October 14, 1994

Attorney General Janet Reno
Department of Justice
10th St. & Constitution Avenue NW
Washington, D.C. 20530

Dear Madame Attorney General:

This letter is a request that you exercise your authority under 21 U.S.C. § 811(b) to request a scientific and medical evaluation of marijuana from the Secretary of Health and Human Services with respect to reconciling your statutory responsibilities under the Controlled Substances Act with the most recent research concerning marijuana's actual and relative potential for abuse.

I am making this request rather than filing a petition pursuant to §811(a)(2) because the last petition with respect to this issue resulted in 22 years of litigation. As a student of the criminal justice system I believe other avenues of due process should be exhausted before utilizing our overburdened courts. It is my hope that the information I cite below will be of sufficient weight to make a case which would require, at a minimum, that you begin the process of "gathering the necessary data" referred to in § 811(b) to prepare and formally consider making such a request.

Section 812(b) states that "a drug or other substance may not be placed in any schedule unless findings required for such schedule are made with respect to such drug or other substance." One such finding for Schedule I is that "the drug or other substance has a high potential for abuse."

Recent research at the National Institute of Mental Health makes it impossible to sustain that finding. This issue was not addressed in the recent litigation over the last marijuana rescheduling petition, nor was it raised in the administrative law hearings which preceded the recent and apparently final round of court action.

The Office of Technology Assessment of the U.S. Congress published a background paper in September of 1993 on the "Biological Components of Substance Abuse and Addiction" (OTA-BP-BBS-117). This report clearly explains that according to the latest medical research:

> The abuse liability of a drug is a measure of the likelihood that its use will result in drug addiction. Many factors ultimately play a role in an individual's drug-taking behavior; nevertheless, the abuse potential of a drug is related to its intrinsic rewarding properties and/or the neuroadaptive responses that result from its prolonged use. . .The capacity to

produce reinforcing effects is essential to any drug with significant abuse potential. . ." (pg. 4)

This same paper reports that no studies which indicate that marijuana has clinically proved reinforcing effects. In fact, the paper explains how effects on the mesocorticolimbic dopamine system in the brain produce the reinforcing effects essential to creating a significant abuse potential. Marijuana does not have a distinguishable effect on this dopamine brain reward system.

The determination that brains had cannabinoid receptors was made in 1988. Their locations in the human brain are reported in the *Proceedings of the National Academy of Sciences* (87:1932-1936, 1990) in an article by Herkenham, Lynn, Little, et al. on "Cannabinoid Receptor Localization in Brain." Miles Herkenham works at the Unit on Functional Neuroanatomy at the National Institute of Mental Health. This paper, which precedes and is cited by the OTA report, concludes that:

> The presence of cannabinoid receptors in the ventromedial striatum suggests an association with dopamine circuits thought to mediate reward. However, reinforcing properties of cannabinoids have been difficult to demonstrate in animals. Moreover, cannabinoid receptors in the basal ganglia are not localized on dopamine neurons. There are virtually no reports of fatal cannabis overdose in humans. The safety reflects the paucity of receptors in medullary neclei that mediate respiratory and cardiovascular functions.

Incidentally, this research also establishes similarity between the effects of marijuana on the brain and the effects of its active ingredient, THC, which has already been rescheduled as a Schedule II drug. The receptors discussed by Herkenham are for all cannabinoids; this research provides a scientific basis for the rescheduling of all cannabinoids. It is also my position, and one I will pursue in court if necessary, that this research conclusively refutes arguments defending separate schedules for marijuana and THC.

A case that marijuana does not have the high potential for abuse shared by other Schedule I drugs could have been made prior to the discovery of the cannabinoid receptor site. The OTA paper, and most papers on cannabinoid receptors, cites a 1986 paper by Leo Hollister of the Stanford University School of Medicine published in the *Pharmacolgical Reviews* on the "Health Aspects of Cannabis" (Vol. 38, 1-20). On this issue, Hollister reports that:

> Physical dependence is rarely encountered in the usual patterns of social use, despite some degree of tolerance that may develop.

Hollister also concludes that:

> Compared with other licit social drugs, such as alcohol, tobacco, and caffeine, marijuana does not pose greater risks. One would wonder, however, if society were given a choice based on current knowledge, whether these drugs would have been granted their present status of acceptance. Marijuana may prove to have greater therapeutic potential than these other social drugs, but many questions still need to be answered.

Some of those questions have been answered by the subsequent discovery of the cannabinoid receptor two years after these remarks were published.

The disparity between the abuse potential of marijuana and other Schedule I or II drugs has long been recognized. While it is true that only 11 states have opted to decriminalize small amounts of marijuana, 45 states in all have made a statutory distinction between marijuana and other federal Schedule I & II drugs such heroin, cocaine, and PCP. In most cases this statutory distinction was created after legislative testimony as to the differences in the abuse potential between marijuana and these far more serious and dangerous drugs.

The distinction was even recognized by the 103rd Congress. The provisions in Title IX of the Violent Crime Control and Law Enforcement Act of 1994 regarding drug trafficking in prisons creates a specific penalty for marijuana (Sec. 90101) but explicitly states that the penalty for marijuana will not be the same as for Schedule I or II drugs, but will be the same as for the sale of Schedule III drugs.

