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Review Article

# Policy Analysis: A Case for Rescheduling Marijuana

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## Abstract

Marijuana policy has been debated for several decades. Since it was first labelled a controlled substance in the early 20th century, the federal government and the rest of society have been at an impasse in opinion about whether it contains medicinal properties. Since the Controlled Substance Act of 1970 was enacted, the federal government has maintained strict control over marijuana, so much so that even researchers are unable to conduct objective studies on its uses. This paper argues for the government to consider rescheduling marijuana so that research-based policies can be created. Further, this paper suggests that the federal government leave all policy making decisions regarding marijuana up to the states based on the research those states produce. Three theoretical approaches: Institutionalism, Conservatism, and Critical Race Theory are critiqued for solutions and contradictions to rescheduling of marijuana.

**Keywords: Marijuana; Rescheduling; Controlled substance; Policy; Institutionalism; Conservatism; Critical race theory**

## Introduction

Marijuana and the benefits of its use have long been debated. While some believe in its healing properties for a variety of mental and physical ailments, others are hesitant, claiming the substance has no medical benefit. This contention has led to larger schisms about legalization, appropriate punitive action, and resources needed to address its use [1,2]. The problem lies in the federal categorization of marijuana. As a Schedule I drug, marijuana is deemed to be one of the most addictive substances without medical benefit, ranking alongside other controlled substances such as heroin and LSD, is consequently considered more addictive than substances such as cocaine, Oxycodone, and methamphetamine. Since it is a Schedule I substance, marijuana can carry harsh legal penalties even for simple possession.

This scheduling also makes scientific research near impossible as there are several steps to take and expensive fees to be paid for scientists to even begin the research process. There are special licenses and registration with the Drug Enforcement Administration (DEA) that are required to research Schedule I substances, meaning a small number of laboratories are qualified to conduct research on marijuana and other Schedule I substances [3]. While this paper does not call for decriminalization of marijuana, it does advocate for lowering its schedule so that it can be further researched to determine its actual benefits, with an official scheduling only being set after enough research has been done for the federal and state governments to make an informed decision.

## Literature Review

### Marijuana

Grown mostly in the Americas (North America, South America, Central America), marijuana is the most used illicit substance in the United States [1]. It is harvested from three cannabis plants: sativa, indica, or ruderalis [4]. When harvested for non-drug use, cannabis is known as hemp. Its second form, Cannabidiol (CBD), does not have mind-altering properties. However, the plants' main cannabinoid, Tetrahydrocannabinol (THC), is the psychoactive ingredient found in the substance commonly consumed by more than 55 million American adults [5].

THC, originally discovered in 1965, derives from the female sativa plant. Its potency depends on cultivation strategies used during harvesting [1]. While more research is being conducted on other components of the cannabis plant, what is known is that the substance has at least 480 other elements besides THC [6]. Marijuana's addictiveness is often disputed with some saying that it has the potential to be highly addictive while others, in comparison to more dangerous substances, say it does not. Danovitch notes that while the definition of "addiction" tends to be broad, medical doctors adhere to four criteria that one must meet to be considered addicted. The first criteria are that a person must have clinical features that align with addiction. These features include, but are not limited to, characteristics such as consuming larger amounts of the substance to get the same effect, cravings to use, impaired functioning in multiple areas of life, recurrent use even when the person knows it is unsafe or can have adverse effects, and tolerance and/or withdrawal. Abuse of marijuana has its own diagnosis in the DSM-V: Cannabis Use Disorder [7], with an extensive list of maladaptive patterns that must be met to be diagnosed.

The second criteria are that in animal studies, animals must demonstrate a desire to self-administer the substance, proving a perceived level of reinforcement or reward from use. Third, the drug must arouse the brain's reward system. While studies of marijuana use in rats show that marijuana is not addictive in the sense that the rats used to the point of overdose as they did with other substances, there was still evidence of rats' desire to self-administer the drug. Lastly, studies must prove "the phenomenon is…persistent and pervasive…[manifesting] across the population among people who are exposed to the substance". Since marijuana use meets all these criteria, it is considered addictive.

### The War on drugs

President Nixon began the War on Drugs in 1971. His want to

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eradicate criminal drug use was his effort to protect the American people against "public enemy number one" [8]. President Nixon allocated federal funding for law enforcement and drug-control. Two years later, the DEA was established whose mission it was to apply and enforce federal substance abuse laws and regulations (DEA, n.d.b).

The War on Drugs initiative expanded with the election of President Reagan in 1981. President Reagan continued financially rewarding law enforcement agencies for their drug control efforts but also established harsher criminal punishment for people caught using and dealing drugs. Mass incarceration of substance users is still a detrimental effect of the War on Drugs. The Anti-Drug Act of 1986 led the US Congress to establish mandatory minimum sentencing laws, specifically for cocaine. The Anti-Drug Act of 1988 maintained sentencing laws but also made discriminatory housing legal based on criminal history and extended the death penalty to serious drug-related offenses [9].

