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I. Letters

1. Letter from the Secretary-General

Dear Delegates,

It is my greatest pleasure to welcome you all to our conference. As the Secretary General I would like to start my letter with special thanks to our academic and organization team who made this conference possible with their efforts , I am truly honored to have the opportunity to meet such passionate, hardworking, and open-minded delegates

Model United Nations is more than debating resolutions. It is a place that people learn diplomacy, leadership, cooperation. Throughout this conference, I encourage each of you to speak with confidence, and most importantly, enjoy every moment of this experience.

I hope this conference becomes not only an unforgettable academic experience, but also a place where you build new friendships and memories. I look forward to welcoming you all.

Sincerely,

Asude Kacırođlu

Secretary-General

2. Letter from the Under-Secretary-General

Dear Senators,

My name is Yağmur Akman, and I am currently a 10th-grade student at Ankara Atatürk High School. It is my utmost privilege to serve as the Under Secretary-General of this committee. The US Senate committee has a special meaning to me; for me, it is the place where I have learned how to debate, how to be an MUNer, and most importantly, how to have the most fun in MUNs. We have a really fun and questioning topic on the floor for you to talk about; I hope you have fun debating. I would firstly like to thank my Co-Under Secretary-General and my best friend, Neşet Erdem Ağırman, for helping me in every way in this MUN community, always supporting me in my downs, and cheering for me in every closing ceremony, or getting happy with me in my ups. I'd also like to thank the Academic Assistant Ali Bakım for being great and also showing importance to his skincare. Also, I'd like to thank the Executive Direktor Hayrunnisa for inviting me to this conference and for making this great conference

come to life and giving us this wonderful chance to put the greatest committee that ever existed in MUNs, "US SENATE." I'd like to conclude my letter by stating that unfortunately I will be unable to attend the conference in real life. However you can still contact me if you have any kind of inquiries. And lastly, I would like to thank everyone who I have forgotten to thank. If you have any inquiries, you can always contact me at yagmurakman2@gmail.com.

Sincerely,

Yağmur Akman

Under Secretary-General of the United States Senate

3. Letter From the Under Secretary-General

Greetings

I am Neşet Erdem Ağırman and I serve as the Co-Under Secretary General of the United States Senate. I live in Ankara but having a conference at the Bursa meeting and introducing the procedure to new people going to make me feel magnificent. I am an 11th grader at Şehit Cengiz Polat AİHL and as I get closer to the final of my highschool era I'll start to have less conferences than usual and that brings about me to come to Bursa for a bucket list.

I want to thank some special people starting with Hayrunisa. She is the best person that has MUN and she helped me solve every single problem and granted every wish that I had. Other than that Yağmur Akman. He's a great partner to have in any kind of

situation and my thanks for comes from my soul. Also I want to thank Ali Bakım, who is a friend of mine from a committee that I can't even forget a minute of it.

Lastly, the US Senate is a total debate committee and it is so fun to watch so now we are having one and if you have any question marks on your mind don't hesitate to ask me for help!!

Thank You!

agrneseterdem@gmail.com

4. Letter from the Academic Assistant

Dear Delegates,

US Senate! It is my pleasure and the honor to act as your Academic Assistant for this conference. I can wait to see all your sessions, ideas and growth in dealing with each other. You may be starting at this your first MUN or the tenth, I hope this will at least empower and spark curiosity to what your council has been like. Academic Assistant (My purpose is to help you with more the academic part of the committee; the agenda items, research tips and resolutions communications). However, I am there before and after the start of this journey in making sure that you are confident. If anything seems weird, weighty or fuzzyness, come at me. There is no pressure to be an expert, just make progress.

An institution which works on peace, collective security and international cooperation on a global scale. Our topics are important nowadays and the range of voices (yours, opinions and ideas) will make a meaningful conversation. Please speak up, collaborate and push yourself.

You are not alone in this. You are a team with us... Chairs, your fellow delegates and myself; we have learned so much together, and we want you to leave your mark on this conference too.

Well done on your “endless” efforts and good luck in what you do keep enjoying the ride. Can not wait to see what you will accomplish. If you have any questions regarding the committee or agenda item, you can contact us here.

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Warm regards,

Ali BAKIM

Academic Assistant – US Senat

II. Introduction

1. Introduction to the US Senate

a. United States Senate

The United States Senate is the upper house of the United States Congress, the legislative branch of the United States Government; the lower house being the House of Representatives. The Senate includes 100 Senators, with two Senators representing each state. The terms of Senators are limited to six years, having no limit to their re-election. The Senate hosts two political parties, the Democratic party, having 45 members, and the Republican party, having 53 members, and two independent Senators, Bernie Sanders (Vermont) alongside Angus King (Maine).

In the Senate, all states are represented equally. Unlike the House of Representatives, each state has two Senators, disregarding the States landmass or the population. Before the ratification of the 17th amendment of the Constitution in 1913, Senators were selected by each state's legislature.

b. Historical Background of the United States Senate

The history of the United States Senate dates back to 1774 with the First Continental Congress, the gathering of representatives from 12 of the 13 colonies. The second one of these Continental Congresses was the meeting where the Declaration of Independence was adopted, on the 4th of July 1776. The Congress of the Confederation was established under the Articles of Confederation in 1781, creating a unicameral system in which each state would have equal representation in. This included the right of veto for each and every state, causing the body unable to come to proper resolutions. This issue sparked the government to become powerless over time and led to the Convention of 1787.

In 1787, the Senate's powers and formation was established under Article 1 under the constitution. The idea of a bicameral system was discussed, and it was said that one branch would be in the words of George Mason from Virginia "*grand depository of the democratic principle of government.*" In order to prevent this view from spreading in the national government, James Madison suggested another house that would be smaller, contemplative, and self-reliant. This idea later became the Senate.

Later on, a compromise plan called the Connecticut Compromise was put in motion allowing both larger and smaller states to benefit from different sides of the chamber. The larger states would benefit from the idea of having representatives chosen by the citizens; and the smaller states would benefit from the Senators being chosen by each respective state's governor.

The separation of power in the United States creates the three branches of the U.S. government being: executive, legislative, and judicial. In order to avoid any abuse of power these branches were given tasks and were to only act upon their own assignments. The branches could check other branches according to the principle of separation of power.

c. Authority and Responsibilities of the United States Senate

The Senate shares its legislative power with the House of Representatives. Additionally, the Senate has the power to accept, or reject presidential nominations to the executive and judicial branches; and to support or deny its "*advice and consent*" to laws discussed among the executive. Furthermore, while the power of impeachment is solely the House of Representatives's, the Senate has the power to try any and all impeachments.

The Senate is conducted by the constitution, the standing rules. The standing rules of the Senate, as it is said in the name, are standing. These rules can not be changed, unlike the adopted Rules of the House of Representatives. The Rules of HoR are adopted every 2 years (the term limit for representatives). The Standing Rules determine how the legislations and resolutions are written, read, and voted; the arrangement of Senate sub-committees, the rules for debate, and how the legislation shall be voted upon.

The Constitution gives the right to approve any treaty written by the executive branch in the Senate by $\frac{2}{3}$ majority vote while also having the power to amend it. The Senate acts upon laws, amendments, motions, resolutions, and nominations by voting. Senators are able to cast their vote in a number of ways including roll-call voting, voice voting, and unanimous consent.

d. Legislation of Bills and Constitutional Amendments

The United States Senate is the upper house of the bicameral legislative system of the United States government and the Senate chamber is the main space where laws are discussed. Senators are to introduce and discuss legislation, which is called a bill. The bills in the Senate, in order, are written, read, and voted upon.

As it is a bicameral system, any bill that passes from the Senate shall be referred to the House of Representatives, and any bill that passes from the House shall be referred to the Senate. Senate (or House) referral is the procedure done when one of the houses passes a bill, and refers it to the other in order for it to become a law. In cases where the bill sent from the House could not have reached a compromise in the Senate, the bill would automatically die. If bills are passed both from the Senate and the House they become laws. The procedure for constitutional amendments is very similar to the procedure of bills; meaning it is also written, read, and voted (including the referrals). The Senate has the power to draft, revise, debate, approve, or dismiss legislative initiatives, exercising its authority through majority decisions.

e. Impeachment

The act of impeachment is used when there are speculations that a government officer might have done wrongful acts and may face a sentence, especially used in the US. The constitution provides the power of impeachment to the House of Representatives, and the power to try all impeachments to the Senate. All civil officers of the United States, including the president and the vice president, are all subject to impeachment with no exceptions.

In the proceeding of an impeachment, the House charges a government official by accepting the articles of impeachment, by simple majority. After the approved articles of impeachment are sent by the House of Representatives to the Senate, the Senate initially becomes a High Court of Impeachment to analyze evidence, host hearings, and vote to discharge or sentence the official which was impeached. In specific occasions, the Senate disallows the then impeached government official to hold a place in public offices in the future. In the United States, there have only been three cases of formal presidential impeachments, which are Andrew Johnson, Bill Clinton, and Donald J. Trump (twice in 2019 and 2021).

f. Treaties

Treaties are documents that are legally binding concessions between states or international organizations. Under the United States Constitution, the president has the authority to make treaties (*“the president shall have Power, by and with the Advice and Consent of the Senate, to make Treaties, provided two-thirds of the Senators present concur”* [Article II, Section 2]). The treaties which the USA is a party to shall also become federal laws also called, by the constitution, *“the Supreme Law of the Land”*.

The Senate, however, does not directly ratify treaties, but follows a procedure of receiving consideration from the Committee on Foreign Relations, and then passing and rejecting a resolution for the ratification of the treaty. If the said resolution is passed, the ratification just takes place when the connection and necessities between the United States and foreign party/parties are met.

Over the years, the Senate has debated and voted upon many treaties, yet, the treaties which were seen as insufficient and/or were not re-submitted at the start of every other Congress would either not get voted upon resulting in the president to withdraw the treaty, or were not to be discussed for a long period. In the past few decades, the presidents approved treaties without the advice or the consent of the Senate, this still made the treaties legally and federally binding to the United States.

g. Filibuster

A filibuster is a political tactic mainly used in the United States Senate, used to delay or block another Senator's speech or a voting procedure causing the debate to last for a long time until there are compromises made. This is mainly caused by the loopholes in the lacking restrictions for Senatorial Debate procedure; according to the Standing Rules, if the floor is not entertained by another speaker, anyone who seeks recognition is able to give their free speech, for as long as they wish. The voting will only be able to cast if the debate ends naturally, or by giving closure.

Rule 22 of the Standing Rules allows the Senate to close the debate by motioning for the "closure of the debate" which is passed by a $\frac{2}{3}$ majority by the Senate, and if there is more

than one vacant votes the majority to pass the voting is 60, making both of the parties to not be able to either pass or reject the motion, resulting in it being rejected.

In conclusion, the power to filibuster is an advantage for the minority party enabling them to have a better chance at flipping tables to their side and blocking the voting until their conditions are met.

h. Voting

The Senate is to vote upon legislation, motions, amendments, and nominations by practicing different methods.