This widening disparity between the medical knowledge about marijuana and its legal status as a Schedule I drug contributes to an erosion in respect for the criminal justice system, a conclusion shared by the National Commission on Marihuana and Drug Abuse.

The argument that marijuana has a lower potential for abuse than heroin, cocaine, PCP, or amphetamines is further corroborated by recent social science data. The number of monthly marijuana users reported by the National Household Survey has dropped dramatically over the last decade, with little notice of millions upon millions of marijuana users requiring medical assistance to overcome their presumed addictions.

Extensive studies on the links between drug use and violent crime have failed to show any psychopharmacalogical connection between marijuana and crime, unlike cocaine and alcohol.

In fact, surveys of inmates in local jails reported by the Bureau of Justice Statistics indicate that the incarceration rates for marijuana users are comparable to the general population. A comparison of the population of inmates who admit being under the influence of a drug, rated against the estimated population of

users of that drug, using 1991 figures, provides these incarceration figures per 100,000 people: non drug users - 137; alcohol - 131; marijuana - 194; stimulants - 347; cocaine - 924; heroin - 6,120. While it is true that 41.3% of jail inmates were under the influence of alcohol when they committed their crime, they are a small percentage of the 124 million people who drink. While there are a small number of people who were under the influence of heroin when they committed a crime, they represent a large percentage of the people who take heroin. In regards to marijuana, there is no evidence the abuse potential of marijuana, however categorized, has any connection to violent crime; whereas the opposite is clearly the case for Schedule I, II, & III drugs represented by heroin, cocaine, and amphetamines.

If I were to file a rescheduling petition, it would be to have marijuana placed no lower than Schedule IV. Schedule III includes amphetamines, which affect the dopamine reward system in the brain and have a far more significant abuse potential than marijuana.

The legislative history of this issue is very revealing. The legislation which created the Controlled Substances Act, and established the Scheduling approach to control, also created a National Commission on Marihuana and Drug Abuse which was charged with advising the Executive Branch on current medical knowledge on marijuana. The presumption at the time was that rescheduling of marijuana from schedule I would be based on this commission's findings. This is reported in a book by Richard Bonnie, who was on the Commission staff and now teaches at the University of Virginia Law School. The Nixon Administration ignored the Commission's findings, though generally, as cited above, state governments did not.

Our society is grappling with very difficult legal, political, and moral questions regarding such issues as the medical use of marijuana, mandatory minimum sentences, and the most effective allocation of limited criminal justice system resources. The fair scheduling of marijuana would greatly simplify resolution of many controversies which otherwise will continue to distract the Department of Justice from its important work and responsibilities.

Most of the controversy over marijuana as medicine is based on debate over whether or not the drug has an accepted medical use in the United States. This debate is irrelevant to the issue of the substances' abuse potential and it's relative scheduling. There are many substances which are approved for consumption in the United States which are generally recognized as safe by the FDA, for example, which have no accepted medical use. The issue is safety, and the burden of proof rests with those who would maintain Schedule I status justify marijuana's continued inclusion in Schedule I.

The Controlled Substances Act was, ironically, a piece of reform legislation which did away with mandatory minimum sentences. The guiding principle of the policy was that criminal penalties would be proportionate to the relative harmfulness of the drugs. Of far greater importance, I believe, was establishing by law, rather than principle, that scheduling of drugs was to be based on medical and scientific, not political, considerations. This is not the case with marijuana, and it never has been.

As Attorney General, responsibility for maintaining the integrity of the scheduling of controlled substances is yours. This is neither a legislative nor an judicial issue. This is a responsibility of the executive branch, and failure to act in this area contributes to the continued usurpation of executive authority by the Congress and the Courts. Failure to schedule marijuana according to new scientific findings would also represent denial of due process to however many millions of otherwise law-abiding citizens who use it.

I was an officer of NORML when the last rescheduling petition was argued before Administrative Law Judge Francis Young, and have been a long time advocate of reform of marijuana laws. I have a graduate degree in justice. But I am not a medical expert regardless of the extent of my own research. And with due respect Madame Attorney General, neither are you, and neither is the Administrator of DEA. This is why the statutory provision exists in Title 21 U.S.C. § 811 (b) for consulting with the Department of Health and Human Services. I believe the findings reported above provide sufficient justification for utilizing § 811(b); I respectfully suggest the law requires it.

I would welcome the opportunity to submit more detailed information substantiating these points and providing further corroboration, as I would welcome an opportunity to meet with you or your staff to discuss these issues.

Finally, in language I think most Americans would understand, the issue is this: For the last century criminal penalties regarding marijuana have been based on the assumption that marijuana was somehow similar to heroin and other opiates. It isn't, and scientists have just recently discovered why. Because of the way our drug laws are written, this scientific discovery has legal significance which obligates the Attorney General to take specific statutory actions. I hope you agree and I await your reply. Thank you for your consideration of these issues.

Sincerely,

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