Those like Dr. Hart [10], neuroscientist, and professor of Psychology at Columbia University, believe the War on Drugs was about more than ridding the United States of unwanted drug use. Dr. Hart [10] posits, "more drug arrests equate to more overtime, more "throwaway people" in prison, and bigger budgets. These practices ensure job security for a select few, including law enforcement personnel and prison authorities". His opinion is that the War on Drugs achieved exactly what it was supposed to: financial support of state and federal law enforcement agencies and prisons. Incentivized law enforcement resulted in stronger efforts on to reduce crime. More people in prison meant more money for the economy. The War on Drugs was fought at the expense of individuals suffering from severe addiction and created further marginalization of those who use substances. Since the start of the War on Drugs, the United States has spent more than $1 trillion dollars on the initiative [11]. Fifty-two years later, we are still seeing a rise in the number of people using illegal substances.

The 1990s saw a dramatic shift in the focus of the drug war [2]. By 1996, the number of arrests for marijuana exceeded those of cocaine and heroin. At its peak in 2008, the War on Marijuana yielded an estimated 847,864 people arrested for marijuana offenses [12]. This was a direct result of zero-tolerance policing. Community policing came second to the zero-tolerance attitude which resulted in police hyper-focusing on offenses that were previously overlooked. King & Mauer [2] noted that in the 1990s, some police officers admitted to targeting low-level drug offenders in a practice known as "quality of life" policing; a patrol tactic made legal under the 4th Amendment, which was assumed to deter people from carrying illegal contraband if there was a heightened police presence in communities, specifically communities of color.

While legalization in some states has created a significant nationwide reduction (80%) in the number of arrests since 2008, the problem remains that many of these arrests are for simple possession and disproportionately target people of color. Since marijuana is still federally classified as Schedule I drug, punishment can be harsh for low-level offenses, with simple possession, a misdemeanor, carrying fines ranging from $250,000 to $1 million or one year in jail with a fine of $1,000 [13].

### Scheduling

The Controlled Substances Act of 1970 (CSA) established five schedules, or classifications, for several substances, both legal and illegal. As a Schedule I substance, marijuana is said to have a high potential for abuse and no accepted medical value [1,13-16]. Table 1 is a list of drug schedules and commonly known substances found in each category.

Marijuana use dates back to 6th century China [15,16]. There is also evidence of marijuana use in Ancient Egypt. Throughout the 1800s, it had several medicinal purposes including being used as a sedative, pain relief for chronic illnesses, and migraine relief. It was not until the Food and Drug Act of 1906 that the Food and Drug Administration (FDA) began regulating substances in accordance with the Act to prove a drug's safety or lack thereof [17].

The Harrison Narcotics Tax Act was passed by Congress in 1914 to combat increased rates of substance use. It also held medical doctors legally responsible for illegal distribution if they wrote prescriptions for opium, heroin, cocaine, or morphine [18]. The Great Depression ushered in the Marihuana Tax Act of 1937. In theory, this Act was going to allow doctors to prescribe marijuana and even accommodated commercial sale and personal possession for $100 per ounce if people paid for a tax stamp to do so [16]. However, because the tax stamp was so expensive, the Act resulted in severe restriction with legal penalties of up to $2000 and five years in prison [15]. Though medical doctors disagreed with Congress' ruling, marijuana was labeled a narcotic by six of the then forty-eight states.

The Marihuana Tax Act was replaced by the Controlled Substances Act of 1970. Still in effect today, CSA was passed to regulate controlled substances and subsequently created five schedules in which substances would be classified. Classifications are determined based on "medicinal value, harmfulness, and potential for abuse or addiction". As will be discussed in later sections of this paper, the Congressional decision to pass CSA seemed arbitrary and without supporting medical evidence, thus resulting in subjective, haphazard scheduling of controlled substances.

For the simple reason that some thought marijuana had no medical value, it was placed on the list of Schedule I substances. Nutt et al. [3] call marijuana's listing an "historical accident" owed to the fact that other substances had predetermined medical uses before the War on Drugs and convening of international conventions. Due to their longstanding presence in the medical world, these substances were placed in lower schedules, while marijuana, with lesser-known uses, was placed in the highest schedule.

When speaking of the United Nations' decision making involved with drug scheduling, Nutt et al. [3] state: The decisions that were made…under this legislation seem to be unclear and inconsistent and may have been for political rather than health-related reasons. This is because for many drugs the decisions were made before modern scientific methods allowed a proper understanding of their pharmacology and toxicology. As a result, the decision…was not based on any consideration of their physical harms but on the assumption that there were no medical benefits.