A roll call vote is done by the request of $\frac{1}{5}$ of senators present, and it may be used for: expelling a senator; imprisoning an impeached official; consenting the ratification of a treaty; overriding a presidential veto. The roll call vote is done by the Clerk of the senate calling out senator's name one by one, and senators responding with either "yea" or "nay". The record of the voting is held by the clerk to a tally sheet. Under most circumstances, a simple majority ($\%50+1$) is required for a roll call vote to pass. In the case of a tie, the president of the senate uses their tie-breaking vote.

Vocal voting is also conducted in the senate. In this context, the assigned officer, mostly the president pro tempore, states the question, then the senators approving state "yea", and the senators opposing say "nay". The president pro tempore announces the results according to his/her best judgement.

The least used way of voting is a standing vote. If senators are speculating that the results of the vocal vote might be wrong, a standing vote may be requested, the assigned officer requests the senators in favor to stand on one side of the room and the ones against to stand on the other. The numbers of senators on both sides of the room are counted, then, the results are announced by the president pro tempore.

2. Senate Leadership Roles

a. Vice President

The Vice President of the United States (VPOTUS) is the second highest ranking office in the United States' executive branch, being the first in the presidential line of succession. The Vice President is also the President of the United States Senate. The VPOTUS is empowered to supervise the Senate, but is not allowed to vote unless there is the need for a tie-breaker. The current President of the Senate is James David Vance (JD Vance).

b. President Pro Tempore

By the guidance of the Constitution, the Senate shall choose a president pro tempore to chair the Senate in the absence of the president of the Senate. The term "*pro tempore*" means "*for the time being*" in Latin. This illustrates that the president pro tempore position was actually intended to be temporary. The framers of the Constitution had always assumed that the Vice President would be administering the Senate at all times, having the president pro tempore position put as a temporary replacement when the Vice President could not attend.

In the Constitution it is not specified who can serve as the president pro tempore. Typically, the Senate would vote upon the position of president pro tempore amongst its members. Ever since the mid-20th century, it has become a tradition that the longest-serving member of the majority party would serve as the president pro tempore.

The president pro tempore is to conduct all oaths, which are required by the Constitution, is able to sign legislation, and is able to chair the House and the Senate when both houses are in joint session. However, the president pro tempore is not allowed to cast the tie-breaking vote during the absence of the vice-president.

c. Majority and Minority Leaders

With the start of each Congress, the Democratic Caucus and the Republican Conference should elect one of their respective members as their leader. Depending on the party which is in power, one party leader serves as the minority leader, and the other serves as the majority leader. The party leaders, also known as the floor leaders, are the designated spokesperson for their party's stances on the issues and regulate their legislative strategies, while occupying the front-row desks of the chamber.

The majority leader is undoubtedly the strongest Senator in the Senate chamber, having the floor's priority over any other Senator, including the opposing party leader. They are also seen as the chief representative of their party in the entirety of the Congress, only if the House of Representatives is controlled by the opposing party. The Senate's executive and legislative issues are also controlled and scheduled by the majority leader.

The current majority leader of the Senate is John Thune of South Dakota from the Republican Party; and the minority leader is Charles E. Schumer (Chuck Schumer) of New York from the Democratic Party.

d. Party Whips

The term “whip” comes from an expression, which is used in fox hunting, “to whipper-in”, as the party whips are responsible to keep the members of their party in line. The party whips are usually serving as the assistant leaders, counting up heads and rounding up party members for votes and quorum calls, and in the absence of their leaders in the chamber, they step up as the leaders.

Currently, the majority whip is John Barrasso of Wyoming from the Republican party; and the minority whip is Richard Durbin (Dick Durbin) of Illinois from the Democratic party.

III. Introduction to the Agenda Item

1. Definition and Scope of Marijuana Legalization

a. Understanding Cannabis and Its Uses

Cannabis refers to the dried leaves, flowers, stems, and seeds of the cannabis plant. The plant has many different chemical compounds, including tetrahydrocannabinol (THC), which has intoxicating—mind altering—effects. Cannabis products with THC can cause changes in mood, thoughts, and perceptions of reality. These products can also cause harmful health effects on the brain and other parts of the body. In recent years, there have been big increases in the variety of cannabis products and how much THC they have, as well as a greater variety

of ways people can consume them. Unless mentioned otherwise, the information on this webpage is about cannabis products with THC. NIDA funds research on the health effects of cannabis products, including impacts on the developing brain and on mental health. The institute also supports research on prevention and treatments for cannabis use disorder, the potential therapeutic uses of cannabis, and the public health impacts of cannabis policies. Cannabis can be used in a number of ways.

The most common ways include:

Smoked in joints (like a cigarette), in blunts (cigars or cigar wrappers that have been partly or completely refilled with cannabis) or in bongos (pipes or water pipes) Vaped using electronic vaporizing devices (like vape pens) or other vaporizers Mixed or infused into foods or drinks (called edibles) like cookies, cakes, or brownies, or tea, cola, or alcohol Additionally, some people inhale the oil concentrates and other extracts from the cannabis plant—this is known as dabbing. THC oils and concentrates used in vaping and dabbing often involve using highly concentrated forms of THC and may contain additives or be contaminated with other substances that may be harmful. How cannabis affects a person depends on several factors,

Including:

Concentration of THC used, frequency of cannabis use, use of cannabis with other substances (e.g., alcohol or other drugs); which could increase risk of harm, mode of cannabis use (e.g., consuming edibles or products with high THC concentration can have delayed or unpredictable effects and increases the risk of overdose or poisoning), Previous experience

with cannabis or other drugs, biology (e.g., genes, DNA), sex (e.g., women may experience more dizziness after using cannabis compared to men)

People also use cannabis as medicine. For example The Food and Drug Administration (FDA) has approved one plant-based cannabis drug called Epidiolex, which contains a purified form of CBD. The prescription medication is approved for treating seizures associated with two rare and severe forms of epilepsy (Lennox-Gastaut syndrome and Dravet syndrome) as well as seizures associated with a rare genetic disorder called tuberous sclerosis complex.

The FDA has also approved two medicines (dronabinol [brand names: Marinol and Syndros] and nabilone [brand name: Cesamet]) that are made from a synthetic or lab-made chemical that mimics THC. These medicines are used to treat nausea in patients with cancer who are having chemotherapy treatment, and to increase appetite in individuals with AIDS who do not feel like eating (wasting syndrome).

These approved products are only available with a prescription from a licensed healthcare provider. There are currently no other FDA-approved uses for cannabis or its derivatives.

b. Difference Between Medical and Recreational Legalization

The most common use for medical marijuana in the United States is for pain control. While marijuana isn't strong enough for severe pain (for example, post-surgical pain or a broken bone), it is quite effective for the chronic pain that plagues millions of Americans, especially as they age. Part of its allure is that it is clearly safer than opiates (it is impossible to overdose

on and far less addictive) and it can take the place of NSAIDs such as Advil or Aleve, if people can't take them due to problems with their kidneys or ulcers or GERD.

In particular, marijuana appears to ease the pain of multiple sclerosis, and nerve pain in general. This is an area where few other options exist, and those that do, such as Neurontin, Lyrica, or opiates are highly sedating. Patients claim that marijuana allows them to resume their previous activities without feeling completely out of it and disengaged.

Along these lines, marijuana is said to be a fantastic muscle relaxant, and people swear by its ability to lessen tremors in Parkinson's disease. I have also heard of its use quite successfully for fibromyalgia, endometriosis, interstitial cystitis, and most other conditions where the final common pathway is chronic pain.

Marijuana is also used to manage nausea and weight loss and can be used to treat glaucoma. A highly promising area of research is its use for PTSD in veterans who are returning from combat zones. Many veterans and their therapists report drastic improvement and clamor for more studies, and for a loosening of governmental restrictions on its study. Medical marijuana is also reported to help patients suffering from pain and wasting syndrome associated with HIV, as well as irritable bowel syndrome and Crohn's disease.

This is not intended to be an inclusive list, but rather to give a brief survey of the types of conditions for which medical marijuana can provide relief. As with all remedies, claims of effectiveness should be critically evaluated and treated with caution.

The FDA understands that there is increasing interest in the potential utility of cannabis for a variety of medical conditions, as well as research on the potential adverse health effects from use of cannabis.

To date, the FDA has not approved a marketing application for cannabis for the treatment of any disease or condition. The agency has, however, approved one cannabis-derived drug **Product:** Epidiolex (cannabidiol), and three synthetic cannabis-related drug products: Marinol (dronabinol), Syndros (dronabinol), and Cesamet (nabilone). These approved drug products are only available with a prescription from a licensed healthcare provider. Importantly, the FDA has not approved any other cannabis, cannabis-derived, or cannabidiol (CBD) products currently available on the market.

There is no difference between the medical and recreational cannabis in botanical terms. Scientists have found that the THC concentration is similar for both the marijuana plant and the products used to treat medical conditions or those used for recreational purposes. The main difference between medical and recreational marijuana is how they are sold.

For example, to purchase medical marijuana through a state's medical program, a person must have authorization from a healthcare provider and the state's approval. With recreational marijuana in qualifying states, any person over the age of 21 can make the purchase.

Many states exempt medical cannabis purchases by qualified patients from sales and use tax. States regulate marijuana differently based on whether the marijuana is medical, medical and recreational, CBD, or medical CBD.

Medical marijuana:

Medical cannabis is only legal for medical purposes if a person has a qualifying condition, such as cancer, glaucoma, or multiple sclerosis. Qualifying conditions vary by state.

Medical and recreational marijuana:

In states where medical and recreational marijuana are legal, there are still major differences in the way that these products are priced, sold, bought, and the laws that business must follow to set up a marijuana business. For instance, the retail marijuana industry is heavily regulated and taxed by both state and local agencies.

Some jurisdictions also have additional business license requirements in addition to state laws. A city or county may also outright ban marijuana businesses altogether, even if the state has legalized cannabis activity.

Cannabidiol (CBD) is an active ingredient in cannabis that is derived from the hemp plant. CBD sales are federally legal if the product contains less than 0.3% THC. While some states allow CBD over-the-counter sales, others only permit the sale of CBD if it has no THC.

Still, there remains much confusion surrounding CBD as federal and state laws change and differ. Kansas, Ohio, Iowa, and Texas have conducted raids on non-compliant hemp and CBD stores, generating news coverage.

Some states allow the use of medical CBD but restrict its use to those who have a prescription.

For example, Georgia authorizes the possession of low THC oil to persons with certain medical conditions or their caregivers if they possess a Low-THC Oil Patient Registry Card. Low THC oil is an oil that contains an amount of cannabidiol and not more than 5% by weight of tetrahydrocannabinol (THC), tetrahydrocannabinolic acid (THCA), or a combination of the two which does not contain plant material exhibiting the external morphological features of the plant of the genus Cannabis.

