UNITED STATES DEPARTMENT OF JUSTICE

Drug Enforcement Administration

In the Matter of **Schedules of Controlled Substances: Proposed Rescheduling of Marijuana**	**DEA Docket No. 1362** **Hearing Docket No. 26-96**

TENNESSEE BUREAU OF INVESTIGATION'S POSTHEARING BRIEF

The Notice of Proposed Rulemaking (NPRM) and the Department of Health and Human Services's (HHS) recommendation that prompted it are unprecedented. The Attorney General long ago assigned his scheduling authority to the Administrator of the Drug Enforcement Administration (DEA), divesting himself of scheduling authority. Yet the Attorney General, not the DEA Administrator, issued the NPRM. That alone is enough to hold the NPRM deficient and keep marijuana in Schedule I.

The NPRM's proposed rescheduling fares no better on the merits, as the requisite eight-factor analysis (8FA) compels keeping marijuana in Schedule I. The NPRM is remarkable in that, despite putatively recommending rescheduling marijuana on behalf of DEA, DEA refused to take a position in the NPRM as to whether marijuana should be placed in Schedule III. DEA's refusal to support the rescheduling of marijuana in the NPRM is not surprising, given the deficiencies of HHS's recommendation and its inconsistent standards. For example, the diversion of marijuana from legitimate channels is an important consideration in determining its potential for abuse—

Factor 1 of the 8FA—but HHS did not investigate diversion of state-licensed marijuana despite considering it a legitimate channel of marijuana distribution. Notably, DEA itself claims that diversion from state-licensed marijuana programs is the primary source of marijuana in the United States. This diversion must be considered under Factor 1 of the 8FA, and it was not.

Similarly, Factor 6 of the 8FA requires examination of marijuana's effect on the public health and safety. But HHS did not consider marijuana-related violent crime despite acknowledging that such crime is a relevant consideration. Nor did HHS consider traffic fatalities related to marijuana—if it had, it would have noticed evidence that marijuana traffic accidents are disproportionately fatal. In Tennessee, the fatality rate of marijuana accidents is *sixtyfold* the fatality rate of traffic accidents generally.

HHS is also required to consider the chemical composition of marijuana under Factor 3—current scientific knowledge. But HHS considered only strains of cannabis with a high Δ9-THC potency. HHS acknowledges cannabis products can has psychoactive cannabinoids other than Δ9-THC, such as Δ8-THC. The U.S. Food and Drug Administration (FDA) has expressed concerned about the rise of Δ8-THC products, noting that historical data on marijuana use cannot be relied on to determine the safety of these products. Notably, Congress has amended the definition of hemp, effective in just a few months, so that cannabis products high in Δ8-THC are also classified as marijuana. But HHS did not consider Δ8-THC products.

And relevant to Factors 4 and 5 regarding the pattern and scope of marijuana use, marijuana is increasingly available to youth and young children, leading to increases in calls to poison control centers, especially with regard to edibles and Δ8-THC products, as must be considered under Factors 4 and 5 regarding the pattern and scope of marijuana abuse.

For these reasons, and as explained further below, marijuana should remain in Schedule I.

BACKGROUND

A. Regulation of Marijuana under the Controlled Substances Act.

Since enactment of the Controlled Substances Act (CSA)[1] in 1970, marijuana has been classified in Schedule I. *See* Letter to Anne Milgram, Administrator of the Drug Enforcement Administration, *Basis for the Recommendation to Reschedule Marijuana into Schedule III of the Controlled Substances Act* (Aug. 29, 2023), ALJ Ex. 1, at 9. Since 2000, HHS has examined the scheduling of marijuana under the CSA four separate times, and each time it has remained in Schedule I. *See id*. at 1. Before this proceeding, HHS's most recent prior analyses of the scheduling of marijuana occurred in 2015 in response to two petitions requesting that marijuana be rescheduled. *Id*. In 2016, DEA reviewed the HHS analyses and maintained marijuana in Schedule I. *Id*. at 1 & n.4 (citing Denial of Petition To Initiate Proceedings To Reschedule Marijuana, 81 Fed. Reg. 53688 (Aug. 12, 2016); Denial of Petition To Initiate Proceedings To Reschedule Marijuana, 81 Fed. Reg. 53767 (Aug. 12, 2016)).

In reaching its decision to maintain marijuana in Schedule I in 2016, DEA went through each of the eight factors that must be considered under 21 U.S.C. § 811(c): (1) marijuana's actual or relative potential for abuse; (2) scientific evidence of marijuana's pharmacological effect, if known; (3) the state of current scientific knowledge regarding marijuana; (4) marijuana's history and current pattern of abuse; (5) the scope, duration, and significance of marijuana abuse; (6) what, if any, risk there is to the public health; (7) marijuana's psychic or physiological dependence liability; and (8) whether the substance is an immediate precursor of a substance already controlled under this subchapter. *See, e.g.*, 81 Fed. Reg. 53690-706. By maintaining marijuana in Schedule I, DEA necessarily determined that: (1) marijuana "has a high potential for abuse"; (2) marijuana

[1] 21 U.S.C. §§ 801-971.