Yet, while some argue the scientific reasoning that marijuana has yet to be federally accepted, others note that racism played a role in why marijuana was and continues to be considered dangerous. Bonnie and White bread explain that in the early 1930s, prior to the passing of the Marihuana Tax Act, the Federal Bureau of Narcotics in collaboration with the William Randolph Newspaper Company, began spreading cultural propaganda about "Mexicans, West Indians, blacks, and underworld whites". People of color were immediately

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**Table 1:** Scheduling of controlled substances.

| Schedule | Definition | Common Substances |
|---|---|---|
| Schedule I | High abuse potential | Marijuana |
| | No accepted medical benefit | Heroin |
| | | LSD |
| Schedule II | High abuse potential | Methamphetamine |
| | Some accepted medical benefits with severe restrictions | Fentanyl |
| | High potential for dependence | Oxycodone |
| Schedule III | Less potential for abuse | Ketamine |
| | Accepted medical benefits | Anabolic Steroids |
| | Low-moderate dependence potential | Tylenol with codeine (<90 mg) |
| Schedule IV | Low potential for abuse compared to Schedule III | Xanax |
| | Accepted medical benefits | Valium |
| | Low potential for dependence compared to Schedule III | Ambien |
| Schedule V | Low potential for abuse compared to Schedule IV | Robitussin AC (<200 mg of codeine) |
| | Accepted medical benefits | Lyrica (nerve pain) |
| | Low potential for dependence compared to Schedule IV | Parepectolin (pain/diarrhea) |

targeted as dangerous and violent, bringing chaos and immorality to Whites.

At the time, marijuana was an unfamiliar import from southern countries. Because it was associated with Mexican immigrants, it was deemed hazardous and consequently criminalized. With no evidence indicating otherwise, marijuana was linked with violent crime and psychosis. By connecting marijuana with minority races and undesirable social behavior, White Congressmen were able to justify its federal regulation [15].

## Legislation

With the unsurety of marijuana's potential came several problems with federal scheduling and decriminalization. There are several arguments for and against adjusting marijuana's Schedule I status. Several organizations and individuals have lobbied for change and each time, efforts have been denied by the federal court system. While there have been medical professionals, local courts, and national organizations that have supported the decriminalization and/or lowered scheduling of marijuana, Congress has been the stonewall in passing legislation that acknowledges either.

Many problems lie between federal and state courts. While some states have legalized marijuana, under federal law and CSA guidelines, it is still illegal. This can cause a multitude of problems and confusion for what is and is not permitted. For example, while a state government may have legalized marijuana use, if a person is legally using but doing so on federal property such as on the grounds of a government building or at the VA Hospital, that person can be arrested on federal charges. Marijuana farmers in California are permitted by the state to grow cannabis but cannot bank with federal institutions because those federal banks could be liable for money laundering.

The first federal case law decided upon regarding marijuana possession was United States v. LaFroscia [19]. Peter LaFroscia was indicted on two federal charges for importing 80 kg of marijuana into the US and being in possession of marijuana. LaFroscia argued that marijuana was inappropriately scheduled based on research conducted by the Commission on Marihuana and Drug Abuse. He felt that because "these findings indicate that marihuana does not possess the requisite qualities for inclusion as a controlled substance" that it should therefore be a Schedule V drug as opposed to Schedule I [19]. Despite this argument, the US District Court denied dismissal of LaFroscia's charges on the grounds that the defendant failed to justify the "decontrolling and reclassifying" of marijuana. According to the court, LaFroscia unsuccessfully argued against Congress' thorough administrative procedures for rescheduling substances [16,19].

The second major court case, also in 1973, was filed by the National Organization for the Reform of Marijuana Laws (NORML). NORML has fought for several decades for the decriminalization of marijuana. In this case, the non-profit organization argued several points [20].

1. That the U.S. ceases to provide financial assistance to companies who provided and sprayed herbicide on marijuana plants as this endangers the health of people who use marijuana.
2. That the U.S. collaborates with the Mexican government to create an environmental impact statement about herbicides and convince the Mexican government to stop using herbicides until said impact statement was acknowledged and agreed upon.
3. That the U.S. creates environmental impact statements with any other countries before providing financial support or herbicides to those countries.
4. That the U.S. violates the Equal Protections Clause, right to privacy, and the right against cruel and unusual punishment by continuing to criminalize marijuana.

The U.S. District Court voted in favor of NORML, requiring that the State Department "prepare, circulate, and consider such an environmental impact statement, and shall include therein the 'environmental analysis' of the program's effect in Mexico" (Nat. Org'n for Reform of Marijuana Laws (NORML) v. US, 1978) [20]. However, a separate petition was denied on the premise that possessing marijuana is not a Constitutional right now is the Equal Protection Clause violated for the same reason. Congress did mandate that the US. Attorney General collaborates with the Secretary of Health, Education, and Welfare and the Scientific Advisory Committee to determine minimum and appropriate scheduling based on scientific evidence [16]. Though the US Circuit Court issued a statement acknowledging marijuana's usefulness, the US Court of Appeals denied every other appeal and petition filed by NORML through 1994.

## Research

Under federal law, Schedule I substances are forbidden from medical prescription, nor can they be subject to scientific research without those researchers first overcoming numerous approval qualifications for the DEA, FDA, and National Institute on Drug Abuse (NIDA) [15]. Nutt et al. [3] argue that such severe restriction on marijuana limits neuroscience research. Because of these restrictions, rescheduling a drug can be an arduous process meaning that there is a chance a drug may never be rescheduled. The process for research

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is costly, strenuous, and time consuming. So much so that for 50 years, the University of Mississippi was the sole proprietor of a DEA approved license since the 1970s. Groff North America Hemplex and Biopharmaceutical Research Company were finally granted licenses in January 2022 [21].

