a drug was a direct cause of the medical emergency."[40]

Despite its limitations, DAWN estimates when fully analyzed remain a valuable part of an overall evaluation of abuse potential. DAWN estimates that of the over 4.9 million drug-related ED visits in 2010, 2.3 million were associated with drug abuse or misuse.[41] Of these ED visits, 1,171,024 involved misuse or abuse of illicit drugs.[42] It is undeniable that the raw numbers support the claim of a high abuse potential for marijuana.[43] As the 461,028, ED visits involving marijuana exceed the totals for all other illicit drugs except cocaine.[44] However, as previously noted absolute totals by themselves should only be part of a total evaluation of all the information the databases provide.

Consideration of the amount of ED visits for a drug in relation to its total user population is also valid in assessing abuse potential.[45] Furthermore, to better assess marijuana's abuse potential the numbers again need to be compared to

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[34] H.R. No. 91-1444, at 628.
[35] David Nutt et al., *Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse*, 369 LANCET 1047, 1047 (2007).
[36] *See id.*
[37] Drug Abuse Warning Network (DAWN), http://www.samhsa.gov/data/emergency-department-data-dawn (last updated Aug. 27, 2010).
[38] U.S. Dep't Health and Human Serv., DRUG ABUSE WARNING NETWORK, 2011: NATIONAL ESTIMATES OF DRUG-RELATED EMERGENCY DEPARTMENT VISITS 1, at 26 (2013). In 2011, the sum of the number of visits by drug was 1,538,380, which are 285,880 more visits than the 1,252,500; total ED visits involving illicit drugs. *Id.*
[39] 76 FED. REG. 40552, 40561.
[40] U.S. Dep't Health and Human Serv., DRUG ABUSE WARNING NETWORK, 2010: NATIONAL ESTIMATES OF DRUG-RELATED EMERGENCY DEPARTMENT VISITS 1, at 25 (2012).
[41] *Id.*
[42] *Id.*, at 26. The sum of the visits by illicit drugs in 2010 was 1,427,702, which is 256,678 more than the total ED visits involving illicit drugs. *See id*., at 26, 30.
[43] This is exactly what the DEA argues when evaluating the DAWN data and marijuana's abuse potential it the last marijuana rescheduling petition. 76 FED. REG. 40552, 40571.
[44] *Id.*, at 30.
[45] The Coalition for Rescheduling Cannabis, Petition to Reschedule Cannabis (Marijuana), 1, 99 (Oct. 9, 2002).

other illicit drugs with established high abuse potentials.[46] In 2010, DAWN estimates that of ED visits involving illicit drugs, 488,101 involved cocaine, 461,028 involved marijuana, 224,706 involved heroin, 94,929 involved methamphetamine, and 53,542 involved PCP.[47] NSDUH data estimates that the user populations for each drug in 2010 was 4,482,000 for cocaine, 29,301,000 for marijuana, 620,000 for heroin, 1,033,000 for methamphetamine, and 119,000 for PCP.[48] Using the data from these databases to determine the rate of ED visits per 100,000 users of each drug produces astounding results. According to the data the rates per 100,000 users were, 44,993 for PCP, 36,243 for heroin, 10,890 for cocaine, 9,190 for methamphetamine, and only 1,573 for marijuana. Thus, despite marijuana being the most commonly used illicit drug[49] it has by far the lowest rate of mentions in drug-related ED visits. Furthermore, given that the limitations of DAWN likely results in the number of ED visits actually resulting from marijuana being inflated, the gap between marijuana and the other drugs is likely even larger.[50] In sum, this data indicates that individuals that use PCP, heroin, cocaine, or methamphetamine are much more likely to seek medical attention as a result of their use than individuals who use marijuana; providing further evidence of a lower abuse potential for marijuana.

Admissions into substance abuse treatment facilities is another relevant aspect of the multi-faceted evaluation of AP. Databases, such as TEDS, that collect data on treatment admissions in the United States provide information that can assist in characterizing the AP of drugs.[51] TEDS maintains a wide array of useful drug-treatment information including the number of treatment admissions by treatment referral source, type of service, primary substance of abuse, and the overall total number of admissions, among others.[52] To a degree each of the different sets of data are useful on their own in evaluating AP. However, in assessing AP an individual can best utilize the sets of data when considering them in conjunction with each other and in association with information from other databases like the NSDUH.

If total admissions per substance were the extent of relevant TEDS data then the DEA's conclusion that "the high absolute number of treatment admissions associated with marijuana [provides] evidence … of a high potential for abuse"[53] would be rational. Indeed the total number of treatment admissions

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[46] *See generally* Petitioners' Opening Brief, *supra* note 21, at 37-42 (arguing that "[a]lthough the CSA does not define the term 'high potential for abuse' its statutory language and framework make clear that a substance must be compared to *other* scheduled substances to determine whether its abuse potential is sufficiently 'high' to warrant Schedule I treatment.") (emphasis in original).

[47] *Id.*

[48] SAMHSA, table 1.1A, supra note 56.