"has no currently accepted medical use," and (3) there is a lack of accepted safety for use of marijuana under medical supervision. 21 U.S.C. § 812(b)(1). *See also* 81 Fed. Reg. 53761 ("DEA finds that marijuana meets the three criteria for placing a substance in schedule I of the CSA.").

On August 29, 2023, HHS issued a recommendation that marijuana, as defined in the CSA, be moved to Schedule III based on HHS's own 8FA. *See generally* ALJ Ex. 1. This recommendation is based primarily on a review performed by the Food and Drug Administration (FDA), which was reviewed by the National Institute on Drug Abuse (NIDA) and the Assistant Secretary of Health. *Id*. at 4. Based on HHS's recommendation, the Attorney General published a NPRM on May 21, 2024, which "proposes to transfer marijuana from Schedule I of the [CSA] to Schedule III of the CSA." Department of Justice, Schedules of Controlled Substances: Rescheduling of Marijuana, 89 Fed. Reg. 44597 (May 21, 2024), ALJ Ex. 2. The NPRM was signed by then-Attorney General Merrick Garland. *Id*. at 44622. The NPRM indicates the Attorney General "conclude[d] that there is, at present, substantial evidence that marijuana does not warrant control under Schedule I of the CSA." *Id*. at 44619.

DEA did not support moving marijuana to Schedule III. Instead, DEA made no "determination as to its views of the appropriate schedule for marijuana." 89 Fed. Reg. at 44601. DEA also solicited "factual evidence (including scientific data) and expert opinions, including additional data regarding different forms, formulations, and delivery methods for marijuana, as well as evidence regarding the effects of marijuana at various dosages or concentrations." *Id*. In soliciting further evidence, DEA specifically requested additional data regarding, among other things, "diversion from State programs," *id*. at 44602; "seizures of marijuana by law enforcement," *id*.; "public safety risks," *id*. at 44614; "other marijuana constituents," *id*. at 44607; and "marijuana's pattern" and "scope" of abuse. *Id*. at 44610, 44613.

B. The Tennessee Bureau of Investigation's Mission and Operations Include Eradicating Marijuana in Tennessee.

The Tennessee Bureau of Investigation (TBI) is the chief law enforcement agency in Tennessee with significant responsibility for combating illicit and dangerous drug use. TBI Comment Letter, TBI Ex. 2, at 1. In fulfilling this role, TBI is also Tennessee's primary law enforcement agency for forensic science. TBI Notice of Appearance, ALJ Ex. 8 at 1. TBI has firsthand experience in combatting drug crimes in Tennessee. As a part of its drug enforcement efforts, TBI operates a Drug Investigation Division and the Tennessee Dangerous Drugs Task Force. Day 8 Transcript (Tr.) 1797: 6-24; *id.* at 1800:15-1801:11; *see also, e.g.*, 2025 TBI Annual Report, TBI Ex. 5, at 27-30. TBI also manages the Governor's Task Force on Marijuana Eradication (GTFME), a multi-agency task force whose focus is on eliminating the domestic cultivation and import of marijuana in Tennessee. Day 8 Tr. 1800:6-14, 1801:20-1802:12; *see also, e.g.*, 2025 GTFME Annual Report, TBI Ex. 15, at 4. Through these efforts, TBI seizes thousands of pounds of marijuana every year. Day 8 Tr. 1818:25-1819:13; *see also, e.g.*, TBI Ex. 5 at 30. Nevertheless, Tennessee has seen a major rise in marijuana use, with one drug testing company finding that the rate of positive tests for marijuana nearly doubled in Tennessee from 2019 to 2021. *See* Millennium Health, *Millennium Health Signals Report* (2022), TBI Ex. 4 at 18.

In response to the NPRM, TBI submitted a comment letter opposing rescheduling marijuana to Schedule III, *see* TBI Ex. 2, and asked to participate in opposition to rescheduling, *see* ALJ Ex. 8. TBI was selected to participate in the hearing as an Interested Party against rescheduling. *See* ALJ Ex. 13.

On August 10, 2026, TBI presented its case-in-chief. Agent Erica Stephens, TBI's Assistant Special Agent in Charge of the Tennessee Dangerous Drugs Task Force, testified in the hearing about the negative impacts of marijuana in Tennessee and TBI's opposition to

rescheduling. *See, e.g.*, Day 8 Tr. 1808:15-1809:9. Agent Stephens's testimony focused on four main areas: (1) marijuana's high potential for abuse as demonstrated by diversion and seizures; (2) the negative second order effects of marijuana in Tennessee, particularly as seen in marijuana's connection with crimes against persons and fatal traffic accidents, (3) increased use of cannabis strains with high potency of THC other than Δ9-THC, especially THCA and Δ8-THC, and (4) concerns about increased exposure among youth, in particular inadvertent exposures due to child-friendly packaging.

Pursuant to the Order for Transcript Corrections and Post-Hearing Briefs, TBI now submits this brief in support of its opposition to moving marijuana to Schedule III of the CSA.