There are three criteria a substance must meet to be considered a Schedule I substance: high potential for abuse, no US accepted medical value, and no safety for use. The conflict between the federal government and state governments makes these criteria confusing and seemingly arbitrary. The federal government says marijuana has no recognized medical value while some states have legalized it for medical use. Per House Report (1970), No. 91-1444, the Schedule I classification of marijuana was supposed to stand "at least until the completion of certain studies now underway and projected that the Presidential Commission's recommendations would "aid in determining the appropriate disposition of this question in the future."" Now in the 21st century, the scheduling of cannabis seems permanent as there has been no schedule movement or reconsideration of such.

Other Congressional arguments against rescheduling include adhering to international treaties and having already approved synthetic THC available for use in medicine. These prescription medications include Epidiolex (CBD), Dronabinol, Syndros, and Nabilone (FDA, n.d.). The legislative belief is that marijuana poses a significant risk to the public because it is a Schedule I substance [3]. Interestingly, when the Comprehensive Drug Abuse Act of 1970 was passed, President Nixon requested that the National Institute of Mental Health (NIMH) conduct research on marijuana. When NIMH's results presented the usefulness of marijuana and the organization suggested decriminalization, President Nixon "made it clear that marihuana would not be decriminalized while he was in office" (Musto, 1999, p. 256) [22]. Since then, only 6% of approved marijuana research has been focused on its benefits. The other 94% has been forced to focus on its harmfulness as this is the research most likely to be approved by governing bodies [23].

Harmful or Helpful research in the 1990s discovered that the human body contains two cannabinoid receptors: CB1 and CB2 [1]. CB1 is found in the brain while CB2 is in the body. CB1 and CB2 interact with anandamide, an endocannabinoid that controls the reward circuit of the brain [24]. When marijuana is consumed, THC binds to these receptors, resulting in the feeling of being "high". The release of dopamine in the brain causes "mild euphoria, altered perception of time, relaxation, difficulty with memory and concentration, and intensification of sensory experiences". That rush of the dopamine hormone can lead to repeated consumption of marijuana because the brain's reward circuit is stimulated, reinforcing use.

While some scientific and medical research says it can be helpful, others say there is severe health risks associated with its use [13]. Thirty-seven states have approved the use of medical marijuana [14]. These states have lists of qualifying illnesses that would permit the prescription of marijuana for treatment. There are several mental and physical health challenges that are eligible including but not limited to PTSD, HIV/AIDS, cataracts, glaucoma, Parkinson's Disease, epilepsy, and ALS. Medical marijuana is also being considered as treatment for Opioid Use Disorder. Severity and longevity of a "high" depends on the amount of marijuana consumed, but on average, an individual may begin to feel effects between 30 and 60 minutes after use. These effects do not usually last longer than three to four hours.

Those that argue against marijuana believe that marijuana can worsen and/or cause health problems. To date, marijuana consumption has not caused any fatal overdoses. However, long term usage can cause permanent damage to the respiratory system, resulting in increased mucus buildup, coughing, and shortness of breath. Glass et al. [25] explain that cannabinoids control cognitive and motor control, interfering with functions such as reduced motor control, forgetfulness, poor attention span, heightened senses, impulsivity, and changes in emotions and behaviors.

Research has shown that there is an association between marijuana and anxiety and depression, however, "we cannot yet determine whether marijuana causes an increase in depression and anxiety, or whether individuals who suffer from depression and anxiety tend to use more marijuana" [1]. There is also some debate surrounding marijuana's potential to cause cancer. Moreau and colleagues (2019) argue that marijuana is effective for the treatment of cancer while the CDC [26] and Denissenko et al. [27] posit that while marijuana itself does not cause cancer, it does release the same carcinogens as tobacco, leading to increased risk of lung cancer.

## Proposal

The government cannot take a simultaneous hands-on and hands-off approach to this issue. While this writer does not promote complete legalization of marijuana, I do advocate for marijuana to be considered for a lower schedule or perhaps removed from scheduling altogether until enough research can be done determining its effects and potential uses for health purposes. At every turn, there are competing policies that only add to the confusion of how marijuana should be handled. On one hand, the federal government wants to regulate its use but also pardon federal offenses. In 2019, even the World Health Organization (WHO) pushed for cannabis to be rescheduled. It is the United Nations (UN) that has been the barrier to this progress [28]. On the other hand, some states find it medically beneficial while others stand by the notion that it is one of the most addictive substances, ready to convict people for simple possession.

To subdue misunderstanding, it seems more efficient to deregulate marijuana at the federal level and let states manage their own scheduling. Without federal regulation, research companies have easier access to marijuana and less stringent protocol to follow, meaning marijuana and its components can be thoroughly studied without pressure from the government to prepare study results that align with governmental bias. Research companies would be free to provide results that are in accordance with their own research thus building a more objective foundation for which to base federal and state law [15].