Meanwhile, in Idaho, it is legal to use cannabis extracts high in CBD to treat qualifying conditions only if the CBD contains zero THC and is derived from industrial hemp (*Cannabis sativa* L.) or one of the five identified parts of the cannabis plant. These parts include mature stalks; fiber produced from the stalks; oil or cake made from the seeds or the achene of such plant; any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalk; or the sterilized seed of such plant which is incapable of germination.

c. Federal vs. State Legal Definitions

A decade ago, the thought of legalized marijuana—even for medicinal purposes—was cutting edge and controversial. In 2021, the conversations around legalized cannabis have dramatically evolved. While there are still critics of legalized cannabis, we have seen a nationwide and largescale embrace of cannabis use ranging from treatment for medical conditions to recreational marijuana. Hemp and CBD products have become mainstream. As of this writing, thirty-seven states, the District of Columbia, and four US territories allow for the use of medical marijuana. Thirteen states and one territory have decriminalized the use of cannabis. Additionally, eighteen states, two territories and the District of Columbia have

enacted laws to allow the recreational use of marijuana. Eleven states allow for the use of low THC, high CBD products for medical reasons. These numbers are trending upward, with several states expected to enact various cannabis legalization bills in 2022. Only three states (Idaho, Kansas, and Nebraska) still do not allow the use of cannabis in any capacity.

Despite the overwhelming majority of states allowing for the use of cannabis at some level, the federal legalization structure is lacking. This complex interplay makes it difficult for business lawyers to advise clients whose businesses involve cannabis—whether those clients are legally selling cannabis or if those clients are cannabis-adjacent. This article will explore how the conflict of law between the narrow federal landscape and the expansion of state cannabis laws has created numerous business law complications, including its impact on the banking rules and regulations, and decisions lawyers and bankers must make without clear guidance and direction. Additionally, this article will provide a high-level overview of the questions a business lawyer should be asking, such as: What are the ethical rules that I should be aware of, and what are the areas I need to troubleshoot for my client that I may never have contemplated would be impacted by the changing state-based marijuana laws?

While this article hopes to provide guidance and advice for the business lawyer in the cannabis space, the conflict that exists between federal law and the state laws may present more questions than we can currently answer. However, even with uncertainty in some of the questions raised, this is an area that is growing and evolving, and every business lawyer should be prepared for issues and questions that may arise in this space.

As we examined in the beginning, states have moved towards embracing the use of cannabis. The federal government, meanwhile, has not made the same move. Under federal law,

cannabis is still classified as a Schedule I substance under the Controlled Substance Act. This means it is considered to have a high potential for dependency and no recognized medical use. For context, other Schedule I substances include ecstasy, heroin, and LSD. Distribution of a Schedule I substance is a federal offense.

Some progress was made on the federal level with the passage of the 2014 and 2018 Farm Bills. While the Farm Bills did not change the legal classification of cannabis, they did remove hemp from Schedule I of the Controlled Substances Act and permitted states to create industrial hemp programs. There was hope that the Farm Bills would also lead to the Food and Drug Administration (FDA)—which retains regulatory authority over drugs—to issue detailed guidance that would provide clarity on whether (and how) CBD could be used. The Farm Bills, however, have led to more confusion. Many thought that the Farm Bills legalized CBD. The day the 2018 Farm Bill became effective, the FDA released a statement asserting its policy that marketing CBD as foods or dietary supplements remained unlawful. This has led to great consumer confusion and even more uncertainty as the market is now saturated with hemp and CBD products that may or may not actually be allowed under federal law.

In 2021, U.S. Senators Cory Booker, D-NJ, Ron Wyden, D-OR, and Charles “Chuck” Schumer, D-NY, proposed the Cannabis Administration and Opportunity Act as a Discussion Draft (hereinafter the “Draft”). The sponsors indicated that the Draft is in anticipation of a final proposal, which Senate Majority Leader Schumer recently stated would be introduced in April 2022. The Draft would remove cannabis from the Controlled Substances Act and direct the Attorney General to remove cannabis from the list of controlled substances. The Draft would impose a federal excise tax on cannabis products. Importantly, the Draft also contains

a number of decriminalization provisions and would allow state-compliant marijuana businesses to have access to financial services such as bank accounts and loans.

2. Social, Economic, and Health Dimensions

a. Public Health Impacts

People who use cannabis can struggle with physical dependency and controlling their use. This is concerning as there is evidence suggesting the use of highly concentrated THC products is associated with more severe cannabis use disorder symptoms. While approximately 3 in 10 persons who report cannabis have a cannabis use disorder, this figure is rising. Some signs and symptoms of cannabis use disorder include trying but failing to quit using cannabis or giving up important activities with friends and family in favor of using cannabis. The risk of developing cannabis use disorder is stronger in people who start using cannabis during youth or adolescence and who use cannabis more frequently. Cannabis use directly affects brain function—specifically the parts of the brain responsible for memory, learning, attention, decision making, coordination, emotions, and reaction time. Cannabis can make the heart beat faster and raise blood pressure immediately after use. It could also lead to increased risk of stroke, heart disease, and other vascular diseases. Cannabis, like alcohol, negatively affects several skills required for safe driving. You can choose not to drive—and remind your friends and family to do the same—after using cannabis. Smoked cannabis, regardless of how it is smoked, can harm lung tissues and cause scarring and damage to small blood vessels. Cannabis use has been linked to social anxiety, depression, and schizophrenia (a type of mental illness where people might see or hear things that aren't really there), but scientists don't yet fully understand the relationships between these mental health disorders and cannabis use. Edibles, or food and drink products infused with cannabis, have some

different risks than smoked cannabis, including a greater risk of poisoning. Some cannabis edibles have packaging designed to mimic the appearance of well-known branded snacks and candy that appeal to children, which increases the risk for unintentional ingestion. Children who consume THC-containing products can become very sick.

b. Criminalization and Its Human Effects

In the United States, regulation on the use, sale, and labeling of cannabis (legal term marijuana or marihuana) began at the state level in the early 20th century, and outright prohibitions began in the 1920s. By the mid-1930s, cannabis was regulated as a drug in every state, including 35 states that adopted the Uniform State Narcotic Drug Act. The first national regulation was the Marihuana Tax Act of 1937.

Cannabis was officially outlawed for any use with the passage of the Controlled Substances Act (CSA) in 1970. Multiple efforts to reschedule cannabis under the CSA have failed, and the U.S. Supreme Court ruled in *United States v. Oakland Cannabis Buyers' Cooperative* (2001) and *Gonzales v. Raich* (2005) that the federal government has a right to regulate and criminalize cannabis, even for medical purposes. Despite this, states and other jurisdictions have continued to implement policies that conflict with federal law, beginning with the passage of California's Proposition 215 in 1996. By 2016, a majority of states had legalized medical cannabis, and in 2012, Colorado and Washington became the first states to legalize recreational use through referendums.

c. Economic Significance of the Cannabis Industry

Marijuana legalization has expanded across the U.S., with numerous states allowing medical and recreational use. This shift has led to economic growth, job creation, and new business opportunities in the legal cannabis industry. States also benefit from increased tax revenue and reduced costs for law enforcement. While marijuana remains federally regulated, ongoing policy discussions suggest the potential for broader national legalization in the future. One of the most immediate effects of marijuana legalization is its effect on tax revenue. In 2023, total cannabis-related tax revenue collected by all states topped \$4.18 billion.

California brought in the most sales tax revenue from cannabis among states where recreational use is legal, drawing in \$1.1 billion. Washington and Colorado are the two states where marijuana has been legalized for recreational use the longest. From 2014 through 2023, Washington collected \$4.1 billion in tax revenue from adult use.

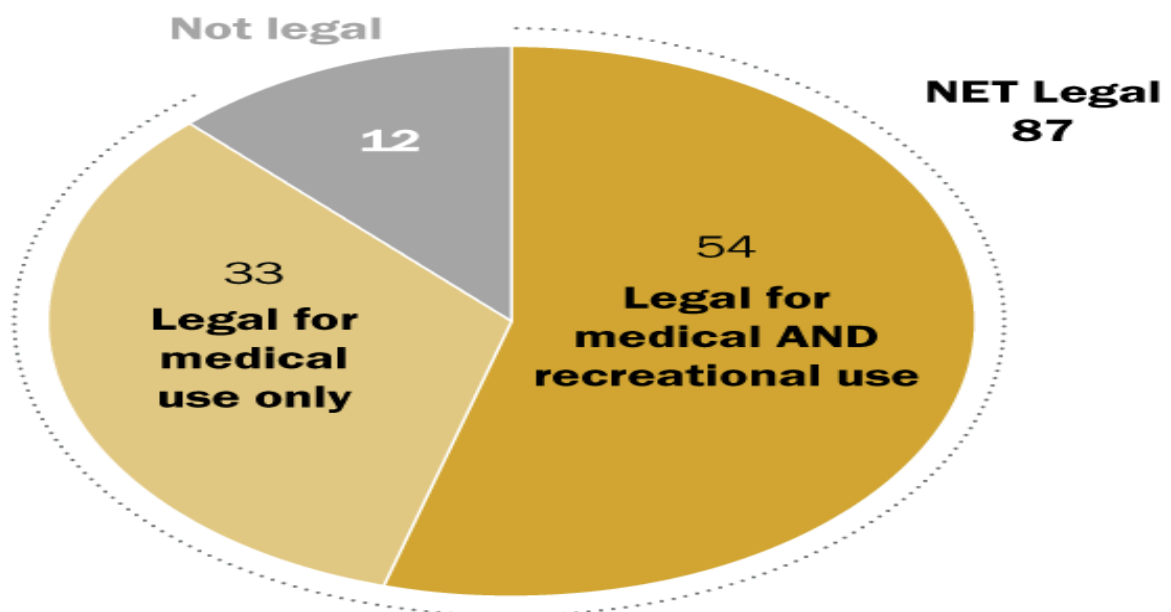
In the same period, Colorado collected \$2.38 billion in total marijuana tax revenue.

Colorado Department of Revenue. "Marijuana Tax Reports."

The vast majority of Americans support legalizing marijuana in some way, according to a January-February 2025 Center survey. Around nine-in-ten U.S. adults say either that marijuana should be legal for medical and recreational use (54%) or that it should be legal for medical use only (33%). Another 12% say the drug should not be legal at all. These views have held relatively steady over the past six years.

Only about 1 in 10 Americans say marijuana use should not be legal at all

% of U.S. adults who say marijuana should be ...



Note: Share of respondents who did not answer is not shown.
Source: Survey of U.S. adults conducted Jan. 27-Feb. 2, 2025.