ARGUMENT

I. The NPRM is *ultra vires*.

The NPRM is *ultra vires* because it was issued by the Attorney General, not the DEA Administrator. Although the CSA vests the Attorney General with authority to schedule, reschedule, or deregulate drugs, 21 U.S.C. § 811(a), the Attorney General long ago "delegated that authority to the DEA Administrator." 89 Fed. Reg. 44601 (May 21, 2024) (citing 28 CFR § 0.100); *see also* 38 Fed. Reg. 18380 (July 10, 1973), *as amended by* 46 Fed. Reg. 52339, 52348 (Oct. 27, 1981). Under this delegation the "functions vested in the Attorney General by the Comprehensive Drug Abuse Prevention and Control Act of 1979, as amended" (which include the Attorney General's rescheduling authority under § 811(a)) "are assigned to, and shall be conducted, handled, or supervised by, the Administrator of the Drug Enforcement Administration." 28 C.F.R. § 0.100.

That delegation divests the Attorney General of his scheduling authority. The regulation "assigns" the Attorney General's authority to the DEA Administrator. To assign is to "convey in full; to transfer." *Assign*, BLACK'S LAW DICTIONARY (12th ed. 2024); *see also assign*, WEBSTER'S SEVENTH NEW COLLEGIATE DICTIONARY (1970) ("[T]o transfer (property) to another esp. in trust

or fort the benefit of creditors."). While the use of "assign" is sufficient to confirm that the regulation transfers such authority to the exclusion of the Attorney General (such as an assignment of rights),[2] this intent becomes unmistakably clear when paired with the use of "shall." "[T]he word 'shall' usually connotes a requirement." *Kingdomware Techs., Inc. v. United States*, 579 U.S. 162, 171 (2016). Here, the regulation conveys the Attorney General's rescheduling authority to the DEA Administrator who "shall" "conduct[], handle[], or supervise[]" any rescheduling. 28 C.F.R. § 0.100. The NPRM thus violates the requirement that rescheduling be conducted by the DEA Administrator.

Case law confirms that the Attorney General cannot exercise delegated authority unless the delegation has been revoked, and 28 C.F.R. § 0.100 has not been revoked. In *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954), the Supreme Court examined the Attorney General's delegation of authority to the Board of Immigration Appeals. *Id*. at 266. The Court held that "as long as the regulations remain operative, the Attorney General denies himself the right to sidestep the Board or dictate its decision in any manner." *Id*. at 267. The Court reaffirmed this analysis in *United States v. Nixon*, 418 U.S. 683 (1974). There, the Attorney General had issued, "pursuant to his statutory authority," a regulation to a special prosecutor for purposes of directing investigations and litigation into the Watergate scandal and 1972 Presidential election. *Id*. at 694 n.8. The Court held that as long as the regulation delegating the Attorney General's authority was operative, the Attorney General "denied himself the authority to exercise" the delegated discretion,

[2] *See, e.g.*, *United States v. Mfrs. Nat'l Bank of Detroit*, 363 U.S. 194, 196 (1960) ("These policies were originally issued to the insured, but he divested himself of the policy rights by assigning them to his wife on December 18, 1936.").

"even though the original authority was his and he could reassert it by amending the regulations." *Id*. at 696; *see also Black v. Snow*, 272 F. Supp. 2d 21, 26 (D.D.C. 2003) ("[O]nce a regulation has been issued delegating power from one officer to a subordinate, the former may not thereafter invoke the delegated power himself, at least as long as the regulation remains in effect."). Accordingly, the Attorney General cannot exercise the rescheduling authority that the has delegated to the DEA Administrator.

The NPRM suggests two possible routes in which the Attorney General retains authority over rescheduling but neither is correct. *First*, the NPRM states that the Attorney General "retains the authority to schedule drugs under the CSA in the first instance," pursuant to 28 U.S.C. §§ 509 & 510. 89 Fed. Reg. 44601. But these sections merely codify the "Attorney General's broad power to make appointments and delegate his duties to subordinates." *Rivera v. Garland*, 108 F. 4th 600, 606 (8th Cir. 2024). Section 509 simply vests with the Attorney General "[a]ll functions of other officers of the Department of Justice and all functions of agencies and employees of the Department of Justice." And section 510 allows the Attorney General to delegate "any function of the Attorney General" to "any other officer, employee, or agency of the Department of Justice." These broad provisions do not preclude the Attorney General from issuing regulations making delegations of authority exclusive. Instead, as noted, courts have found such delegations can be exclusive, and the plain language of 28 C.F.R. § 0.100 indicates that the Attorney General's delegation of rescheduling authority to the DEA Administrator is exclusive. *See supra* p.7.

Second, the NPRM references the Attorney General's statutory authority to schedule drugs "under the schedule he deems most appropriate to carry out [international] obligations." 89 Fed. Reg. at 44599 (quoting 21 U.S.C. § 811(d)(1)). But that statute does not allow the Attorney General to issue the NPRM here, where there is no dispute that international obligations are

currently met. For one, that statutory authority has also been delegated exclusively to the DEA Administrator under 28 C.F.R. § 0.100. For two, that authority only applies where rescheduling is "required by United States obligations under international treaties, conventions, and protocols in effect on October 27, 1970." 28 U.S.C. § 811(d)(1). As the D.C. Circuit has held, this authority applies "only to the extent that placement in that schedule is necessary to satisfy United States international obligations." *Nat'l Org. for Reform of Marijuana L. v. Drug Enf't Admin.*, 559 F.2d 735, 746 (D.C. Cir. 1977) ("*NORML*"). This reading is also supported by 21 U.S.C. § 812(b), which indicates that "a drug or other substance may not be placed in any schedule unless the findings required for such schedule are made with respect to such drug or other substance" "[e]xcept where control is required by United States obligations under an international treaty."