Once enough research has been conducted to warrant a detailed understanding of marijuana, states can decide how they want to proceed with scheduling and regulation. The public is treated unjustly when the FDA fails to fulfill its social obligation to public health by fully assessing all the risks and benefits to marijuana use. Without clarity of its uses, marijuana and its policies will continue to contribute to an inundated criminal justice system and subjective policymaking. Currently, resources are ineffectively spent on prevention of low-level drug offenses, taking time and attention away from serious crimes.

Not only would states be able to control their own legislation, but schedule reconsideration would give medical professionals and pharmacists a chance to give expert input on how marijuana can be used. As it stands, the DEA and Congress are the only two entities that

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can change a substance's schedule [14]. With the current CSA policy in place, Congress can make decisions about marijuana regulation without considering expert testimony from doctors and other medical/ scientific professionals. Failure to include expert opinion owes to the capricious and subjective lawmaking that has plagued the U.S. since marijuana was first introduced to the states.

## Analysis

**Controlled substances act of 1970:** The Congressional Research Service (2023) states, "The CSA simultaneously aims to ensure that patients have access to pharmaceutical controlled substances for legitimate medical purposes while also seeking to protect public health from the dangers of controlled substances diverted into or produced for the illicit market". The 118$^{th}$ Congress describes the CSA's scheduling system as its "heart" since the scheduling system is the basis for any legal action on controlled substances [14]. The CSA's duty is twofold: establish registration guidelines for companies working with controlled substances and enforce trafficking laws which establish criminal penalties for illegal manufacturing, dealing, and possession of controlled substances. Regarding marijuana, the CSA recognizes the discrepancy between federal and state regulations yet justifies continued federal governance by preventing the Department of Justice (DOJ) from allocating tax money to prohibit state autonomy from marijuana regulation.

Even without using taxpayer money to control state regulation, the problem remains that the DOJ still reinforces prosecutorial discretion for federal offenses without addressing inconsistency in federal law. Under the CSA, the FDA can use purely subjective data to classify a substance as pharmaceutical. This is evident in the fact that some states acknowledge marijuana as pharmaceutical while others do not. This begs the question of how the FDA continues to regulate a substance that is not even agreed upon due to the lack of research that has been prohibited by the FDA and the DEA. Interestingly, substances that are scientifically proven to cause health problems and even death, such as alcohol and tobacco, are not classified as controlled substances and therefore are not scheduled under the CSA. In some states intoxicated driving is a lesser offense than possessing marijuana, yet marijuana continues to be overregulated while more harmful substances go overlooked.

The CSA has also allowed states to enforce a modification of its policy called the Uniform Controlled Substance Act (UCSA). The states that do enact this statute do so in accordance with their own interests and laws. The UCSA is purposefully vague as it allows states to interpret it how they see fit resulting in a wide variety of criminalization, penalties, and other legal processes for controlled substances [14]. The Congressional Research Service (2023) explains:

There is not a complete overlap between drugs subject to federal and state-controlled substance laws for several reasons. First, states may elect to impose controls on substances that are not subject to the CSA…Second, states may wish to adopt federal scheduling decisions at the state level but lag behind federal regulators due to the need for a separate state scheduling process. Third, states may decide to impose state controls on substances subject to the CSA or they may impose modified versions of federal controls at the state level.

Yet, in its following paragraph, this legal review goes on to state that if federal and state law conflict, federal law takes precedent. This means that in cases such as marijuana, federal law is the law, taking control away from the states with federal control "[remaining] in effect and potentially enforceable in those states" (Gonzales v. Raich, 2005). Put this way, it seems states are convinced that they have control over their own drug laws when in fact the federal government still has a hand in their procedures. It is erroneous to say that states can establish their own drug legalities while simultaneously saying that if those legalities conflict with federal law, then federal law takes precedent. If the federal government is going to let states create their own drug laws, then the federal government should consider taking themselves out of this issue altogether. It is causing too much chaos for the federal government to continue regulating marijuana while also pretending to be laissez-faire.

## Institutional perspective

The institutional approach seeks to understand social policy from a human welfare perspective, more specifically; it endorses sharing of resources and collective action [29]. It prioritizes peoples' values and assesses how those values can be implemented to increase social wellbeing. Another tenet of this perspective is the belief that the government has a hand in social welfare and should therefore place its efforts in relieving social ills.

Based in the economic ideas of Marshall and Titmuss [29], the Institutional approach recognizes that because the government has historically promoted inequitable ideas about whom and what constitutes U.S. citizenship, it should then be responsible for establishing policies that address this issue. Marshall [30] contends there are still groups such as the homeless and those who lack education who cannot be regarded as full citizens because of their socioeconomic status. Intervention at the state level is necessary for equitable rights. Titmuss reinforced Marshall's ideas but also called for collective action. He believed that society is responsible for its own wellbeing and should thus use the state to achieve social welfare.

If the government is to address the needs of all citizens, then continuing to regulate marijuana so strictly is in direct conflict with that premise. The federal government releasing its oversight will allow states to fulfill its obligation to citizens, more specifically to citizens who could benefit from using marijuana for the various ailments it can treat. Again, full decriminalization is not the immediate answer, nor should it be. That could potentially cause more social problems that will not be addressed here. However, states are unable to move forward with research that could establish objective reasoning for the rejection or acceptance of marijuana use due to federal guidelines.