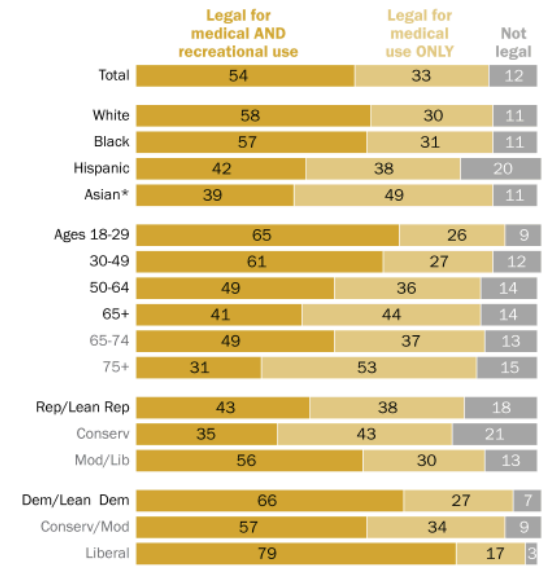
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Views on marijuana legalization differ by age, political party and other factors, according to the January survey. While small shares across demographic groups say marijuana should not be legal at all, those least likely to support legalization for both medical and recreational use include:

A horizontal stacked bar chart showing that views on legalizing marijuana differ by race and ethnicity, age, partisanship.

Views on legalizing marijuana differ by race and ethnicity, age, partisanship

% of U.S. adults who say marijuana should be ...



* Estimates for Asian adults representative of English speakers only.
 Note: White, Black and Asian adults include those who report being only one race and are not Hispanic; Hispanics are of any race. Shares of respondents who did not answer are not shown.
 Source: Survey of U.S. adults conducted Jan. 27-Feb. 2, 2025.
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Older adults: 31% of Americans ages 75 and older favor legalizing marijuana for both uses, as do 49% of those ages 65 to 74. By contrast, 65% of adults under 30 support legalization for both uses.

Republicans: 43% of Republicans and GOP-leaning independents favor legalization for both uses, compared with

66% of Democrats and Democratic leaners. Notably, moderate and liberal Republicans (56%) and conservative and moderate Democrats (57%) express similar levels of support.

Hispanic and Asian Americans: About four-in-ten Hispanic (42%) and Asian (39%) adults support legalizing marijuana for both uses. That compares with more than half of White (58%) and Black (57%) adults.

b. Federal State Policy Conflicts

Marijuana is a psychoactive drug that generally consists of leaves and flowers of the cannabis sativa plant. Marijuana is a Schedule I controlled substance under the federal Controlled Substances Act (CSA; 21 U.S.C. §801 et seq.), and thus is strictly regulated by federal authorities. In contrast, over the last several decades, most states and territories have deviated from a comprehensive prohibition of marijuana and have laws and policies allowing for some cultivation, sale, distribution, and possession of marijuana.

Marijuana is the most commonly used illicit drug in the United States. According to data from the National Survey on Drug Use and Health (NSDUH), in 2022 an estimated 61.9 million individuals aged 12 or older used marijuana in the past year, and 42.3 million reported using it in the past month (NSDUH defines current use as past month use). The percentage of individuals 12 or older who reported past-month marijuana use gradually increased from 6.1% in 2008 to 15.0% in 2022—a time frame during which a majority of states repealed state criminal prohibitions on marijuana and allowed for its recreational and/or medical use. The rate of past-month marijuana use among youth (ages 12-17) has fluctuated during this time—it was 7.0% in 2008 and 6.4% in 2022, while adult (ages 18+) use steadily increased—from 6.3% in 2008 to 15.9% in 2022.

In 1996, California became the first state to amend its drug laws to allow for the medicinal use of marijuana. As of May 2, 2024, 38 states, the District of Columbia (DC), Puerto Rico, Guam, and the U.S. Virgin Islands have comprehensive laws and policies allowing for the medicinal use of marijuana. Nine additional states allow for "limited-access medical cannabis," which refers to low-THC cannabis or CBD oil. Idaho, Kansas, Nebraska, and American Samoa do not allow for the use of medical marijuana or low-THC cannabis.

Current federal law does not recognize the distinction some states make between the medical and recreational uses of marijuana. Marijuana's classification as a Schedule I controlled substance reflects a finding that marijuana has a high potential for abuse and no currently accepted medical use in the United States. Moving marijuana from Schedule I to Schedule III, without other legal changes, would not bring the state-legal recreational marijuana industry into compliance with the CSA. If marijuana were moved to Schedule III, it could theoretically be used for medical purposes consistent with federal law. However, Schedule III controlled substances may only legally be dispensed pursuant to a valid prescription and, as discussed below, marijuana is not currently a prescription drug approved by the Food and Drug Administration (FDA). The process for getting approval to conduct research with marijuana involves both DEA and FDA. Before conducting research with marijuana, an investigator must obtain a DEA registration, FDA review of an investigational new drug application (IND) or research protocol, and marijuana from a DEA-registered source.

The Medical Marijuana and Cannabidiol Research Expansion Act (P.L. 117-215), among other things, imposed new requirements on DEA to expedite registration for marijuana researchers and requires the Department of Health and Human Services to report on the therapeutic potential of marijuana for various conditions such as epilepsy, as well as on marijuana's effects on adolescent brains and on users' ability to operate a motor vehicle.

Although state laws do not affect the status of marijuana under federal law or the ability of the federal government to enforce it, state legalization initiatives have spurred a number of questions regarding potential implications for federal laws and policies, including federal drug regulation, and access to banking and other services for marijuana businesses. Thus far, the federal response to states' legalizing marijuana largely has been to allow states to implement their own laws. The Department of Justice (DOJ) has nonetheless reaffirmed that

marijuana growth, possession, and trafficking remain crimes under federal law irrespective of states' marijuana laws. Federal law enforcement has generally focused its efforts on criminal networks involved in the illicit marijuana trade.

Federal banking regulators have yet to issue any formal guidance in response to state and local marijuana legalization efforts; however, in February 2014 the Treasury Department's Financial Crimes Enforcement Network issued guidance on financial institutions' suspicious activity report requirements when serving marijuana businesses.

c. National Debate and Partisan Positions

Republican Perspectives on Medical Cannabis:

Republicans frequently frame medical cannabis policy through the lens of states' rights. Rather than supporting sweeping federal legalization, many GOP lawmakers argue that states should decide for themselves. In practice, this means some Republican-led states have enacted programs, while others remain resistant. While there is growing Republican support, skepticism remains. GOP lawmakers often highlight concerns about the potential for abuse and insufficient research. These arguments are typically used to justify restrictive laws such as strict dispensary caps. Generational change is reshaping Republican views. Polls show younger conservatives more supportive, particularly when considering tax revenue and job creation. However, older leadership often slows this shift.

Democratic Perspectives on Medical Cannabis:

Democrats generally champion federal reform. Many leaders call for removing cannabis from the Controlled Substances Act, effectively legalizing it nationwide. Their argument centers on patient rights, healthcare access, and social justice. Democrats often view cannabis through a healthcare lens. They argue it should be treated like any other medicine, citing NIH/NIDA research roles and patient needs. For Democrats, cannabis ties into criminal justice reform. Federal proposals often include expungement measures, which appeals to progressive voters.

Where Republicans and Democrats Converge:

Both parties recognize strong public support. Outright opposition is now politically risky. Cannabis is a multi-billion-dollar industry. Republicans cite economic growth, while Democrats emphasize funding healthcare and education through tax revenue. One area of bipartisan agreement is veterans' access. Recent votes in both the House and the Senate support policies allowing VA doctors to recommend cannabis to veterans.

IV. Background of Marijuana Policy in the United States

1. Early Cannabis Use and Regulation

Cannabis is a genus of flowering plants in the family Cannabaceae that is widely accepted as being indigenous to and originating from the continent of Asia. The plant is also known as hemp, although this term is usually used to refer only to varieties cultivated for non-drug use. Industrial hemp textile products are made from cannabis plants selected to produce an abundance of fibre.

Cannabis also has a long history of being used for medicinal purposes, and as a recreational drug known by several slang terms, such as *marijuana*, *ganja*, *pot* or *weed*. Various cannabis strains have been bred, often selectively to produce high or low levels of tetrahydrocannabinol (THC), a cannabinoid and the plant's principal psychoactive constituent. Compounds such as hashish and hash oil are extracted from the plant.

In the late 1800s, several countries in the Islamic world and its periphery banned cannabis, with the Khedivate of Egypt banning the importation of cannabis in 1879, Morocco strictly regulating cannabis cultivation and trade (while allowing several Rif tribes to continue production) in 1890, and the Kingdom of Greece banning hashish in 1890.

At the start of the 20th century, many more countries proceeded to ban cannabis. In the United States, the first restrictions on the sale of cannabis came in 1906. It was outlawed by the Ganja Law in Jamaica in 1913, in South Africa in 1922, and in the United Kingdom and New Zealand in the 1920s. Canada criminalized cannabis in *The Opium and Narcotic Drug Act, 1923*, before any reports of the use of the drug in Canada.

In the United States in 1937, the Marihuana Tax Act was passed, and prohibited the production of hemp in addition to cannabis. Regulations and restrictions on the sale of *Cannabis sativa* as a drug began as early as 1906. The head of the Federal Bureau of Narcotics (FBN), Harry J. Anslinger, alleged, in the 1930s, the FBN had an increase of reports of people using marijuana. In 1935, he gained the support of president Franklin D. Roosevelt lobbying states to adoption the model Uniform State Narcotic Act to regulate of cannabis. The Marihuana Tax Act, according to Clinton Hester, the then-Assistant General Counsel to the United States Treasury Department.

"The primary purpose of this legislation must be to raise revenue, because we are resorting to the taxing clause of the Constitution and the rule is that if on the face of the bill it appears to be a revenue bill, the courts will not inquire into any other motives that the Congress may have had in enacting this legislation."

The total production of hemp fiber in the United States in 1933 decreased to around 500 tons per year. Cultivation of hemp began to increase in 1934 and 1935, but production remained low compared with other fibers.

The reasons that hemp was also included in this law are disputed—several scholars have claimed that the act was passed in order to destroy the US hemp industry. Shortly thereafter, the United States was forced back to promoting rather than discouraging hemp cultivation; hemp was used extensively by the United States during World War II to make uniforms, canvas, and rope. Much of the hemp used was cultivated in Kentucky and the Midwest. During World War II, the U.S. produced a short 1942 film, *Hemp for Victory*, promoting hemp as a necessary crop to win the war. In Western Europe, while the cultivation of hemp was still legal in the 1930s, commercial cultivation had stopped due to decreased demand; hemp could not compete with increasingly popular artificial fibers. In the early 1940s, world production of hemp fiber ranged from 250,000 to 350,000 metric tonnes, with Russia being the leading producer.

2. The War on Drugs and Federal Prohibition

In 1925, an agreement was struck at an international conference in Geneva. Termed the Second International Opium Convention, the regulatory treaty banned exportation of "Indian

hemp" to countries that had prohibited its use, while requiring importing countries to issue certificates affirming that cannabis shipments were "exclusively for medical or scientific purposes". It also required parties to "exercise an effective control of such a nature as to prevent the illicit international traffic in Indian hemp and especially in the resin." However, these controls applied only to pure extract and tincture, not to derivatives and medicinal preparations. In 1935, after complaints from Egypt about cannabis-containing medicines sold by Parke-Davis, the health branch of the League of Nations (International Office of Public Hygiene) granted countries the right to submit medicinal products containing cannabis to similar controls as those of pure extracts and tinctures under the 1925 Opium Convention.

