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Moving Marijuana to Schedule III Would Aid Access to Legal Care

Perkins Coie's Andrew Kline and Porter Wright's Shane Pennington write that reclassifying marijuana as a Schedule III substance would facilitate medical use and allow resources to be focused on more harmful drugs.

Last week, Kevin Sabet, former drug policy adviser in the Executive Office of the President, published a letter from multiple former Drug Enforcement Administration and Office of National Drug Control Policy leaders claiming marijuana is "addictive." This rhetoric is actually quite dangerous, thwarting the public health and safety imperatives they proclaim to want to protect.

The letter asserts that moving marijuana to Schedule III will "supersize the cannabis industry" by providing tax relief and further normalizing the state-regulated market. In the name of public health and safety, we should all hope that the letter's authors are 100% right. It's the state-regulated industry that tests its products, conducts age verification, and mandates packaging and labeling standards.

Among other misstatements, the letter asserts criminal penalties will change because of rescheduling. Criminal penalties are tied to weight, not schedule, so moving marijuana from Schedule I to Schedule III will do nothing to change them.

The evidence offered for the claim that marijuana is "addictive" is thin and misleading, stating that "[r]esearch has found that 3 in 10 people who use marijuana become addicted to the drug." As Matt Zorn recently noted in his own critique, however, not all "addictions" are created equal.

Studies show, for example, that 3 in 10 coffee drinkers are addicted to caffeine, and yet the authors aren't calling for criminalization of coffee shops and imprisonment of all coffee drinkers.

The far more important question is what, if any, harm is associated with use of marijuana, coffee, or other widely used substances. With opioid addiction plaguing our country, killing about 100,000 people last year and causing a nationwide public health emergency, these assertions are ill-conceived.

Our limited attention and resources should be focused on the drugs that are actually causing harm—marijuana has never been on that list. According to the DEA, there have been zero deaths attributable to marijuana use. These former officials cite research suggesting marijuana is "more addictive than several other Schedule I drugs, including LSD, GHB, ecstasy, and khat."

This assertion is tragic. There's a significant difference between a "use disorder" and "addiction," and the letter conflates the two in its unsubstantiated point. Relevant evidence actually points to the contrary: Marijuana has less abuse potential than drugs in Schedule I or II. And not all abuse potential is the same.

Relatedly, the multiple signatories indicate they are “gravely concerned” about moving marijuana to Schedule III, arguing “there has been no evidence that marijuana’s schedule should change” since the federal government last considered a rescheduling petition in 2016.

We recently published a report pointing out that marijuana’s widespread state-level acceptance as medicine and its use by patients in treatment in the US (currently 38 states) means marijuana has a currently accepted medical use in treatment in the US.

And medical marijuana use in compliance with state law no longer qualifies as “abuse,” thus requiring a complete recalibration of the plant’s abuse potential. The Food and Drug Administration evidently agrees.

Ironically, initial clinical trial results with MDMA and psilocybin (two other Schedule I drugs) have been so promising that the FDA granted breakthrough therapy designations to both MDMA-assisted therapy for post-traumatic stress disorder and two psilocybin therapies for life-threatening forms of depression (treatment-resistant depression and major depressive disorder).

This means the FDA hopes to accelerate the approval timeline for these potentially lifesaving therapies, which demonstrated a substantial improvement over currently available treatments for these serious conditions.

Yet paradoxically, the Schedule I status of MDMA and psilocybin impedes access to these substances, both for clinical research and compassionate use—the same is true for marijuana.

Veteran suicide rates have reached epidemic levels in this country, conservatively estimated between 17 and 22 per day, and nationwide deaths of despair continue to rise despite increased spending on mental health care.

We can’t help but wonder whether the letter’s authors support veteran access to drugs that alleviate chronic pain, anxiety, and PTSD—even if currently Schedule I drugs.

Most significantly, throwing stones at the state-regulated marijuana marketplace is misguided and dangerous. This effort could instead be focused on the illicit marijuana market and/or hemp-derived products that Congress arguably legalized in the 2018 farm bill.

These products are being sold direct to consumers without THC limits, age verification, lab testing, packaging or labeling standards, restrictions on marketing to children, product tracing, or any of the other protections attributable to the state-legal marijuana marketplace.

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