Thirty-seven states have legalized medical marijuana use [14]. Chronically and terminally ill patients and patients with Severe Mental Illnesses (SMI) such as PTSD deserve as much consideration as other marginalized groups as they have high needs for medication and resources to improve their quality of life. Medication for these groups is often unaffordable even if covered by insurance. Patients who are 65+ and patients of color often experience unaffordability more than others [31].

Opponents of the Institutionalist approach believe that it stunts the economy, creating "unproductive underclass and undermined cherished moral values" [29]. It can be argued that the underclass only continues to be socially inferior because of the capitalism and economy that the government has established, resulting in inaccessible, unaffordable basic needs. For example, contenders argue that THC is already found in certain FDA/DEA approved medications. However, without insurance, those medications carry exorbitant prices. Three of the four of these medications are used to treat HIV and AIDS

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patients, who under the Affordable Care Act, cannot be denied insurance because of their health status. That insurance coverage alone can be quite costly, with approximately 30% of people living with HIV or AIDS not having insurance at all [32,33]. Adalja [32] noted that it can cost almost $1 billion to introduce a new drug so to make a profit on this cost; prices for prescription drugs are inflated. If marijuana were found to be a suitable treatment for these diseases, it could be a cheaper option since it does not have to be modified or lab created to produce alleviating effects. Instead, it seems an entire population of people has been financially and medically marginalized by being forced to pay outrageous dollars for a medication that could otherwise be readily available to them without pharmaceutical gain attached to it. Table 2 shows the details of the four federally approved cannabinoid-containing medications [34,35].

Unfortunately, legalizing medical marijuana makes marijuana subject to the same tax and pricing as the aforementioned medications. By inflating prices, the government mirrors passive aggressive regulation set forth in the Marihuana Tax Act of 1937, making medical marijuana legal but taxing it so high that it is unaffordable, essentially achieving prohibition of any use while continuing to criminally punish those who seek the cheaper recreational option. In some states, such as Minnesota, medical marijuana can be double the price of recreational marijuana, sometimes costing patients up to $500 a month, not including the annual fee to keep their medical marijuana card [36].

Institutionalists would argue that state governments are obligated to pay due diligence in that the government should exhaust all possibilities of treatment for the various illnesses that these groups experience without making those treatments financially unattainable. Doing so means reconsidering primordial laws and policies that may prohibit certain treatments from accessibility and challenging preconceived notions about treatments that have not historically been considered. To do this, state governments need to be autonomous from federal control which means the federal government would also have to be retrospective about current policies and be willing to release control over scheduling of marijuana.

Institutionalists would also call for underserved groups to fight for their seat at the policymaking table. The federal government has made legislative decisions about marijuana that do not include expert opinion nor do these decisions account for life experience. Marginalized populations such as the chronically and terminally ill and those with SMI should be at hearings, testifying on their experiences so lawmakers can hear their needs. Rather than calling for immediate decriminalization, compromise with scheduling reconsideration so lawmakers are willing to collaborate rather than shutting down arguments that do not support their bias. Ultimately, the fight is not about legality, it is about welfare. Achieving social welfare takes small, actionable steps. In this case, the first step would be meeting lawmakers where they are at in their decision base and framing rescheduling as a means to self-educate and promote social welfare.

One critique of the Institutionalist approach is that it does not address the potential conflict between states. If scheduling and criminal action were left to the states, there is still the issue of states managing marijuana issues differently. In this regard, federal oversight would be useful for limiting the extent that people can be punished in states that criminalize marijuana. For instance, setting a federal precedent for fine caps without prison time for simple possession. States could also be required to provide supporting evidence for why they chose criminalization or legalization. This would quell any inconsistencies in punishment and policy making.

Institutionalism also does not consider the true power of federal government. It is easier said than done to believe that collective action will force the government to reconsider its policies and that the government will become solely responsible for social welfare. The government can be obstinate when what society wants does not align with what the government wants. Historically, the government has expected some level of collective effort to maintain social welfare. With that being said, the likelihood that it would take full responsibility for social welfare is unlikely.

### Conservative perspective

Conservatists believe in maintaining the traditional American values of family, free market economy, and traditional religious and cultural practices [37]. The tenets of Conservatism are self-responsibility, limited government involvement, and fidelity to religion, law, and partisanship, with certain populations being considered either deserving or undeserving of government assistance such as people with severe disabilities, children, and the elderly. According to Ginsberg [37], conservatism avoids "involvement in human affairs such as social welfare". There are ideals and norms which guide how society functions. Those who do not conform to those ideals are either ostracized or punished.

There is no argument from this writer that illegal substance uses and substance related offenses can threaten American values. However, if the government is going to call itself laissez-faire in certain domains, then there should be no involvement whatsoever in state proceedings unless those proceedings violate inherent rights of an individual. To say that states have control over their own drug laws but at the same time saying if those laws conflict with federal laws, then federal law rules is not hands-off governing. It is governmental hover-parenting that threatens the welfare of the states.