In 1925, in parallel, cannabis herb, extract, and tincture appeared in the Second Brussels Agreement for the harmonization of pharmacopoeias, a treaty precursor to the International Pharmacopoeia.

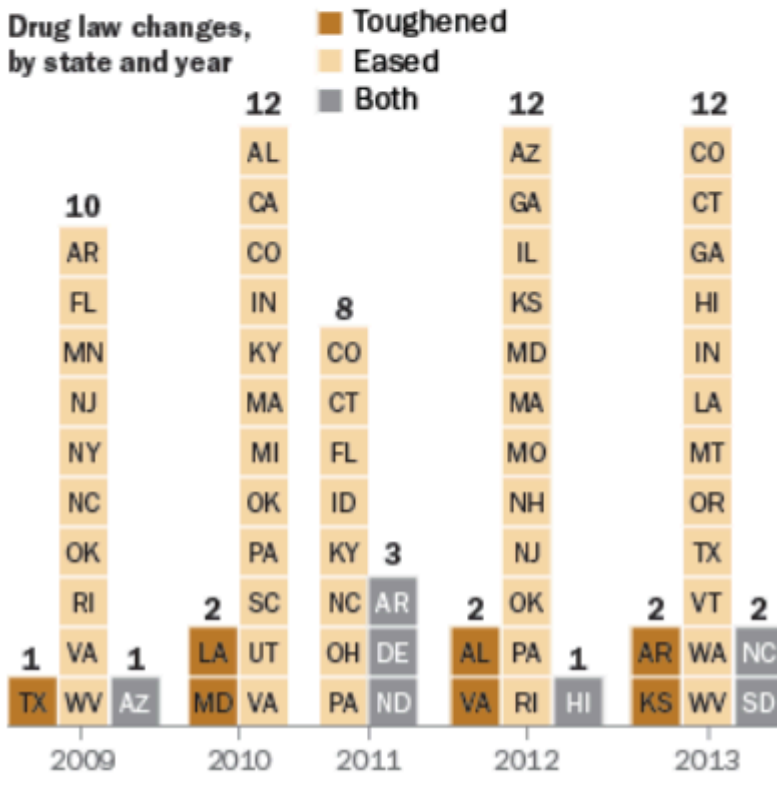
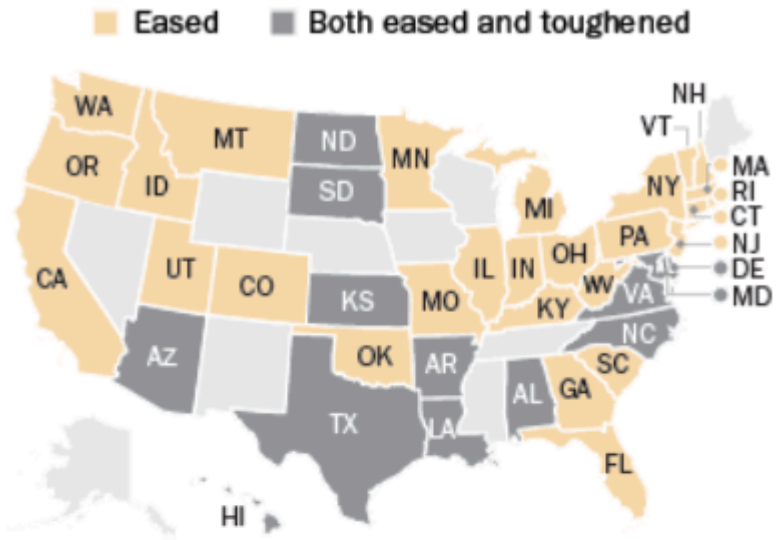
Shortly after World War II, a World Health Organization (WHO) committee withdrew cannabis and other herbal medicines from the international pharmacopoeia. Between 1952 and 1960, another WHO committee produced numerous negative conclusions regarding the therapeutic utility of cannabis. Coupled with a strong political determination from a number of countries, these events laid the groundwork for the placement of "cannabis and cannabis resin" on Schedule IV of the quasi-universally ratified 1961 Convention on narcotic drugs, with Schedule IV being the most restrictive level of international mandatory control.

Federal drug policy is in the midst of a major conceptual shift away from the long, automatic prison sentences and zero-tolerance policies of the "War on Drugs" era. But it's the states,

whose prisons house the vast bulk of U.S. convicts, that have been leading the way in changing drug laws.

Much of the current rethinking of America's drug war speaks to today's environment: Violent crime has fallen, attitudes towards drugs have shifted and the Great Recession has squeezed public budgets.

Changes to State Drug Laws, 2009-2013



There's also wide public support for changing government drug policies. In a new Pew Research Center report, 67% of people said government should focus more on treating people who use illegal drugs, compared with 26% saying prosecution should be the focus. More than

six-in-ten (63%) now say that state moves away from mandatory prison sentences for non-violent drug offenders is a good thing, versus 32% who called it a bad thing.

It's quite a different story than in 1990, when 73% of Americans favored a mandatory death penalty for "major drug traffickers," and 57% said police should be allowed to search the houses of "known drug dealers" without a court order.

Attorney General Eric Holder recently called for reduced sentences for low-level drug offenders in federal cases, with the aim of reducing the growth of the federal prisoner population. (About half of the nearly 200,000 federal inmates have been convicted of a drug offense.) Earlier, he said low-level drug offenders wouldn't automatically be charged with offenses that carried strict mandatory minimum sentences, and gave Washington and Colorado the go-ahead to implement marijuana-legalization initiatives. This month, the U.S. Sentencing Commission is expected to vote on a set of amendments to the sentencing guidelines used by federal judges.

The interest in sentencing reform now spans Washington D.C.'s normal partisan and ideological battle lines. The Smarter Sentencing Act of 2014, now pending before the Senate, would cut mandatory minimums for a host of federal drug crimes. Its sponsors include Senate Majority Whip Richard Durbin, liberal Democrats Patrick Leahy and Sheldon Whitehouse, Maine independent Angus King, and libertarian Republicans Rand Paul and Mike Lee.

The federal moves come after years of similar changes at the state level. Between 2009 and 2013, 40 states took some action to ease their drug laws, according to a Pew Research Center analysis of legislative data provided by the National Conference of State Legislatures and the

Vera Institute of Justice. Twenty-seven states moved only in the direction of easing, while 13 other states eased some laws and toughened others — often as part of a broader rethink of their drug policies.

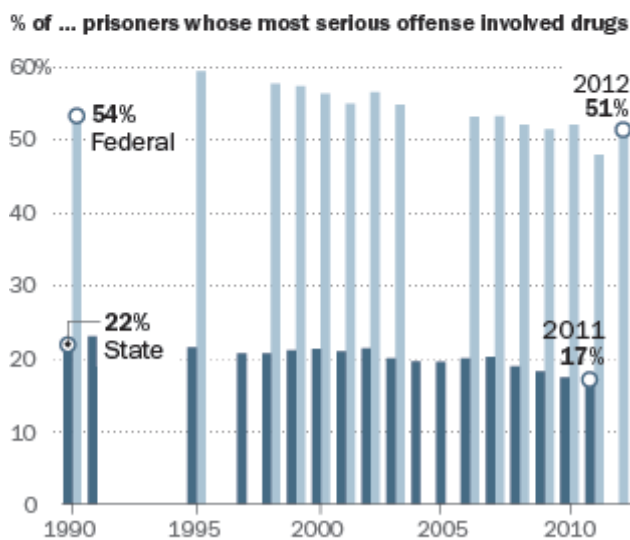
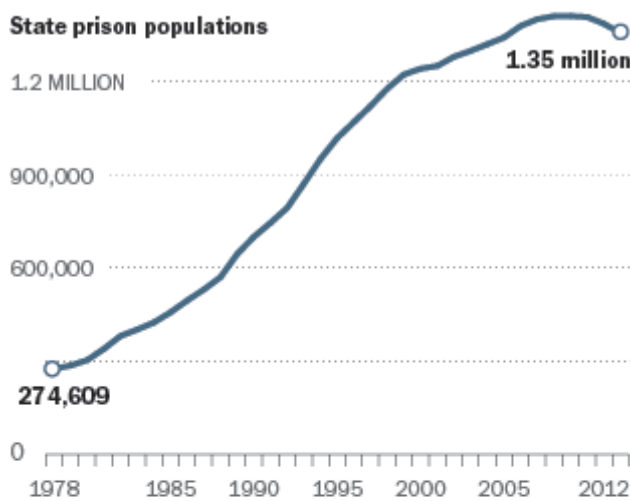
State-level actions have included lowering penalties for possession and use of illegal drugs, shortening mandatory minimums or curbing their applicability, removing automatic sentence enhancements, and establishing or extending the jurisdiction of drug courts and other alternatives to the regular criminal justice system. Some have been minor tweaks, such as Idaho's 2011 change that allowed people convicted of violent felonies to participate in drug courts under certain circumstances. Other states have taken very different approaches to drugs: New York, for instance, moved away from its harsh Rockefeller-era drug laws in 2009.

Last year, Vermont decriminalized possession of less than an ounce of marijuana, while Oregon (where possession of less than an ounce has been a noncriminal violation since 1973) made possession of more than an ounce a misdemeanor rather than a felony. All told, 16 states have passed laws decriminalizing marijuana; Maryland, which reduced penalties for marijuana possession and use in 2012, is now considering decriminalization legislation.

State-level policy changes may not get the attention of federal moves, but they can affect many more people. State prisons house more than six times as many prisoners as federal prisons — more than 1.35 million in 2012, according to the Bureau of Justice Statistics. And for 16.6% of all state prisoners, a drug crime is their most serious offense (down from 20% in 2006).

A key driver of state action has been rising prison populations and the expense of keeping people locked up. Nationally, per-inmate costs range from range from \$14,603 in Kentucky to \$60,076 in New York, according to a 2012 study of 40 states (based on fiscal 2010 data) by the Vera Institute. The total cost per inmate averaged \$31,286 when pensions and retiree health care, capital expenditures, legal costs and other expenses are included.

Drug Crimes Driving Growth in Prison Populations



Source: Bureau of Justice Statistics
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Those costs add up. Texas, for example, spent \$2.3 billion to add 108,000 prison beds between 1983 and 1997, said Richard Jerome of The Pew Charitable Trusts' Public Safety Performance Project. But by 2007, the state was again out of prison space and the corrections department was asking for \$900 million to build more prisons and operate the existing ones.

“Legislative leaders of both parties looked at this and decided it just didn’t make sense to put all of that money into prisons,” Jerome said. Instead, Texas expanded a range of treatment and diversion programs in 2007, including drug courts. Since then, Jerome said, the state has been able to close three prisons while the crime rate has continued to fall.

