Statement on Drug Schedules

Student National Medical Association
Health Policy and Legislative Affairs Committee
Statement on Drug Schedules

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INTRODUCTION

Founded in 1964 by medical students from Howard University College of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation’s oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians.

Cannabis, including marijuana, cannabidiol (CBD) and other cannabinoids, refers to products derived from the Cannabis plant. Medical cannabis has been used to manage chronic and neuropathic pain, cancer-related nausea, post-traumatic stress disorder, and has been approved by several states for a myriad of other indications. Similarly, psilocybin is a psychedelic most commonly known as “shrooms,” which has been shown to have potential to treat depression and obsessive-compulsive disorder, as well as a range of other psychiatric and behavioral disorders. Currently, cannabis and psilocybin are classified as Schedule I substances by federal law under the Controlled Substance Act (CSA). A Schedule I classification deems cannabis and psilocybin as drugs with “high potential for abuse and no accepted medical use,” even though patients report several therapeutic benefits and both of the active compounds have been independently isolated and used pharmaceutically as approved drugs. While these substances show promising medical benefits, there has been limited and/or inconclusive clinical research conducted to establish efficacy of cannabis. This is largely due to federal restrictions posing a barrier to access and procurement of these substances for research purposes.

Drug schedule laws are rooted in a history of racial discrimination, dating back to the Marihuana Tax Act (MTA) and the CSA, which were eventually used to target minority communities, especially the Black/African American community. Over the years, the war on drugs has led to mass incarceration, disproportionately affecting African American men. Due to our organization’s commitment to address the need of underserved communities, the SNMA urges the Drug Enforcement Administration (DEA) to redesign the drug scheduling system, including the de-escalation of cannabis and psilocybin from Schedule I classification.
BACKGROUND

Cannabis & Related Substances

Drugs, substances, and certain chemicals that are used to make drugs are classified into five distinct categories or schedules determined by the drug’s acceptable medical use and drug’s abuse, or dependency potential.\(^7\) Cannabis is classified as a Schedule I substance; however, the toxicological effects of said drug are less than that of opiates and cocaine which are in higher and less restrictive class schedules.\(^8\) In addition, tobacco and alcohol arguably have more harmful effects than cannabis but are not as restricted. A study examining the toxicological risk assessment of different illicit drugs used the Margin of Exposure (MOE) method to compare the health risk assessment of the recreational substances, where a lower MOE indicated higher health risk.\(^8\) Findings demonstrated that in terms of population, alcohol had an MOE < 10 (classified as “high risk”), other substances like opiates, cocaine and ecstasy had MOEs > 100 placing them in the “risk” category while THC, a cannabis-derived compound, had an MOE > 10,000 placing it above safety thresholds, and thus low risk.\(^8\) Cannabis is inexpensive, low maintenance, and has widespread availability across the nation. Prior to 1937, marijuana was legal to use and highly recommended for medical treatment in the form of hemp fiber, ailment ointments, and oils. Upon creation of the Marihuana Tax Act of 1937, the legal functioning and usage of cannabis was halted due to unbiased and unwarranted fear of cannabis becoming a gateway drug under the premise of its “addictive” properties.\(^2\)

Currently, cannabis has proven to be effective in some medical situations; extensive research must be done, however, to establish the potential therapeutic effects this substance may have.\(^2\) The DEA classification of cannabis as a Schedule I substance is based on “its history and current pattern of abuse; the scope, duration, and significance of abuse; and the psychological effects”.\(^7\) However, most federal policies surrounding cannabis were not formed as a result of evidence-based research. After the MTA was deemed unconstitutional in 1969, the Shafer commission was formed to “establish the dangers of cannabis”.\(^6\) Despite the commission’s conclusion that cannabis is not as dangerous as perceived, as well as its recommendation to decriminalize cannabis, the CSA was passed and moved to categorize cannabis as a Schedule I substance.\(^6\) Several derivatives of cannabis have been approved by the U.S. Food and Drug Administration (FDA) for therapeutic uses, including Marinol and Syndros (synthetic forms of THC) as well as Cesamet (contains a synthetic analog of THC as its active agent).\(^9\) These drugs
are categorized as Schedule III, Schedule II, and Schedule II respectively, and are used clinically for treatment of nausea and vomiting for patients undergoing chemotherapy. In 2018, the FDA approved the first drug containing CBD, Epidiolex, for treatment of “difficult-to-treat seizures” experienced by patients with Lennox-Gastaut syndrome and Dravet syndrome. Epidiolex and Marinol are evidence that both of the active compounds in cannabis have acceptable medical use and should be de-escalated from Schedule I. De-escalation would allow for the freedom to research further uses for components of cannabis, representing medical progress ultimately to the benefit of patients. As of September 2020, 33 states have legalized the use of cannabis for medical purposes and limited research on the effectiveness for medical use has started.