Conservatists would call for individuals suffering from chronic illnesses to take the initiative to find more osteopathic treatment that does not involve illegal substance use. While this may work for some, others find it more difficult to treat the whole person if the symptoms are not managed first. For those who are non-responsive to traditional medications, the conservatist monopoly on marijuana is only hindering their wellness. That argument would also not justify why substances that have been scientifically proven to be much more addictive and harmful than marijuana is less regulated.

**Table 2:** Information about THC medications.

| Medication | Use | Compound | Price |
|---|---|---|---|
| Dronabinol (Schedule II) | AIDS-related weight loss | THC | $47- $304 |
| Epidiolex (limited distribution) | Epilepsy | CBD | $1000-$2000 |
| | Noncancerous tumors | | |
| Nabilone (Schedule II) | HIV- related weight loss and vomiting | THC | ~$2000 |
| | Cancer-related weight loss and vomiting | | |
| Syndros (Schedule II) | AIDS-related weight loss and vomiting | THC | $1200-$1800 |

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Some conservatists argue that social welfare programs keep people in undesirable conditions. For instance, welfare programs that address poverty keep people poor. Some of the policy and regulations for these programs require certain standards be met to be eligible for their programs, often meaning individuals who are part of these programs must maintain low wages, a certain number of work hours, particular medical conditions, etc. to keep their benefits. A counterargument to that is that when speaking of medical issues, it is not about people wanting to maintain poor health just to receive benefits. One would hope that people do not enjoy being chronically or terminally ill just to say they can legally smoke marijuana. The federal government giving up control of marijuana for the purposes of research could result in significant findings, opening the door to the possibility that people can achieve wellness and functionality thus decreasing the reliance on other government funded programs like Social Security, unemployment benefits, and TANF. Less people relying on government assistance is progress for social welfare which is exactly what Conservatists promote.

If social welfare is truly a Conservatist concern, then it would be appropriate to allow research companies to freely study any means that may improve citizen wellbeing. According to the tenets of Conservatism, people with severe physical and mental illness are grouped in the category of individuals worthy of government intervention. Fentanyl is one of the most dangerous drugs in the United States [38], but is scheduled lower than marijuana and is approved for medical use. If the government can allow that, then reconsidering marijuana as treatment should not be out of the realm of possibility. Consequences of too much governmental control are evident in the contradictory policies claiming not enough is known about marijuana to approve medical use but also preventing ease of access to the substance for research which could provide that knowledge.

A problem that could arise with allowing researchers to have ease of access to marijuana is the time it would take for thorough research to be completed. Yes, it is a solution for chronically and terminally ill patients. But, in the amount of time it would take to produce results, they can just continue taking the medication they are already prescribed and still maintain some quality of life. For some, the wait time may not be a feasible possibility. Assuming not all research is going to conclude that marijuana is useful; they are risking a 50/50 chance that the substance could even relieve their illness. Even if they must stay on government benefits, the need for wellness far exceeds the want to wait or risking the possibility that their state's research deems that marijuana is useless.

### Critical Race Theory (CRT)

It is important to understand how race and racism are defined and thus explained by CRT. Race is a "distinct biological type of human being, usually based on skin color, or other physical characteristics" [39]. It is a socially constructed concept based on phenotype. Racism is "any…practice of discrimination, segregation, persecution, or mistreatment based on membership in a race. Racism, whether overt or covert, is the power structure designed to keep certain groups inferior to others based on race. Therefore, CRT was developed to evaluate the relationships between race, racism, and power and how laws are created for the benefit of Whites [15,39,40].

Laws that arose from the War on Drugs such as the Three Strike Rule and mandatory minimum sentencing directly targeted people of color, leading to mass, racialized incarceration. In states where there has been no policy change for marijuana, Black adults continue to be arrested at disproportionately high rates compared to Whites adults [41]. Figure 1 displays the number of arrests among White and Black adults and youth from 2000-2020. Ironically, in the same time frame, states that legalized marijuana saw an increase in youth arrest rates. In states that continue to criminalize marijuana, there is no change in arrest rates for White adults while arrest rates for Black adults continue to rise. In states that have decriminalized and/or legalized cannabis, arrest rates for both racial groups have decreased. However, trends show that arrests were already decreasing in these states before policy changes, so it is unknown how much effect policy change truly had on marijuana arrests.