Arkansas, where the prison population doubled between 1990 and 2010 and corrections costs rose nearly eightfold, revised its drug laws in 2011 to reduce sentences for drug users and steer more of them into probation and other prison alternatives.

Such policy changes, along with falling crime rates, have helped lead to lower imprisonment rates in 31 states. From 2007 to 2012, the overall state imprisonment rate fell from 447 sentenced prisoners per 100,000 population to 413 per 100,000. Over the same period, the federal imprisonment rate edged higher, from 59 to 62 sentenced prisoners per 100,000.

3. Emergence of Recreational Legalization

The marijuana policy landscape in the United States (US) is rapidly evolving. Marijuana is the most frequently used controlled substance in the US, with over half of Americans reporting lifetime use (Substance Abuse and Mental Health Services Administration, 2014). While still illegal under federal law, as of 2016 20 states have passed laws ending or reducing criminal penalties for possession of small amounts of marijuana 23 states and the District of Columbia (DC) have legalized marijuana for medical use, and four states (AK, CO, OR, WA) and DC have legalized marijuana for recreational use by adults aged 21 or older. With the exception of the DC policy, which only allows home cultivation and private consumption of small amounts of marijuana, recreational marijuana legalization at the state level involves the development of regulated retail markets. The US Department of Justice has stated that it is unlikely to enforce federal marijuana laws in states with legal markets, so long as states implement regulations that achieve several goals, including preventing marijuana distribution

to youth, avoiding marijuana-impaired driving, and preventing violence related to marijuana cultivation and sales.

These shifts in marijuana laws signal a major change in US drug control policy. Marijuana has been illegal under federal law since the late 1930s and, like other controlled substances in the US, has long been portrayed negatively through purported ties to violence and racial/ethnic stereotypes. Changes in the marijuana policy landscape correspond with shifts in public attitudes: in 1969, only 12% of American adults thought marijuana should be made legal; by 2015, that percentage had risen to 53% overall and 68% among millennials (ages 18–34 at time of poll). While support for legalization has increased across the political spectrum, more Democrats (59%) and Independents (58%) than Republicans (39%) favored legalizing marijuana in 2015.

The advent of recreational marijuana legalization in the US presents multiple challenges for the public health field. The best available research, which is limited, suggests that key public health concerns of legal recreational marijuana relate to its effects on youth health and educational attainment, cannabis use disorder, and marijuana-impaired driving. Regulation and enforcement could prevent or mitigate these adverse public health outcomes, but states are faced with uncertainty regarding whether and how regulatory options can be used to achieve public health goals.

Some key interest groups – such as the American Academy of Pediatrics – have come out in opposition to legalization due to concerns about potential adverse effects on the public's health. Other actors, such as the American Public Health Association (APHA), have recommended strict regulatory action in states that legalize marijuana for recreational use.

Stakeholders from outside the public health realm, such as the American Civil Liberties Union (ACLU), support legalization due to the policy's potential to reduce arrest and incarceration rates, especially among minorities, for non-violent drug offenses. In the face of state budget shortfalls, the potential for new tax revenue generated by commercial recreational marijuana markets is appealing to many policymakers.

4. Shifting Public Attitudes Over Time

More than six-in-ten (63%) say that state governments moving away from mandatory prison terms for non-violent drug crimes is a good thing, while just 32% say these policy changes are a bad thing. This is a substantial shift from 2001 when the public was evenly divided (47% good thing vs. 45% bad thing).

Across nearly all demographic groups majorities say that the move away from mandatory prison terms is a good thing, and in most cases these percentages have increased by double digits since 2001. Majorities of both men (64%) and women (62%) view these policy changes as a good thing – up 13 points among men and 20 points among women. In 2001, women were less supportive than men of sentencing revisions. Half of women said it was a bad thing compared with 40% of men.

Most See Shift Away from Mandatory Drug Sentences as a Good Thing

States moving away from mandatory drug sentences ...	2001		2014		Change in good thing
	Good thing %	Bad thing %	Good thing %	Bad thing %	
Total	46	45	63	32	+17
Men	51	40	64	31	+13
Women	42	49	62	33	+20
White	48	44	66	30	+18
Black	45	44	61	33	+16
Hispanic	-	-	52	41	
18-29	50	44	66	30	+16
30-49	47	48	68	28	+21
50-64	47	44	63	33	+16
65+	43	43	49	43	+6
Republican	41	51	49	45	+8
Independent	48	45	69	28	+21
Democrat	48	44	66	29	+18

Survey conducted Feb. 14-23, 2014. Don't know responses not shown. Whites and blacks include only those who are not Hispanic; Hispanics are of any race. Too few Hispanics to report in 2001.

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As is the case with opinions on other issues related to illegal drug use, older Americans and Republicans are most likely to have reservations about state governments moving away from mandatory drug sentences.

About half of those 65 and older (49%) say that the move away from mandatory drug sentences is a good thing, up only modestly from 2001 (43%). By contrast, majorities among younger age groups have a positive view of the elimination of mandatory drug sentences, and this view has increased by double digits among

those under 65 since 2001.

About half of Republicans (49%) have a positive view of the move away from mandatory drug sentences; in 2001, 41% viewed this change positively. Nearly seven-in-ten independents (69%) and 66% of Democrats say this is a good thing, up from 48% each in 2001.

The pattern is similar in opinions about how the government should deal with people who use illegal drugs such as heroin and cocaine. Two-thirds (67%) say the government should focus more on providing treatment for people who use these type of drugs. Just 26% think the focus should be more on prosecuting illegal drug users.

Public Wants Government Drug Policy to Focus More on Providing Treatment

Dealing with drug policy, gov't should focus more on ...

	Prosecuting illegal drug users %	Treatment for illegal drug users %	DK %
Total	26	67	7=100
White	27	66	7=100
Black	15	81	4=100
Hispanic	33	61	6=100
18-29	20	77	3=100
30-49	25	68	7=100
50-64	27	66	6=100
65+	35	54	12=100
College grad+	18	73	8=100
Some college	25	69	5=100
HS or less	32	61	7=100
Republican	42	51	6=100
Democrat	18	77	5=100
Independent	24	69	7=100

Half or more in virtually every demographic and partisan group says the priority should be treatment, not prosecution. But there are differences across racial and ethnic lines: 81% of blacks say the government should focus more on treatment for drug users,

compared with 66% of whites and 61% of Hispanics.

In addition, while large majorities of Democrats (77%) and independents (69%) want the government's focus more on treatment, a smaller share of Republicans (51%) favor this approach. Those 65 and older are less likely than those in younger age groups to say that the government should focus on providing treatment for drug users rather than prosecuting them.

Those who view drug abuse across the country as a crisis are about as likely as those who do not to favor treatment rather than prosecution for those using illegal drugs like heroin and cocaine. Among those who say drug abuse is a crisis in their neighborhood, 64% favor the treatment option, about the same percentage as those who view the problem less seriously (68%).

Public support for legalizing marijuana use is at an all-time high of 54%, though it is virtually unchanged from last year (52%). There is even more agreement that people convicted of possessing small amounts of marijuana should not serve time in jail.

About three-quarters of Americans (76%) say that if marijuana use is not legalized, those who are convicted of possessing small amounts of marijuana should not serve jail time. Just 22% favor jail time for those convicted of minor marijuana possession.

Views of the legalization of marijuana remain divided along partisan, age and ethnic lines. While support for legalization has increased by 15 points among both parties since 2010, Republicans continue to be far less likely than Democrats to favor legalization (39% vs. 63%). Opposition to legalization also is much higher among those 65 and older than younger people and among Hispanics than non-Hispanic whites or blacks.

However, majorities across nearly all partisan and demographic groups say possession of small amounts of marijuana should not result in jail time. The partisan differences in these opinions are relatively modest – 79% of Democrats, 78% of independents and 69% of Republicans do not think people convicted of having small amounts of marijuana should serve time in jail.

People who have tried marijuana are more likely than those who have not to oppose jail time for minor possession. Still, a majority of those who have never tried marijuana (63%) say people convicted of small amounts of marijuana should not spend time in jail. Among those who have tried marijuana, but not in the past year, 88% oppose jail time for possession of small amounts of marijuana, as do 97% of those who have used it in the past year.

V. Legal and Policy Frameworks

1. Federal Legal Framework

a. Controlled Substances Act (CSA)

The Controlled Substance Act (CSA) establishes a federal policy to regulate the manufacturing, distribution, importation, exportation, and use of regulated substances. The CSA lays the framework for categorizing controlled substances and creates a legal foundation for their regulation. This statute was an effort to combine all previous federal drug laws and allow for federal law enforcement of controlled substances, serving as the legal foundation in the federal fight against drug abuse. The cornerstone of the CSA is the classification system by which it regulates controlled substances. This system has 5 schedules of these drugs, numbered I through V. The CSA stratifies these based on a substance's accepted medical use, potential abuse/addiction, and harmfulness. This activity highlights the categorization

schedules, amendments, prescription requirements, and other pertinent factors for interprofessional team members to understand and apply the legal structure to their clinical practice.

b. Role of DEA, DOJ, and FDA

i. FDA

The Food and Drug Administration (FDA) is a federal agency of the United States Department of Health and Human Services. The FDA is responsible for protecting and promoting public health through the control and supervision of food safety, tobacco products, caffeine products, dietary supplements, prescription and over-the-counter pharmaceutical drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), cosmetics, animal foods & feed, and veterinary products.

The FDA's primary focus is enforcement of the Federal Food, Drug, and Cosmetic Act (FD&C). However, the agency also enforces other laws, notably Section 361 of the Public Health Service Act as well as associated regulations. Much of this regulatory-enforcement work is not directly related to food or drugs but involves other factors like regulating lasers, cellular phones, and condoms. In addition, the FDA takes control of diseases in the contexts varying from household pets to human sperm donated for use in assisted reproduction.

In the mid and late 1980s, ACT-UP and other HIV activist organizations accused the FDA of unnecessarily delaying the approval of medications to fight HIV and opportunistic infections. Partly in response to these criticisms, the FDA issued new rules to expedite approval of drugs

for life-threatening diseases, and expanded pre-approval access to drugs for patients with limited treatment options. All of the initial drugs approved for the treatment of HIV/AIDS were approved through these accelerated approval mechanisms. Frank Young, then commissioner of the FDA, was behind the Action Plan Phase II, established in August 1987 for quicker approval of AIDS medication.

In two instances, state governments have sought to legalize drugs that the FDA has not approved. Under the theory that federal law, passed pursuant to Constitutional authority, overrules conflicting state laws, federal authorities still claim the authority to seize, arrest, and prosecute for possession and sales of these substances, even in states where they are legal under state law. The first wave was the legalization by 27 states of laetrile in the late 1970s. This drug was used as a treatment for cancer, but scientific studies both before and after this legislative trend found it ineffective. The second wave concerned medical marijuana in the 1990s and 2000s. Though Virginia passed legislation allowing doctors to recommend cannabis for glaucoma or the side effects of chemotherapy, a more widespread trend began in California with the Compassionate Use Act of 1996.