The purpose of the CSA is to ensure the safe and efficient manufacturing, distribution and dispensing of controlled substances in an effort to preserve and protect public health. However, the criminalization and restriction of some of these substances--specifically cannabis--has had detrimental effects on minority communities. The conception of this federal law was based heavily on racial bias, as made evident by Oval Office tapes from the Nixon administration. A senior advisor from the administration was quoted stating “we knew we couldn’t make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities”. The criminalization of cannabis has done just that: Black/African American and Hispanic/Latinx individuals have been incarcerated at disproportionate rates for cannabis related offenses. Although people of all races in the United States use and sell marijuana at similar rates, a Black/African American person is 3.73 times more likely to be arrested for marijuana possession. The 2010 nationwide arrest rate was 192 per 100,000 White people, compared to 716 per 100,000 Black/African American people. Discriminatory law enforcement practices, as well as institutionalized racism, have contributed to the mass incarceration of Black, Indigenous, and people of color (BIPOC) as well. Incarceration and convictions not only affect the individuals charged, but their families and communities as a whole (e.g., the creation of single-parent households). The resultant challenge then contributes to both medical mistrust and socioeconomic instability in these communities. With economic instability comes limited access to healthcare, which can eventually contribute to health disparities observed in minority communities. Additionally, even after serving their respective sentences, individuals convicted of marijuana
possession have difficulties re-assimilating into society. Barriers in securing and maintaining employment or housing can result in lifelong financial instability.\textsuperscript{14}

\textit{Psilocybin}

Psilocybin is a naturally occurring hallucinogen present in small amounts in specific species of mushrooms.\textsuperscript{16} Psilocybin is a Schedule I controlled substance, according to the CSA. However, since the 1970s, national surveys have been developed and distributed, now demonstrating psilocybin and psychedelics have a lower risk potential for abuse and severe adverse events than other major categories of drugs including alcohol, tobacco, amphetamines, and benzodiazepines.\textsuperscript{17} Of note, the once ongoing debate as to whether or not mushrooms and psilocybin are addictive has resulted in the consensus that psilocybin is not a physiologically addictive substance.\textsuperscript{18} Evidence illuminated through a centuries-long tradition of psilocybin consumption for medicinal use contributed to the 1992 recommendation by both the National Institute on Drug Abuse and the FDA to resume psychedelic clinical research.\textsuperscript{4} Recent studies performed as a result of this recommendation have demonstrated the medical potential of psilocybin use, showing improvements in depressive symptoms, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), smoking cessation, and addiction management.\textsuperscript{17} Despite this medical potential, psilocybin remains a Schedule I substance.

In 1970, the CSA was enacted to limit the use of psilocybin, halting research on potential therapeutic uses.\textsuperscript{19} Despite the 1992 decision, this scheduling poses an obvious threat to patients whose mental and physical wellbeing would benefit from therapeutic use of psilocybin. There exists a tendency in lawmaking and policymaking to be overly cautious in clinical experimentation with medicinal uses for drugs. These “inappropriate constraints linked to over-cautious drug control measures” serve as an additional barrier for patients, suppressing access to and proper testing of more effective treatment options for various conditions. While there is an understandable fear in consciously subjecting patients to an experimental treatment, there is also reason to be wary of causing harm through lack of action. Laws like the CSA that excessively impede progress in the medical field to the degree that has been seen can only be understood as unethical, most explicitly seen through the barrier to use of psilocybin in research, a drug already suspected to have beneficial effects on mental health prior to the enactment of the CSA. Schedule I categorization is especially harmful, determining these drugs have no acceptable medical use at
this time, while preventing the clinical research necessary to determine any potentially successful medical use.\textsuperscript{20} The resultant hindrance of progress in patient care is an issue of public health concern.