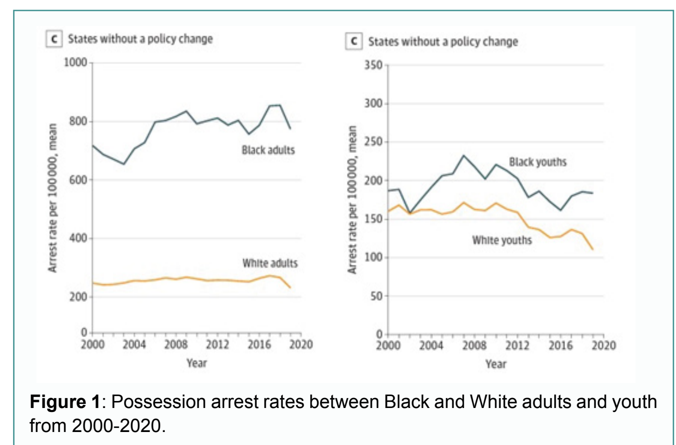


**Figure 1**: Possession arrest rates between Black and White adults and youth from 2000-2020.

Though research finds that Black and White men use marijuana at equal rates, Black men are four times more likely to be arrested for possession [42,43]. Criticalists question why cannabis reformation laws that were supposed to suppress racial and legal disparities have yet to do such. They believe the answer can be found in degenerative policymaking [44]. Degenerative policy making creates in and out groups, delineating the worthy from the unworthy in the legislative process. Those who are seen as unworthy are the same who are classified as social degenerates and burdens to society [43]. Recall that this is a Conservatist legislative ideal.

Degenerative policymaking trickles down to policy enforcement (i.e.: policing) resulting in the continued disproportionate arrest and incarceration of people of color. For example, traffic stops are conducted more often on Black people resulting in higher arrest rates for simple possession. There is no evidence that Black people commit traffic infractions at higher rates than other races yet while they make up 73% of all traffic stops, 81% have their vehicles searched, making them twice as likely as Whites to be arrested during a traffic stop. In the 21st century, we have not progressed far from the early 1900s where America saw the beginning of racial blaming and subsequent targeting for its drug problem.

The Critical approach argues that policies are created to the extent that they protect White livelihood. To avoid uncomfortable conversations, White legislators ignore discriminatory policies resulting in the perpetually unequal enforcement of the law [40,45]. Alexander and Stivers [40] explain that addressing racial disparities in the law means that White policymakers will be forced to acknowledge the discriminatory nature of colorblindness in the law which is a risk they are not willing to take.

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Because CRT is embedded in policy, a solution would be to hire macro social workers in State Houses and the White House and to elect more legislators of color. Macro social workers who are well versed in policy and legislation can be hired specifically to evaluate current drug policies and how they may disproportionately affect communities of color. They could also be the mediators of those uncomfortable conversations between legislators, opening the door for more progressive thinking and challenging the status quo [46]. The same is true for electing more legislators of color. Legislators of color may be able to speak from personal experience about how certain policies have impacted their communities and thus be able to offer insight on how to modify those policies. As mentioned earlier, Congress often makes policy decisions without additional expertise. It costs nothing to consult with a colleague of color about the possible implications to a policy decision. Personal experience is expertise and should weigh heavily on the legislative process [47].

The problem to this solution is threefold: 1) how does the government recruit more legislators of color, 2) how do you prove policies are racist and need to be changed, and 3) how do social workers remain embedded in political culture without becoming political? Unlike an everyday job, people must be elected to governmental positions [48]. One does not often hear of recruitment and retainment strategies in politics, so it is unclear what Diversity, Equity, and Inclusion (DEI) tactics look like in the political arena. If no person of color is running for a governmental seat, then there is no person of color to elect and therefore no legislator of color to critically evaluate the discriminatory nature of certain policies. Further, social workers would need to be included in policy making decisions without asserting their own political opinion [49]. They would need to remain an impartial party in policy evaluation to avoid inserting their own opinion in those analyses [50].

Lastly, short of admittance, it is difficult to prove that policies are discriminatory. Certain policies and laws are vague for the purpose of interpretation which means at times, how they are applied is purely subjective. While one might think or feel that a policy is racist or prejudice, another could provide evidence that it is not. It would become a never-ending cycle of trying to prove the other wrong without making any headway in policy change. If there is to be equality in the law, there first must be equality in the House [51,52]. While most federal lawmakers are straight White males, there is hope that the 118th Congress will start to produce nondiscriminatory policies, as there is more diversity in Congress now than there ever has been in American history. Currently there are 133 federal lawmakers of color (including the House and Senate) with 128 women and 13 people who identify as LGBTQ+ (including the House and Senate) [53-55]. Having these diverse perspectives will promote social equity and critical consideration of policy application.

## Conclusion

The federal government maintains a strict hold on controlled substances and their classifications. Though there is evidence of the usefulness of marijuana dating back to the 6th century, America deemed it a criminal substance and as a result has continued to demonize it despite there being some states who have relinquished punishment for possession. Because the federal government continues to schedule marijuana as one of the most addictive substances, researchers are unable to access it to prove that it can or cannot be helpful for certain medical conditions. While this paper does not promote legalization or decriminalization, it does argue that rescheduling should be considered to provide ease of access to states who are interested in furthering research on marijuana to objectively apply the law. This paper also argues that the federal government should be truly laissez-faire in enforcing marijuana policy. Maintaining control over marijuana policy is causing confusion in the law and how it is applied at the state level.

Three perspectives: Institutionalism, Conservatism, and Critical Race Theory provide the basis for these arguments. Institutionalism says that rescheduling marijuana addresses the government's willingness to cater to social welfare. Conservatism says that rescheduling marijuana puts American values at risk. CRT says that America continues to push a White Conservatist narrative at the expense of the freedom of people of color. All three approaches have their risks and benefits. Considering an approach that combines the three is a topic that should be further researched.

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