[49] *Id.*

[50] *See id.*, at 22, 29 (noting the limitations of DAWN data and that estimates for heroin-related ED visits may be underestimated slightly).

[51] 76 FED. REG. 40552, 40561, 40571.

[52] *See generally* SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., HHS PUB. NO. SMA 13-4772, TREATMENT EPISODE DATA SET (TEDS) 2001 – 2011: NATIONAL ADMISSIONS TO SUBSTANCE ABUSE TREATMENT SERVICES (2013) (including in characteristics of treatment admissions age, race, gender, frequency of use, referral source, prior treatment admissions, and type of service, among others) (hereinafter TREATMENT EPISODE DATA SET (TEDS) 2001 – 2011).

[53] Initial Brief for Respondent, Americans for Safe Access v. DEA, No. 11-1265, at 50 n.17 (D.C. Cir. Mar. 23, 2012) ("The Administrator reasonably relied on the high absolute number of treatment admissions associated with marijuana abuse as evidence that the drug has a high potential

for marijuana yearly is high in relation to many other illicit drugs. From 2001 to 2011, marijuana had the highest number of admissions in every year except for 2001 when it was second behind heroin.[54] Additionally, total marijuana admissions has exceeded 300,000 from 2005-2011.[55] On average, marijuana accounted for 16.5 percent of the total drug treatment admissions from 2001-2011, representing a larger percentage than any other illicit drug.[56] While this data would tend to support the argument of "high" AP for marijuana, it is not the only relevant data. Instead, TEDS data extends well beyond the absolute number of treatment admissions.

Attention to the various sources of referral for admission into drug treatment is also crucial; helping to avoid conclusions based off a hasty generalization by giving total admissions for a drug the proper amount of weight in the overall evaluation.[57] Failing to acknowledge distinctions between different referral sources implicitly treats all admissions as identical, regardless of the manner an individual arrived in treatment.[58] Viewing treatment admissions this way is illogical, as the various referral sources are recognizably different.

In particular, there are clear distinctions between admissions through self-referral and those through criminal justice (CJ) referral. An individual entering treatment on their own initiative or through the influence of personal relationships generally does so to deal with chronic addiction, adverse social and familial effects of their drug use, or both.[59] In contrast, some or all of these issues are often absent with individuals admitted to treatment through CJ referral, as individuals eligible for drug diversion programs in many states include first time drug offenders and individuals without a drug addiction.[60]

Given the differences of CJ referrals compared to self-referrals, consideration of the proportion of total treatment admissions for a drug, attributable to each is essential to a proper evaluation of TEDS data. This additional inquiry provides compelling evidence that marijuana does not have a

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for abuse and was not required to discount that statistic merely because a high proportion of such admissions resulted from criminal justice referrals.").

[54] TREATMENT EPISODE DATA SET (TEDS) 2001 – 2011, supra note 52, at 43 tbl. 1.1a.

[55] *Id.*

[56] The averages over the same eleven-year period are 14.4 percent for heroin, 11.9 percent for cocaine, and 6.3 percent for methamphetamine. *Id.*, at 44 tbl. 1.1b.

[57] *See* Coal. For Rescheduling Cannabis, *Petition to Reschedule Cannabis (Marijuana): Filed with the Drug Enforcement Administration*, 1, 99 (Oct. 9, 2002), available at http://www.drugscience.org/PDF/Petition_Final_2002.pdf.

[58] The DEA continuously cites the overall number of treatment admissions for marijuana without discussing any differences in the admissions. *See generally* 76 FED. REG. 40552 (denying rescheduling of marijuana in part based on the high number of treatment admissions associated with marijuana).

[59] *Id.* ("The abuse potential of the more dangerous drugs is so severe that addicts seek treatment on their own…").

[60] Furthermore, "drug courts generally have a very strong interest in admitting … [and may even] actively seek out 'low-risk' nonaddicted clients and [attempt] to 'skim' high-risk clients away from their programs." Thus, for some CJ referred individuals in treatment the only adverse consequence from their marijuana use is legal trouble stemming from marijuana's status as an illicit drug. Alex Kreit, *The Decriminalization Option: Should States Consider Moving from a Criminal to a Civil Drug Court Model?*, 2010 U. CHI. LEGAL F. 299, 314 (noting this stems from funding for drug courts often depending on their ability to show results and treatment of a sufficient amount of individuals).

high AP. First, each year a large portion of marijuana admissions are CJ referrals. From 2002 to 2011 an average of 56.2 percent of marijuana admissions were CJ referrals, revealing that a majority of individuals admitted to treatment for marijuana, do so under a court order or agreement.[61] In 2011 for example, there were 333,578 marijuana admissions, 172,126 of which came from the CJ system.[62]

The CRC rescheduling petition argued that this supports a finding of a lower AP for marijuana in relation to other drugs.[63] Disagreeing, the DEA asserts that other high AP drugs – PCP and methamphetamine in particular – also have large proportions of CJ referrals, thus making it "[im]possible to establish or predict relative abuse potentials from ranking of proportions of [CJ referred] treatment admissions."[64] While basing (AP) determinations solely off CJ referrals would be illogical, the proportion of CJ referrals is nevertheless relevant to assessing relative AP in terms of drug treatment admissions. As noted, data on CJ referrals allows for a better understanding of the absolute numbers that the DEA so heavily relies on by providing information on the makeup of individuals in treatment for a specific drug. This Information is undeniably relevant to and thus deserves consideration in a determination of AP of a drug.