Not only does the NPRM not support any finding that rescheduling is required by international obligations, it concedes that moving marijuana to Schedule III as proposed in the NPRM *would violate* international obligations. *See* 89 Fed. Reg. 44620 ("If marijuana were listed in schedule III, *most* of the Single Convention's obligations would continued to be met by CSA statutory authorities." (emphasis added)); *see also NORML*, 559 F.2d at 751 ("[S]everal requirements imposed by the Single Convention would not be met if cannabis and cannabis resin were placed in CSA schedule III, IV, or V."). The NPRM suggests that certain "gap[s] caused by placing marijuana in Schedule III could be "filled using the CSA's regulatory authorities." 89 Fed. Reg. at 44620. But even if regulations could fill the gap, those regulations would need to precede rescheduling to avoid causing conflict with international obligations, and no such regulations have been promulgated.

Accordingly, the Attorney General has no authority to issue the NPRM. Any rule resulting from the NPRM would be "not in accordance with the law" under the Administrative Procedure Act. 5 U.S.C. § 706(2)(A).

II. DEA Has Not Met Its Burden to Show Marijuana Should Be in Schedule III.

The Government, as the proponent of rescheduling, bears the burden of proof to show that marijuana should be placed in schedule III of the CSA. *See* 21 C.F.R. § 1316.56. Accordingly, DEA must establish that marijuana, when all required factors are considered, belongs in Schedule III rather than Schedule I. *See Dir., Off. of Workers' Comp. Programs, Dep't of Lab. v. Greenwich Collieries*, 512 U.S. 267, 276 (1994) (holding that the burden of proof under the APA means the burden of persuasion). Since enactment of the CSA in 1970, marijuana has been classified in Schedule I. *See* HHS Recommendation, ALJ Ex. 1, at 9. A Schedule I drug meets three criteria: (1) "a high potential for abuse," (2) "no currently accepted medical use," and (3) "a lack of accepted safety for use . . . under medical supervision." 21 U.S.C. § 812(b)(1). In contrast, a Schedule III drug: (1) "has a potential for abuse less than the drugs . . . in schedules I and II," (2) "has a currently accepted medical use in treatment in the United States," and (3) "may lead to moderate or low physical dependence or high psychological dependence." *Id.* § 812(b)(3).[3]

When evaluating marijuana's placement schedule, DEA "shall consider the following factors": (1) its "actual or relative potential for abuse," (2) "[s]cientific evidence of its pharmacological effect, if known," (3) "[t]he state of current scientific knowledge regarding the drug or other substance," (4) "[i]ts history and current pattern of abuse," (5) "[t]he scope, duration,

[3] If marijuana has a currently accepted medical use, precluding continued placement in Schedule I, placement of marijuana in Schedule II may be appropriate. A drug qualifies for Schedule II if it (1) has a high potential for abuse, (2) has a currently accepted medical use, and (3) abuse of the drug may lead to severe psychological or physical dependence. 21 U.S.C. § 812(b)(2).

and significance of abuse," (6) "[w]hat, if any, risk there is to the public health," (7) "[i]ts psychic or physiological dependence liability," and (8) "[w]hether the substance is an immediate precursor of a substance already controlled under this subchapter." *Id*. § 811(c).

Here, HHS's recommendation failed to consider important aspects of Factors 1, 3, and 6 and inadequately considers Factors 4 and 5, and nothing in the hearing record fills in the gaps in a way that would support moving marijuana to Schedule III or establish that the factor has been considered by DEA. *Cf. Carlson v. Postal Regul. Comm'n*, 938 F.3d 337, 344 (D.C. Cir. 2019) (holding that an agency decision is arbitrary and capricious "if it entirely fails to consider an important aspect of the problem"). And to the extent that such factors may have been considered, they wholly depart from the evidence before DEA and no explanation has been given for such departure. *Cf. Nat'l Fuel Gas Supply Corp. v. FERC,* 468 F.3d 831, 839 (D.C. Cir. 2006) ("Normally, an agency rule would be arbitrary and capricious if the agency has . . . offered an explanation for its decision that runs counter to the evidence before the agency." (quoting *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). Therefore, the record does not show, at a minimum, that marijuana has less potential for abuse than the drugs in Schedules I and II. Marijuana accordingly does not belong in Schedule III.

A. Factor 1: DEA has not accounted for diversion of state-licensed marijuana.

When determining a drug's potential for abuse under Factor 1, "DEA and HHS have typically weighed" four factors: (1) "[w]hether there is evidence that individuals are taking the drug . . . in amounts sufficient to create a hazard to their health or to the safety of other individuals or to the community," (2) "[w]hether there is a significant diversion of the drug . . . from legitimate drug channels," (3) "[w]hether individuals are taking the drug . . . on their own initiative rather than on the basis of medical advice from a practitioner licensed by law to administer such drugs,"

and (4) "[w]hether the drug . . . [is] so related in [its] action to a drug or drugs already listed as having a potential for abuse to make it likely that it will have the same potentiality for abuse." 89 Fed. Reg. 66601-02.