When the FDA requested Endo Pharmaceuticals on June 8, 2017, to remove an extended-release formulation of *oxymorphone hydrochloride* from the market, it was the first request in FDA history to recall an effective drug over its potential for misuse.

In February 2025, FDA food division head Jim Jones quit in protest of the "indiscriminate" layoffs of 89 staff members by the Donald Trump administration.

In May 2025, the FDA announced changes in its COVID-19 vaccine policy, intending to limit approved indications use for adults over 65 and individuals at higher risk of complications in the fall. For healthy Americans younger than 65, the agency indicated it would likely require additional clinical trials with placebo controls to demonstrate benefit before approving wider access.

ii. DOJ

The United States Department of Justice (DOJ) is an executive department of the United States federal government that oversees the domestic enforcement of federal laws and the administration of justice. It is equivalent to the justice or interior ministries of other countries. The department is headed by the U.S. attorney general, who reports directly to the president of the United States and is a member of the president's Cabinet. Pam Bondi has served as U.S. attorney general since February 4, 2025.

The Justice Department has announced that the Attorney General has submitted to the Federal Register a notice of proposed rulemaking initiating a formal rulemaking process to consider moving marijuana from a schedule I to schedule III drug under the Controlled Substances Act (CSA).

Marijuana has been classified as a schedule I drug since Congress enacted the CSA in 1970. On Oct. 6, 2022, President Biden asked the Attorney General and the Secretary of Health and Human Services (HHS) to launch a scientific review of how marijuana is scheduled under federal law. After receiving HHS's recommendations last August, the Attorney General

sought the legal advice of the Justice Department's Office of Legal Counsel (OLC) on questions relevant to this rulemaking. In light of HHS' medical and scientific determinations, and OLC's legal advice, the Attorney General exercised his authority under the law to initiate the rulemaking process to transfer marijuana to schedule III.

The rescheduling of a controlled substance follows a formal rulemaking procedure that requires notice to the public, and an opportunity for comment and an administrative hearing. This proposal starts the process, where the Drug Enforcement Administration will gather and consider information and views submitted by the public, in order to make a determination about the appropriate schedule. During that process, and until a final rule is published, marijuana remains a schedule I controlled substance.

iii. DEA

The Drug Enforcement Administration (DEA) is a United States federal law enforcement agency under the U.S. Department of Justice tasked with combating illicit drug trafficking and distribution within the U.S. It is the lead agency for domestic enforcement of the Controlled Substances Act, sharing concurrent jurisdiction with the Federal Bureau of Investigation and U.S. Customs and Border Protection. The DEA is responsible for coordinating and pursuing U.S. drug investigations both domestically and internationally.

The **Domestic Cannabis Eradication/Suppression Program (DCE/SP)** began funding eradication programs in Hawaii and California in 1979. The program rapidly expanded to include programs in 25 states by 1982. By 1985, all 50 states were participating in the DCE/SP. In 2015, the DCE/SP was responsible for the eradication of 3,932,201 cultivated outdoor cannabis plants and 325,019 indoor plants for a total of 4,257,220 marijuana plants.

In addition, the DCE/SP accounted for 6,278 arrests and the seizure in excess of \$29.7 million of cultivator assets.

In 2014, the DEA spent \$73,000 to eradicate marijuana plants in Utah, though they did not find a single marijuana plant. Federal documents obtained by journalist Drew Atkins detail the DEA's continuing efforts to spend upwards of \$14 million per year to completely eradicate marijuana within the United States despite the government funding allocation reports showing that the Marijuana Eradication Program often leads to the discovery of no marijuana plants. This prompted twelve members of Congress to push for the elimination of the program and use the money instead to fund domestic-violence prevention and deficit-reduction programs.

c. Federal Enforcement and Prosecution

Although millions of Americans have experienced cannabis' medical benefits, the federal government incorrectly classifies cannabis as a Schedule I drug, which is reserved for drugs like heroin that have a high potential for abuse and little to no medical benefit. In 2022, the Biden administration advised the U.S. Department of Health and Human Services (HHS) and the Attorney General's office to conduct a scientific review of cannabis' schedule under the Controlled Substances Act (CSA).

In August 2023, the HHS and FDA recommended that cannabis be reclassified to Schedule III. The agencies' scientific review found that cannabis has currently accepted medical use and a lower potential for abuse than Schedule I and II drugs. The Department of Justice proposed rescheduling in 2024 and opened a public comment period shortly after. More than

90% of the over 42,000 comments submitted called for re-scheduling or descheduling. During the public comment window, MPP mobilized thousands of supporters, including physicians and health and medical organizations.

At the end of 2024, the DEA appointed Judge John Mulrooney to oversee the rescheduling hearing and named 25 witnesses to participate in the proceeding. Questions arose regarding whether the DEA should be included in the hearing as the proponent, given its apparent bias against rescheduling, as evidenced by its collaboration with individuals who opposed rescheduling to enable them to be witnesses. Judge Mulrooney cancelled (stayed) the hearings until the challenge was settled or resolved.

Since then, rescheduling has stalled as the presidential administration and DEA leadership changed, and Judge Mulrooney has retired. During the 2024 campaign, Donald Trump said, "we will continue to focus on research to unlock the medical uses of marijuana to a Schedule 3 drug." However, it remains unclear whether the Trump Administration will complete the rescheduling process.

MPP will continue to push for full federal rescheduling and legalization. We remain focused on advancing cannabis freedom state by state to build the critical mass of support that will make nationwide legalization a reality.

VI. Previous and Current Legislative Actions

1. Major Federal Legislative Attempts

Even though marijuana is still classified as a Schedule I drug under federal law, several bipartisan bills have tried to bridge the gap between federal prohibition and state legalization. The most notable are the MORE Act, SAFE Banking Act, and STATES Act. Each takes a different approach: one pushes for national legalization, another focuses on financial safety for the industry, and the third respects state decisions. Together, these bills show how lawmakers are wrestling with public health, criminal justice fairness, economic opportunities, and how much freedom states should have in drug policy.

Ever since California voters legalized medical marijuana via a ballot initiative in 1996, many advocates in the U.S. have embraced direct democracy as a means to bypass reluctant legislatures and advance marijuana legalization and broader drug policy reforms. There are now 24 states that have legalized adult-use marijuana, in addition to Washington D.C. On November 7, 2023, Ohio joined the list of 14 out of those 24 states that have legalized adult-use marijuana via the ballot box. Prior to the November 2024 election, marijuana was legal for medical use in 38 states. Of those, 18 states passed medical marijuana at the ballot box, with the other 20 passing medical marijuana via the legislature. The 2020 ballot saw Oregon decriminalize possession of small amounts of all drugs, though a 2024 law passed by Oregon's legislature has mostly rolled back the measure. Voters in 2022 approved a ballot initiative decriminalizing some psychedelic plants and fungi in Colorado.

This page details the drug-related ballot initiatives that were up for a vote in the November 2024 election and provides a timeline of efforts to enact and implement marijuana reforms via the ballot box since 1996. It also provides information on the 2022 ballot initiatives, as well as the 2023 ballot initiatives in Oklahoma and Ohio, and the results of six Ohio localities that sought to decriminalize marijuana via local ordinances in November 2022.

a. The MORE Act

The Marijuana Opportunity Reinvestment and Expungement (MORE) Act is the boldest federal proposal so far. Instead of small changes, it aims to completely change the federal government's role. If passed, it would remove marijuana from the Controlled Substances Act, ending federal prohibition and criminal penalties for possession, use, and distribution at the federal level.

What sets the MORE Act apart is its focus on justice and fairness, not just legalization. The bill's supporters highlight how decades of strict drug laws have disproportionately hurt minority communities. It includes automatic expungement of past federal marijuana convictions, giving people a chance to move past old criminal records.

The Act would also impose federal taxes on marijuana products, using that money to support job creation, reentry programs, and community investments. This approach treats marijuana as more than just a legal product—it's a way to address past harms.

Critics worry that legalizing marijuana federally might increase use or strain public health systems. This debate between correcting past injustices and protecting public health continues to shape discussions around the MORE Act.

b. The SAFE Banking Act

Unlike the sweeping goals of the MORE Act, the SAFE Banking Act is more focused and practical. It recognizes a simple fact: even where marijuana is legal, businesses often can't use banks because marijuana is still illegal federally. This forces many cannabis companies to operate mostly in cash, creating risks like robberies, tax problems, and lack of transparency. Consumers also face inconsistent standards and fewer protections.

The SAFE Banking Act would let banks work with state-licensed marijuana businesses without fear of federal penalties. This would make the industry safer and more regulated. The bill has wide bipartisan support, especially from senators in states with strong marijuana markets, but still faces some political hesitation.

c. The STATES Act

The STATES Act takes a federalism approach. Instead of legalizing marijuana nationwide, it says if a state legalizes marijuana, the federal government shouldn't interfere. People and businesses acting legally under state law would be protected from federal prosecution.

The STATES Act represents a significant federalism-based approach to marijuana policy reform, emphasizing respect for state sovereignty while maintaining federal regulatory boundaries. Instead of pursuing nationwide legalization, the Act proposes that if a state legalizes marijuana—whether for medical or recreational use—the federal government should refrain from interfering with individuals or businesses that operate legally under that state's laws. This protection would shield compliant actors from federal prosecution, which currently poses a significant legal risk and uncertainty due to marijuana's continued classification as a Schedule I substance under federal law.

For everyday users, the STATES Act would provide much-needed clarity and peace of mind. Currently, federal rules can impact employment opportunities, housing eligibility, and access to federal benefits, even in states where marijuana is legal. By ensuring federal non-interference, the Act would reduce these conflicts, allowing individuals to participate in state-legal marijuana markets without fear of federal repercussions. This clarity is particularly important for marginalized communities disproportionately affected by federal drug enforcement.

For lawmakers, the STATES Act offers a pragmatic compromise. It allows states to serve as “laboratories of democracy,” enabling them to experiment with diverse marijuana policies that reflect their populations’ values and needs, while the federal government maintains its traditional regulatory stance elsewhere. This approach acknowledges the patchwork reality of marijuana laws across the country, where some states have fully legalized marijuana, others permit only medical use, and some maintain prohibition.

Despite its practical benefits, critics argue that the STATES Act falls short in several key areas. It does not directly address social equity concerns, such as the disproportionate impact of drug laws on minority communities or the need for expungement of past convictions. Furthermore, it lacks provisions to establish consistent public health standards across states, which vary widely in their regulatory frameworks, potency limits, and consumer protections. The Act also leaves unresolved the question of interstate commerce, which remains illegal under federal law, complicating the potential for a unified national market.

Nevertheless, the STATES Act is a pivotal legislative proposal because it formally recognizes and legitimizes the grassroots momentum behind marijuana legalization. It reflects a political reality where numerous states have moved forward independently of federal policy, creating a de facto acceptance of cannabis use in many parts of the country. By codifying non-interference, the Act reduces federal-state conflicts and provides a framework for coexistence.