In addition, the low proportion of self-referrals for marijuana further distinguishes its AP from drugs whose AP is high. Self-referrals for marijuana from 2002 to 2011 averaged 15.7 percent of total admissions.[65] In comparison, the average percentage of self-referrals for other drugs were 22.8 for PCP, 23.2 for methamphetamine, 29.8 for non-crack cocaine, 37.5 for crack cocaine, and 57.9 for heroin.[66] Accordingly, the difference in the ratios of individuals seeking treatment voluntarily is considerable.

Certainly, an argument exists for the proportion of CJ and self-referrals for marijuana being relatively comparable to those for PCP and methamphetamine. Under cutting this argument however, is application of admissions for each drug to its relative user population, which differentiates the risk of a user of each needing drug treatment. Using NSDUH and TEDS data from 2001-2010, the average of users in treatment per 100,000 users was 1,168, for marijuana, 2,297 for PCP, and 7,974 for methamphetamine.[67] Finally, complied treatment data on prior treatment episodes, type of service at admissions, and DSM dependence diagnosis, furthers the argument that the AP of marijuana is lower than high AP drugs.[68]

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[61] The percentage of CJ referrals for other major illicit drugs were 51.8 percent for meth/amphetamine, 46.4 percent for PCP, 39 percent for cocaine, 28.2 percent for smoked cocaine, and 16.3 percent for heroin. *See* attached tables, tbl. 1.

[62] TREATMENT EPISODE DATA SET (TEDS) 2001 – 2011, *supra* note 52, at 63, tbl. 2.6.

[63] 76 Fed. Reg. 40552, 40574 ("The petitioner … presents data from TEDS … in which a larger proportion of all marijuana treatment admissions are referred to by the criminal justice system … compared to much smaller percentages for heroin and cocaine … and claims that this difference establishes marijuana's relative abuse potential as lower than the other drugs.").

[64] *Id.*

[65] *See* attached tables, tbl. 1.

[66] *Id.*

[67] *See* attached tables, tbl. 2, 3, & 4.

[68] According to TEDS, marijuana had the highest percentage of no prior treatment admissions and lowest percentage of three or more treatment episodes; the highest percentage of ambulatory service and outpatient ambulatory service; the lowest percentage of rehabilitation services; lowest percentage of detoxification services; and lowest percentage of dependence on primary substance

IV. CONCLUSION

In sum, the CSA's process of classifying drugs is flawed and ambiguous presenting the DEA with nearly unchecked authority over the scheduling of drugs, which the DEA has utilized in assessing the (AP) of marijuana. However, an in depth evaluation of three national databases the DEA uses for evidence indicative of drug abuse and dependence evinces an AP for marijuana lower than the major Schedule I and II drugs. Marijuana has a lower probability for abuse or dependence than cocaine and heroin. Additionally, marijuana had the lowest rate of ED mentions per 100,000 users. Finally, multiple aspects of drug treatment data clearly distinguished marijuana from other illicit drugs in terms of AP. Given this information, Congress should consider performing its own evaluation of the abuse potential of marijuana. Ultimately, the focus of policy makers should be whether marijuana's AP justifies its continued prohibition, especially in light of the harms prohibition itself causes.[69]

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of abuse at admission. *See* TREATMENT EPISODE DATA SET (TEDS) 2001 – 2011, *supra* note 52, at 62 tbl. 2.5, 64 tbl. 2.7, 68 tbl. 2.11.

[69] The following sources provide interesting views of the many negatives of marijuana prohibition including economic costs, racial disparity in enforcement, and the many collateral sanctions associated with conviction for a marijuana offense. *See generally*, ACLU, The War on Marijuana in Black and White, June 2013 (discussing the racial disparity in enforcement of marijuana laws); Richard Glen Boire, *Life Sentences: The Collateral Sanctions Associated with Marijuana Offenses*, CTR. FOR COGNITIVE LIBERTY & ETHICS (July 2, 2007) (discussing the many additional negative effects of a marijuana offense beyond conviction); Jeffrey A. Miron, *The Budgetary Implications of Marijuana Prohibition*, June 2005 (detailing the many economic aspects of marijuana prohibition); Eric Blumenson and Eva Nilsen, *No Rational Basis: The Pragmatic Case for Marijuana Law Reform*, 17 VA. J. SOC. POL'Y & L. 43 (2009) (discussing the many negative effects of marijuana prohibition and arguing that these clearly show there is no rational basis for a continued marijuana policy of absolute prohibition).