Here, HHS did not consider diversion of marijuana from state-licensed marijuana markets, even though it considered state-licensed marijuana to be legal, and therefore a legitimate drug channel. In its recommendation, HHS examined only "legitimate *federally sanctioned* drug channels in the United States." ALJ Ex. 1 at 8 (emphasis added). These channels were limited to use by "researchers for clinical research under investigational new drug (IND) applications" and "DEA-registrants who . . . are approved . . . for use in DEA-authorized nonclinical and clinical research." *Id*. Dr. Chiapperino confirmed that HHS did not consider diversion from state-licensed marijuana programs. Day 1 Tr. 205:20-206:5.

HHS provided no basis for not considering diversion from state-licensed marijuana, rather HHS considered state-licensed marijuana to be a legal channel for marijuana. The HHS Recommendation itself distinguishes between "illicit cultivation and production" and "state programs that permit dispensing of marijuana for medical use and, in some cases, recreational use." ALJ Ex. 1 at 8. Moreover, HHS considered the legal availability of marijuana for other aspects, such as its relative abuse versus other controlled substances. For example, HHS included alcohol, a non-controlled substance, in its analysis even though it "rarely, if ever, use[s] an uncontrolled substance as a comparator." Day 1 Tr. 75:1-15. HHS decided to include alcohol as a comparator because "the number of people using marijuana is larger than a lot of the comparators," and marijuana abuse purportedly "resembles the use of alcohol" because of the "large amount of access people have legally." *Id*. Dr. Chiapperino clarified that these considerations were due to the legality of marijuana on a state level. Day 1 Tr. 204:11-22 (stating

HHS included alcohol to provide context "because marijuana is legal in many states"). It is clear that HHS considered state-licensed marijuana as a legitimate channel, but did not include state-licensed marijuana in its analysis of diversion from legitimate channels.

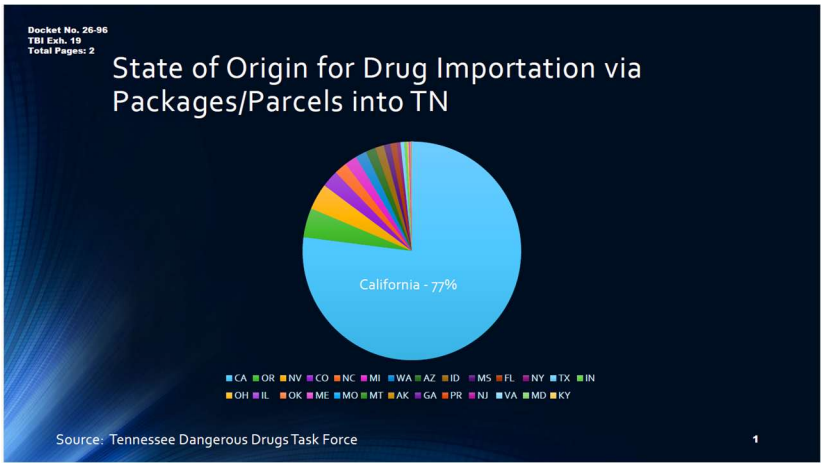
This failure to consider diversion of marijuana from state programs is especially notable given that HHS not only relied on the legal availability of marijuana in its evaluation generally, but it also relied on its marijuana's legal availability through the states with respect to Factor 1, the same factor that considers diversion. ALJ Ex. 1 at 6-7. Specifically, HHS used alcohol as a comparator with respect to whether there is "evidence that individuals are taking [marijuana] in amounts sufficient to create a hazard to their health or to the safety of other individuals or to the community." *Id*. Indeed, HHS noted that marijuana is abused 4-5 times more often than comparator scheduled drugs, clearly indicating a high potential for abuse. *Id*. at 7; *see also* Drug Enforcement Administration, 2020 National Drug Threat Assessment (2020 NDTA), TBI Ex. 13, at 51 ("Marijuana . . . is the most commonly used illicit drug in the United States."). In a plain effort to minimize the impact of this finding, HHS compared marijuana to the non-controlled substance, alcohol, whose use is 5-6 times greater than non-medical use of marijuana, noting alcohol's "extensive availability and use . . . which is also observed for nonmedical use of marijuana." ALJ Ex. 1 at 5.

HHS has provided no basis for considering the state-level legality of marijuana for some purposes under Factor 1 but not for diversion. And this diversion from state-level sources is significant. In fact, since at least 2020, DEA has concluded that the primary source of illicit marijuana is diversion from state-sanctioned marijuana markets. *See* Drug Enforcement Administration, 2025 National Drug Threat Assessment, TBI Ex. 11, at 52 (2025 NDTA) ("Cannabis growers in states where cultivation is legal are the main suppliers of illicit marijuana

markets in the rest of the United States."); *See* Drug Enforcement Administration, 2024 National Drug Threat Assessment, TBI Ex. 12, at 41 (2024 NDTA) ("The main suppliers of marijuana to the U.S. markets are cannabis growers and processors operating inside the United States."); 2020 NDTA, TBI Ex. 13, at 51 ("[I]n U.S. markets, Mexican marijuana has largely been supplanted by domestic-produced marijuana."); *see also id.* at 54 ("State-approved medical marijuana is diverted to the illicit market in several ways.").