At the state level, ballot initiatives and legislative models have been the primary engines driving marijuana reform, especially as Congress has been slow to act. Beginning with California's groundbreaking medical marijuana law in 1996, states have pioneered a variety of policy approaches, including medical marijuana programs, recreational (adult-use) legalization, and decriminalization efforts. These initiatives have evolved over time, reflecting changing public attitudes, scientific understanding, and political dynamics.

Medical marijuana programs have played a crucial role in shifting public perception and policy. Millions of Americans use cannabis to manage chronic pain, epilepsy, PTSD, cancer symptoms, and other health conditions. States have developed comprehensive regulatory systems for testing, labeling, and quality control, which have helped build consumer trust and laid the groundwork for broader legalization efforts.

Recreational legalization, first enacted in Colorado and Washington in 2012, has transformed the marijuana landscape. Adults aged 21 and older can purchase cannabis products in licensed dispensaries, with states imposing regulations on potency, packaging, advertising, and taxation. These markets have generated substantial tax revenue and reduced illegal sales

but also raise concerns about impaired driving, youth access, and the health effects of high-potency products.

Decriminalization laws, which replace criminal penalties with civil fines for small possession amounts, offer a middle ground. While they do not create legal markets, they reduce arrests and the long-term consequences of minor offenses, serving as a transitional step toward full legalization in many states.

Together, these state-level policies have created a complex and uneven patchwork of marijuana laws across the nation. This diversity challenges federal lawmakers to consider how to harmonize regulations, address cross-border issues such as interstate commerce, and ensure equitable access and public health protections.

The dynamic between the federal restraint embodied in the STATES Act and the active, varied state reforms highlights the evolving and often contentious landscape of marijuana policy in the United States. For delegates in a Model U.S. Senate committee, understanding this interplay is essential. The tension between respecting local autonomy and achieving national coherence raises fundamental questions about the future of drug policy, federalism, and social justice.

2. State-Level Ballot Initiatives and Legislative Models

While Congress has moved slowly, states have been the real innovators in marijuana reform. Starting with California's medical marijuana law in 1996, states have led the way with medical programs, recreational markets, and decriminalization efforts.

Medical Marijuana

Medical marijuana laws have helped change public views on cannabis. Millions now use it to treat conditions like chronic pain, epilepsy, PTSD, and cancer symptoms. States have built detailed systems for testing, labeling, and regulating these products, which helped build trust and paved the way for recreational legalization.

Recreational (Adult-Use) Legalization:

Starting with Colorado and Washington in 2012, recreational legalization has changed how Americans see marijuana. Adults 21 and older can buy marijuana in licensed stores, and states regulate everything from potency to packaging, advertising, and taxes.

These markets bring challenges, like concerns about impaired driving, youth exposure, and effects of high-potency products. But they also generate tax revenue and reduce illegal sales.

Decriminalization

Decriminalization replaces criminal penalties with fines for small possession amounts. It doesn't create legal markets but reduces arrests and long-term consequences for minor offenses. Many states used decriminalization as a step toward full legalization.

Together, these state policies create a patchwork system that raises big questions for federal lawmakers—like how to harmonize rules across states and whether interstate marijuana commerce should be legal.

3. Notable Supreme Court Cases

The Supreme Court has shaped marijuana policy by reinforcing federal authority even as states expand legalization.

Gonzales v. Raich (2005)

This key case involved two California residents growing medical marijuana at home. They argued their cannabis should be exempt from federal law. The Supreme Court disagreed, ruling that even small-scale, state-legal activity falls under federal law because marijuana is part of a national market.

This decision confirmed that federal law can override state legalization, setting up ongoing conflict between states and the federal government.

Other Relevant Cases

Cases like *United States v. Oakland Cannabis Buyers' Cooperative* (2001) rejected medical necessity as a defense against federal law. Tax cases have reminded marijuana businesses that federal prohibition affects deductions and reporting.

These rulings show that states can innovate, but the federal courts have consistently upheld the federal government's power to regulate and criminalize marijuana.

4. Recent Congressional Hearings and Debates

As more Americans live in states with legal marijuana, Congress has held more hearings on public health, justice reform, and economic impacts.

Public health experts have raised concerns about high-potency cannabis, effects on adolescent brain development, and the need for more research. Others argue regulated markets reduce harm by replacing untested street products.

Criminal justice discussions focus on racial disparities in arrests and clearing old records—key issues behind support for the MORE Act.

Economic debates cover banking access, taxes, interstate commerce, and environmental impacts. Lawmakers often note that federal prohibition conflicts with state policy, confuses businesses, frustrates consumers, and creates loopholes.

A common theme is that federal prohibition is increasingly out of step with state laws and public opinion.

VII. Relevant Groups and Societies

4. Governmental and Legislative Bodies

a. U.S. Senate Committees Related to Drug Policy

The Senate Caucus on International Narcotics Control was created to “monitor and encourage United States Government and private programs seeking to expand international cooperation against drug abuse and narcotics trafficking” and to “monitor and promote international compliance with narcotics control treaties.” As a formal organization of the U.S. Senate, the Caucus has the status of a standing committee. The Caucus exercises oversight on a wide range of issues, including international counternarcotics assistance and domestic drug prevention and treatment programs. The Caucus has held numerous hearings over the years and has issued a number of reports on U.S. narcotics control policy.

Members being:

Majority Members (4)

Cornyn, John (TX), Chairman

Grassley, Chuck (IA)

Risch, James E. (ID)

Moreno, Bernie (OH)

Minority Members (3)

Whitehouse, Sheldon (RI), Chairman

Blumenthal, Richard (CT)

Lujan, Ben Ray (NM)

b. Drug Enforcement Administration (DEA)

The mission of the Drug Enforcement Administration (DEA) is to ensure the safety and health of American communities by combating criminal drug networks bringing harm, violence, overdoses, and poisonings to the United States. To accomplish this mission, the DEA employs approximately 10,000 personnel throughout the world – Special Agents, Diversion Investigators, Intelligence Analysts, Chemists, and professional staff – across 241 domestic offices in 23 Divisions and 93 foreign offices across the globe.

c. Food and Drug Administration (FDA)

The Food and Drug Administration (FDA) is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA also provides accurate, science-based health information to the public.

d. Department of Justice (DOJ)

The mission of the Department of Justice is to uphold the rule of law, to keep the country safe, and to protect civil rights. The United States Department of Justice (DOJ) is an executive department of the United States federal government that oversees the domestic enforcement of federal laws and the administration of justice. It is equivalent to the justice or interior ministries of other countries. The department is headed by the U.S. attorney general, who reports directly to the president of the United States and is a member of the president's Cabinet. Pam Bondi has served as U.S. attorney general since February 4, 2025.

e. Office of National Drug Control Policy (ONDCP)

ONDCP leads and coordinates the nation's drug policy so that it improves the health and lives of the American people. ONDCP is responsible for the development and implementation of the National Drug Control Strategy and Budget. ONDCP coordinates across 19 federal agencies and oversees a \$44 billion budget as part of a whole-of-government approach to addressing addiction and the overdose epidemic. ONDCP also provides hundreds of millions of dollars to help communities stay safe and healthy through the High Intensity Drug Trafficking Areas Program and the Drug-Free Communities Program.

5. Medical and Scientific Institutions

a. American Medical Association (AMA)

The American Medical Association (AMA) is an American professional association and lobbying group of physicians and medical students. This medical association was founded in 1847 and is headquartered in Chicago, Illinois. Membership was 271,660 in 2022.

The AMA's stated mission is "to promote the art and science of medicine and the betterment of public health." The organization was founded with the goal to raise the standards of medicine in the 19th century primarily through gaining control of education and licensing. In the 20th century, the AMA has frequently lobbied to restrict the supply of physicians, contributing to a doctor shortage in the United States. The organization has also lobbied against allowing physician assistants and other health care providers to perform basic forms of health care. The organization has historically lobbied against various forms of government-run health insurance.

b. Centers for Disease Control and Prevention (CDC)

The Centers for Disease Control and Prevention (CDC) is the national public health agency of the United States. It is a United States federal agency under the Department of Health and Human Services (HHS), and is headquartered in Atlanta, Georgia.

The agency's main goal is the protection of public health and safety through the control and prevention of disease, injury, and disability in the US and worldwide. The CDC focuses national attention on developing and applying disease control and prevention. It especially focuses its attention on infectious disease, food borne pathogens, environmental health, occupational safety and health, health promotion, injury prevention, and educational activities designed to improve the health of United States citizens. The CDC also conducts research and provides information on non-infectious diseases, such as obesity and diabetes, and is a founding member of the International Association of National Public Health Institutes.

As part of the announced 2025 HHS reorganization, CDC is planned to be reoriented towards infectious disease programs. It is planned to absorb the Administration for Strategic Preparedness and Response, while the National Institute for Occupational Safety and Health is planned to move into the new Administration for a Healthy America.

c. National Institutes of Health (NIH)

The National Institutes of Health (NIH) is the primary agency of the United States federal government responsible for biomedical and public health research. It was founded in 1887

and is part of the United States Department of Health and Human Services (HHS). Many NIH facilities are located in Bethesda, Maryland, and other nearby suburbs of the Washington metropolitan area, with other primary facilities in Research Triangle Park in North Carolina and smaller satellite facilities located around the United States.

6. International and Intergovernmental Organizations

a. United Nations Office on Drugs and Crime (UNODC)

UNODC's mission is to contribute to global peace and security, human rights and development by making the world safer from drugs, crime, corruption and terrorism. This Strategy for the next five years will equip UNODC to deliver effectively, efficiently and with accountability, elevating our support to Member States to build just, inclusive and resilient societies that leave no one behind.

b. World Health Organization (WHO)

The World Health Organization (WHO) is a specialized agency of the United Nations which coordinates responses to international public health issues and emergencies. It is headquartered in Geneva, Switzerland, and has six regional offices and 150 field offices worldwide. Only sovereign states are eligible to join, and it is the largest intergovernmental health organization at the international level.

c. Organization of American States (OAS)

The Organization of American States (OAS or OEA; Spanish: Organización de los Estados Americanos; Portuguese: Organização dos Estados Americanos; French: Organisation des États américains) is an international organization founded on 30 April 1948 to promote cooperation among its member states within the Americas.

Headquartered in Washington, D.C., United States, the OAS is a "multilateral regional body focused on human rights, electoral oversight, social and economic development, and security in the Western Hemisphere", according to the Council on Foreign Relations. As of November 2023, 32 states in the Americas are OAS members.

Albert Ramdin of Suriname was inaugurated as OAS secretary general in May 2025, replacing Luis Almagro of Uruguay.

d. International Narcotics Control Board (INCB)

The International Narcotics Control Board (INCB) is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions. It was established in 1968 in accordance with the Single Convention on Narcotic Drugs, 1961. It had predecessors under the former drug control treaties as far back as the time of the League of Nations.

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