Johns Hopkins set a precedent for the rescheduling of psilocybin, recommending de-scheduling of psilocybin from Schedule I to Schedule IV.\textsuperscript{21} The SNMA stands by this precedent, for psilocybin as well as cannabis.

**Scope of the Problem**

Worldwide, communities of color have exponentially high numbers of encounters with law enforcement and probability of incarceration, especially Black/African American and Latinx communities. The federal prison population consists of 80\% Black/African American and Latinx persons with drug-related charges; 60\% in state prisons.\textsuperscript{22} This also affects the ability of the Black/African American and Hispanic/Latinx communities to impact legislation, as one in thirteen Black/African American people of voting age are denied the right to vote due to felony convictions for drug-related charges.\textsuperscript{22} Jim Crow laws perpetuate criminalization; with Black/African American and Latinx persons receiving maximum sentences more often than their White counterparts.\textsuperscript{22}

Advocating for marijuana as an illegal substance started with Commissioner Harry Anslinger and the creation of the marijuana tax act of 1937.\textsuperscript{23} With this accomplished, the manufacturing and fabrication for everyday use declined, especially after the release of Reefer Madness. This movie portrayed marijuana as an agent to allow Black/African American and Hispanics to act violently. The media associated marijuana with the risk of using more dangerous drugs, such as heroin and the risk of hallucinations, causing “blacks to forget their place in society”.\textsuperscript{24} Black/African American and Mexican American individuals have resultingly been consistently arrested more than White individuals for the same charge, with sentencing requiring two to five years of incarceration and fines up to $2,000, based on the Boggs Act of 1952.\textsuperscript{24} The Nixon administration task force denied the addictive effects of marijuana and the disproportionate impact on the Black community. The U.S. government continues to limit research on the addictive properties of marijuana as well as the examination of its efficacy.

Furthermore, the War on Drugs has created a more severe mistrust between minority communities and the medical community, a relationship that has been damaged for decades, that
the SNMA has been working on improving since its inception. The War on Drugs has resulted in decades of discriminatory arresting and prosecuting which has deepened the already tumultuous mistrust between minority communities and the police/political establishment.

The DEA and FDA have been the primary entities involved with marijuana-related scheduling and processing. The American Civil Liberties Union reports 88% of arrests from 2001-2010 were simple possession charges, with Black/African American persons more likely to be arrested.\textsuperscript{15} Such charges prevent qualification for public housing, student financial aid, many employment opportunities, child custody eligibility, immigration status, and numerous other rights and privileges. Even in states that have legalized and/or decriminalized marijuana possession and use, the number of marijuana-related arrests of Black/African American persons has not decreased.\textsuperscript{25} DEA drug scheduling laws are outdated and require immediate attention to allow research of the many meaningful uses and health benefits of cannabis. Current drug schedule laws impede scientific research and progress in the medical field, thereby inhibiting clinical researchers’ ability to improve patient care and public health, including mental health.

**STATEMENT OF POSITION AND RECOMMENDATIONS**

The SNMA is an organization dedicated to the development of future generations of socially and culturally competent physicians capable of providing the best possible care to communities that historically have been mistreated by health professionals in the US. As such, the SNMA calls for the redesign of the current drug scheduling system by the DEA.

Each year, medical students and physicians across the U.S. take an oath to their patients and their communities, promising to do no harm. The current drug scheduling system is in direct conflict with this oath. The current system, while convenient for the purposes of efficient categorization, ultimately represents a failure of medical progress that indirectly harms countless patients and upholds a system that is directly harmful to Black and minority communities. This pattern of unnecessary harm is seen most clearly through the scheduling of cannabis and psilocybin. Recognizing the danger in failing to amend legislation that is deleterious to the health of the American public, the SNMA recommends that the redesign of the system includes the de-escalation of cannabis and psilocybin from Schedule I drug classification. Increased access to these drugs for the purposes of clinical research allows exploration of potential medications for
many common physical, psychological, and behavioral disorders, including chronic pain, depression, and alcohol dependence.\textsuperscript{2,26} Cannabis is being used by many physicians as a treatment for these ailments without federally-approved research to support or oppose the indicated use.

This redesign has the potential to benefit patients that may in the future use medications derived from drugs like cannabis or psilocybin whose production would have been delayed indefinitely should research limitations remain as they are at present. More importantly, redesign has the potential to reflect a national consciousness that is actively working to dismantle the systems of inequality that have defined the laws of the past.
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