The impact of this diversion is felt in Tennessee, which experiences significant issues with marijuana abuse despite the fact that non-hemp marijuana is not legal in any form in Tennessee. Day 8 Tr. 1813:24-1814:9. Even when a person has a prescription for marijuana from a practitioner in a different state, it is still illegal to use marijuana in Tennessee. *Id*.; *see also State v. Osborne*, No. M2007–02213–CCA–R3–CD, 2020 WL 481202, at *4 (Feb. 11, 2010). Despite the lack of any legal uses of marijuana in Tennessee, it is still the most abused illicit drug in the State. Day 8 Tr. 1814:18-25. Year in and year out, marijuana is the most seized drug by TBI. *Id*. at 1815:1-5; *see also, e.g.*, 2025 TBI Annual Report, TBI Ex. 5 at 30; 2023-2024 TBI Annual Report, TBI Ex. 7, at 30. Additionally, marijuana was the number 1 tested drug in TBI's forensic labs until 2019 when changes in the definition of marijuana to exclude hemp necessitated use of different forms of testing, including field testing. Day 8 Tr. 1815:1-5; *see also* TBI 2023 Cannabis Impact Report, TBI Ex. 3, at 8. Despite these changes, marijuana remains the second most tested drug in TBI's crime labs. Day 8 Tr. 1815:1-5, *see also* TBI Ex. 3, at 8. These figures show that marijuana abuse is a serious issue in Tennessee, even compared to other Schedule I and Schedule II drugs. *See* 89 Fed. Reg. 44602 (noting that "data on seizures of marijuana by law enforcement . . . may be appropriate for consideration" to determine actual and relative abuse of marijuana); *id.* at 44613 (discussing national prevalence of marijuana testing in crime labs).

In Tennessee, this marijuana supply comes primarily from two different forms of diversion: (1) diversion from states with legal marijuana channels, and (2) diversion from state-licensed hemp growers. Day 8 Tr. 1821:2-10. Under the first, traffickers grow marijuana in states with licensed-marijuana programs, and then illicitly import it into Tennessee. *Id*. at 1821:2-1822:6. This form of diversion is significant, as Agent Stephens testified that TBI recently seized approximately 7,000 pounds of THC products that were shipped from California. Day 8 Tr. 1822:7-17; *see also* TBI Ex. 19 (showing that 87% of TBI's intercepted marijuana shipments come from California). These producers use the cover of other states' laws to produce illicit marijuana to market in Tennessee and other states. Day 8 Tr. at 1831:12-1833:6.



The second is diversion through licensed hemp farms. In Tennessee and federally, cannabis can be grown as hemp, which means that the plant has no more than 0.3% Δ9-THC by dry weight.[4] *See* Tenn. Code Ann. § 39-17-402(16) (definition of marijuana), *id*. § 43-27-101(3) (definition of hemp); *see also* 21 U.S.C. 802(16) (definition of marijuana); 7 U.S.C. 1639o(1) (definition of hemp). As with state-licensed marijuana, producers use the cover of hemp laws to produce illicit marijuana. Day 8 Tr. 1825:13-1826:12; *see also* TBI Ex. 3 at 14 (discussing how hemp licensing

[4] This definition has lead to a proliferation of cannabis strains and products that enhance the potency of other cannabinoids, like Δ8-THC and THCA. *See* II.C, *infra*.

"has produced a black market within the state that has allowed for illegal marijuana growers to mask as hemp cultivators"); TBI Ex. 13 (DEA acknowledgement that "traffickers use their state-issued hemp documentation as cover for large scale marijuana grows and marijuana loads transported across state lines"). And as with state-licensed marijuana, this diversion has a significant impact on Tennessee. *See* Day 8 Tr. 1825:13-1826:12; *see also* Cannabis Impact Report, TBI Ex. 3, at 15 (discussing seizure of 1100 marijuana plants and 22 pounds of processed marijuana from a licensed hemp grow).

Ultimately, as Dr. Chiapperino conceded in his testimony, diversion from state and recreational programs is relevant evidence about the abuse of marijuana. Day 1 Tr. 250:5-15. Not only is it relevant, it is a part of the required 8FA. *Id*. at 249:24-250:4. But HHS did not consider it. *Id*. at 250:16-17. Accordingly, HHS did not perform the required analysis with respect to the relative and absolute abuse potential of marijuana, and no evidence that DEA elicited during the hearing fills in this gap. HHS's failure to consider this information is fatal to its recommendation.

B. Factor 6: DEA has not accounted for marijuana's impact on the public health.

Factor 6 considers marijuana's impact on the public health, which also encompasses public safety.[5] *See* 89 Fed. Reg. 44614 (indicating that DEA "anticipates that additional data on public safety risks" is relevant to Factor 6). HHS's Recommendation fails to account for the impact that marijuana related crime and traffic fatalities have on the public health. Particularly, TBI and DEA agree that criminal organizations, like drug trafficking organizations (DTOs) and Transnational Criminal Organizations (TCOs) are heavily involved in the cultivation and distribution of marijuana. These DTOs further violent crime and the distribution of other controlled substances.

