Controlled substances act and medical marijuana research paper examples

Literature, Russian Literature

The U. S. has made many attempts over time to restrict access to addictive and dangerous drugs and medications in order to protect its citizens. The result was more than 200 drug and medication laws that were impossible to monitor and was not effective in solving drug problems in the country. Compliance with the numerous state and federal laws which often differed substantially was hard to enforce and those dealing substances illegally could often get off by dealing in a different state and pleading ignorance if they were caught. Due to the major differences in numerous large and small details related to amount, classification, dangerousness and medical usefulness among many other facets that characterize drugs sold on the street, trying to enforce drug laws was largely unmanageable.

Throughout its history, the United States has made many attempts to outlaw addictive drugs and enact laws concerning consumer protections and public health. This effort resulted in over 200 drug laws that were hard to keep track of and didn't effectively meet the country's drug problems. In an attempt to remedy this, President Richard Nixon signed the Controlled Substances Act (CSA) in 1970. It combines all prior existing federal drug laws into one single statute.

The Controlled Substances Act of 1970 incorporates several laws which regulate the production and sales of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and a variety of chemicals used when manufacturing controlled substances in an illicit manner. Substances that are included under this act are those which have a high incidence rate of abuse or addiction and which are frequently produced and sold illegally. All drugs are assigned to one of five different schedules based on medical usefulness,

harm potential, and abuse and/or addiction potential. Schedule 1 includes drugs that are considered to be most dangerous, having high rankings for harm potential and abuse/addiction potential and the lowest rankings on medical usefulness. They are considered unsafe for use even under the supervision of a medical professional. Examples of drugs included in each schedule are listed below.

- Examples of Drugs under Schedule I: Ecstasy, LSD, and Heroin. Although the criteria for Schedule 1 drugs include the specification that the drug has no medical benefits, Marijuana is included as a Schedule 1 drug despite the legal use of Medical Marijuana for medical related benefits approved in a number of states.
- Examples of Drugs under Schedule II: Morphine, Codeine and other opiates, Methadone, and Cocaine
- Examples of Drugs under Schedule III: Anabolic steroids, Vicodin, and Marinol, (used to decrease chemotherapy related nausea).
- Examples of Drugs under Schedule IV: Ambien, Xanax, and Valium.
- Examples of Drugs under Schedule V: Lyrica and cough suppressants with limited amounts of codeine defined as not more than 200 milligrams per 100 milliliters such as Robitussin AC

The Controlled Substances Act also ensures that controlled substances used in research follow federal laws with extensive licensing, registration, storage, security and disposal requirements mandated. Those conducting the research are also required to register with the state and to fulfil other regulatory specifications.

The schedule system utilized in the Controlled Substances Act, makes it less

complicated to pursue criminal indictments. The act decreases complexity by grouping substances into a structural hierarchy that includes associated consequences for illegal production, trafficking and use of a large number of substances without the need to list each drug and associated consequences separately within the text. The system also allows drugs to be added or removed from inclusion easier as well as the decisions to include or removed drugs based on similarity or dissimilarity with a laundry list of substances. It also provided for uniformity of state and federal laws decreasing confusion over definitions, legal statutes, appropriate action for criminal activity related to substances, and drug categories. Creating state laws is more straight forward and can be accomplished more quickly than in the past since by definition state laws can be narrower in scope than Federal laws but cannot be more inclusive or conflict in any way with them (Spillane, 2004). According to the Controlled Substance Act, penalties for drug related criminal activities are determined by which schedule the substance is in. The more serious the drug as defined by the schedule it is included in, the more serious the offense is believed to be and the more severe the penalty or punishment. For example, according to Federal statute, someone caught selling less than 50 kilograms of marijuana, a Schedule I drug, can be sentenced to up to 5 years in federal prison and up to a $250, 000 fine. Someone caught in possession of a Schedule V drug like codeine can be charged with a misdemeanor offense and sentenced to up to one year in prison. Many critics of the act have protested the way sentencing is determined since many of the Class I drugs can be obtained cheaply while the lesser severe categories include expensive drugs making it easier for the

poor to purchase Class I drugs vs. Class IV and V schedule drugs. When caught with the same amount of different drugs, the poor are sentenced to far harsher sentences that the wealthy as drug of choice is often based strictly on economics (Mensah, 2012).

The Controlled Substance Act classifies marijuana as a Schedule I drug, indicating that not only is it considered among the most dangerous and addicting drugs available but also that it has no medicinal value. Yet at the same time many states now allow the use of medical marijuana for a variety of problems including nausea from chemotherapy, glaucoma and to decrease wasting in chronic disorders such as HIV/AIDS. However, the inherent contradictions allowing medical medication on the one hand while keeping medical marijuana in the Schedule I category provides conceptual problems and disagreements as to how to treat those using the substance with a prescription.

Although the restrictions allowing research into the usefulness of medical marijuana are many, the research that has been conducted has shown that the substance is useful for decreasing a variety of symptoms in different disorders. The fact that NIDA has refused to supply marijuana for three large treatment studies produces a bias as so far as the substance is viewed. Additionally, marijuana is the only schedule I drug that is not allowed to be produced in private labs for research use. Only one lab at the University of Mississippi is allowed to produce marijuana for use in research. At the same time, a number of states permit patients to use the substance for approved medical reasons by prescription. However, whereas legal drugs can be obtained from a prescription provided by a physician, because of marijuana’s

schedule designation, physicians provide prescription to obtain it and can only recommend that a patient be able to use it without providing legal access to the substance or protection for those who use it based on such recommendations.

The contradictions involved in confirming marijuana’s usefulness to treat certain with physicians sworn to do only good and no harm to patients recommending it’s use, and not allowing physicians to actually proscribe it or protect those using it for approved reasons at the approved dose make conceptualizations of the drug difficult. Is it or is it not medically useful in some cases? The research suggests it is in a variety of cases. If it has medical value why is it still classified as a Schedule I substance? The only answer is that it doesn’t fit and remains there for political reasons and strong voices that oppose it’s use under any circumstances. If physicians are willing to prescribe it for the benefit of certain patient’s why can’t they prescribe it? Again, the political reasons are wide and there are enough powerful people opposed to itsuch that a compromise that really isn’t one is that physicians can approve of it’s use and recommend use for certain patients but cannot go further legally.

These problems created by the method of classification of substances and refusal to alter the ordering of substances which new research shows are medically beneficial, creates frustration for policy makers, patients and health care providers alike. The drug policy alliance actually recommends the de-scheduling of medical marijuana to allow patients who can use it to their benefit immediate access to the drug and the ability to grow their own if they desire. This is in response to not only research but the treatment of

those using it legally. In some cases, individuals using the substance for legitimate purposes, such as work. Although state law regarding the use of a substance is stated to be required to be consistent with federal law, the case of medical marijuana use is the exception to the rule. Even in cases where the state permits use of the substance for medical purposes, since it is classified as having no medical benefit, it cannot be used for medical purposes according to the federal law. In all cases, use of marijuana for any purpose is illegal based on the federal law. In cases where States permit use, it is still illegal based on federal which takes precedence. This means that there is no protection for those using it which can be especially difficult for those who have found an improved quality of life from decreased symptoms of different medical problems. There is no redress for individual's fired from jobs due to the discovery that they are using the substance even for medical purposes. Additionally, those caught with the substance even with a label indicating it is being used for medical reasons, face the same charges and consequences as those using it illegally to alter their mood. Flying with the substance is also banned in all cases and this can cause individuals in need of the substance to be unable to travel due to the negative effects of returned symptoms without the substance (Bostwick, 2012).

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