[5] Marijuana-related violent crime and traffic injuries also impact the safety of the community. (Factor 1).

Moreover, marijuana traffic crashes are much more likely to be fatal than even other drug-involved crashes. As with diversion, no evidence DEA submitted during the hearing counters these issues.

The connection between marijuana and organized crime is well established. DEA itself acknowledges that "[o]ver the past 10 years, Chinese TCOs have come to dominate the cultivation and distribution of marijuana throughout the United States." 2025 NDTA, TBI Ex. 11, at 53; *see* 2024 NDTA, TBI Ex. 12 at 43 ("[C]riminal organizations exploit loopholes in the laws and regulations governing the marijuana 'industry' to establish large cultivation sites and reap huge profits from the sale of marijuana and other THC products."); 2020 NDTA, TBI Ex. 13, at 54 ("A myriad of DTOs cultivate illicit marijuana nationwide."); *see also* 2022 GTFME Annual Report, TBI Ex. 17, at 3 ("In Tennessee domestic DTOs deal in products that contain dried hemp, usually containing higher levels of THC, and THC in liquid form."). Marijuana is a major source of profit for these criminal organizations. *See* 2020 NDTA, TBI Ex. 13, at 58 ("Marijuana generates millions of dollars [for DTOs] that furthers the scope of their criminal activity throughout the US."); *see also* 2024 NDTA, at 43 ("Chinese and other Asian drug trafficking organization collect millions of dollars in illicit drug proceedings from cultivating and trafficking marijuana and the money is used to fund other criminal activities."); 2022 GTFME Annual Report at 3 ("Under the cover of hemp laws, unscrupulous domestic DTOs produce large quantities of hemp products laced/infused with dangerous chemicals and synthetic analogs containing large quantities of Delta 8, Delta 9, and Delta 10 that are sold locally and/or shipped and sold out of state at high prices.").

Unsurprisingly, DTOs resort to violence to protect their cash crop, as DEA concedes. *See* 2024 NDTA at 43 ("The traffickers and investors also protect their illicit marijuana cultivation sites through violence."); *cf.* 2020 NDTA at 6 ("Drug trafficking . . . feed[s] the violence that plagues many of our communities."). Indeed, a study in Denver found that neighborhoods with

dispensaries experienced a significantly higher rate of violent crime than those neighborhoods without dispensaries. Lorine A. Hughes et al., *Marijuana Dispensaries and Neighborhood Crime and Disorder in Denver, Colorado*, JUSTICE QUARTERLY, VOL. 37, NO. 3, at 465 (TBI Ex. 23). This study found that predicted counts of murder and aggravated assaults were significantly higher in neighborhoods with marijuana dispensaries than those without. *See id*. at 16.

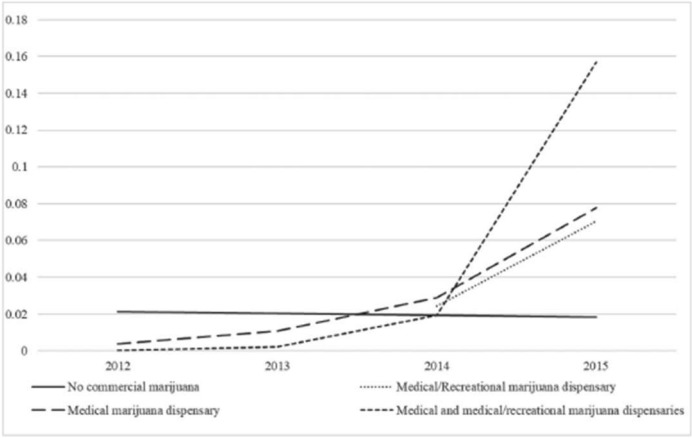


Figure 1. Predicted count of murders (per 1000 persons), by year.

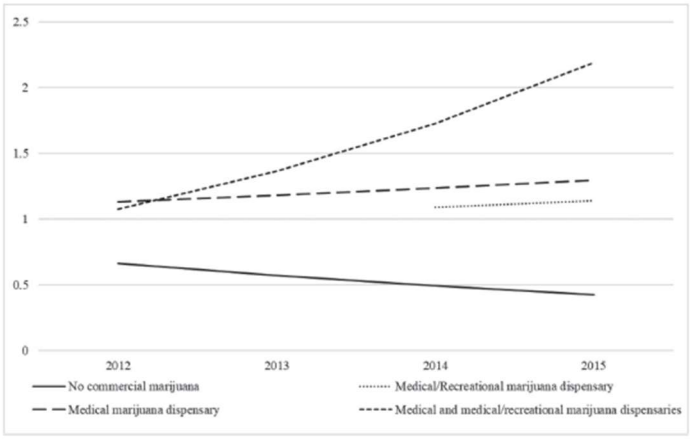


Figure 2. Predicted count of aggravated assaults (per 1000 persons), by year.

Similarly, TBI understands that marijuana is one of the greatest drivers of violence against postal carriers. Day 8 Tr. 1837:8-16.

The connection between violent crime and marijuana holds true in Tennessee as well. *See* TBI Semi-Annual Report, TBI Ex. 6 at 21 ("Drug traffickers earn their living violating federal and state drug laws, and the associated violence with drug trafficking can be traced to competition for

drug markets, competition for customers, disputes among traffickers, and disputes between traffickers and customers."). And "marijuana has consistently been the number one drug associated with . . . violent criminal offenses" in Tennessee. Day 8 Tr. 1837:2-7. For example, in 2021, "marijuana was collected in 56.5% of all" "crimes against persons . . . reported to law enforcement in Tennessee." TDDTF Cannabis Impact Report, TBI Ex. 3 at 12. And incidents of violent crime in Tennessee "involving marijuana have only grown and far outnumber cases involving other substances like heroin, cocaine, and methamphetamine." *Id*.

Additionally, marijuana sales help to perpetuate the trafficking and abuse of other drugs. TBI often finds other dangerous drugs (and firearms) when it seizes marijuana. Day 8 Tr. 1835:13-1836:7 (discussing other drugs, including cocaine, fentanyl, and heroin, GTFME has found when seizing marijuana); *see also* 2020 NDTA at 58 ("Marijuana is often seized in conjunction with other illicit drugs.")

Not only is the public health impacted by violent crime, but marijuana has had a deadly impact on Tennessee roads and highways. Notably, the HHS Recommendation does not address accidents related to marijuana use, only "the prevalence of reported driving under the influence of marijuana." HHS Rec at 50. But the prevalence of driving under the influence of marijuana falls far short of showing the full picture because of the catastrophically high fatality rates associated with marijuana. Indeed, in Tennessee from 2023 to 2025, only 3,298 of 525,909 (or 0.6%) of all traffic accidents in Tennessee were fatal. *See* Tenn. Dep't of Safety and Homeland Sec., *Tennessee Traffic Crashes by Year, Type and County*, TBI Ex. 24 at 56, 60, 64. Where any form of drug was involved, this number increases to 14%. *See* TBI Ex. 24. But in accidents involving marijuana, 36.3% of accidents were fatal. *See id*. Accordingly, although HHS determined that 4% of drivers have driven under the influence of marijuana within the past year, ALJ Ex. 1 at 50, marijuana

traffic crashes have represented approximately 13.5% of all fatal traffic crashes in Tennessee in the past three years. And evidence suggests Tennessee is not an outlier. A six-year study of one county in Ohio found that 41.9% of all deceased drivers tested positive for active THC in their blood. *See* Am. College of Surgeons, *Over 40% of Deceased Drivers in Motor Vehicle Crashes Test Positive for THC, Study Shows*, (Oct. 3, 2025), TBI Ex. 33 at 1. These fatality rates are far greater than the 4% prevalence of driving while under the influence of marijuana identified by HHS. ALJ Ex. 1 at 50. As DEA has noted, this impaired driving certainly represents a public health risk from the acute use of marijuana. 89 Fed. Reg. 44614. But HHS does not include *any* information about marijuana-related traffic fatalities in its recommendation, nor did DEA present any evidence regarding marijuana's effect on traffic safety.

Accordingly, neither HHS nor DEA has adequately accounted for the second order effects of marijuana abuse that affect the public safety, including violent crime and fatal traffic accidents.

C. Factor 3: DEA failed to account for other psychotropic forms of marijuana.

Factor 3 considers the chemical makeup of marijuana. As HHS recognized, "[t]he potential for high variability of marijuana and marijuana-derived products, both in product composition and impurity profile, are major considerations for the potential variability of drug effects and safety." ALJ Ex. 1 at 19. But neither HHS nor DEA accounted for the rise in strains of cannabis that concentrate the potency of psychoactive cannabinoids other than Δ9-THC. Notably, HHS indicated that the change in the legal definition of marijuana constituted "[a]n important difference in the present scientific and medical evaluation relative to the HHS 8FAs for marijuana from 2015," which concluded that marijuana should remain in Schedule I. ALJ Ex. 1 at 2. This change in the definition of marijuana was "important" because it narrowed the scope of what is considered marijuana" by defining marijuana relative only to Δ9-THC concentrations and "decontrolling

many products containing predominantly cannabidiol (CBD) derived from hemp." *Id*. at 2-3; *see also* Day 1 Tr. 209:18-22 ("We focused on marijuana products that have delta-9 in them at a level that would make it marijuana and not hemp.").

This deregulation of cannabinoids other than Δ9-THC led to the development of strains of cannabis and development of cannabinoid products that have increased amounts of other psychoactive cannabinoids, such as Δ8-THC. Delta-8 THC "has psychoactive and intoxicating effects, similar to Delta-9 THC." Food & Drug Admin., *5 Things to Know about Delta-8 Tetrahydrocannabinol- Delta-8-THC*, TBI Ex. 27 at 2; *see also* Day 1 Tr. at 209:3-10 ("[W]e are aware [Δ8-THC] is a CB1 agonist.") But HHS did not specifically examine these products with increased Δ8-THC potency. Day 1 Tr. at 209:11-17. As Dr. Chiapperino testified, HHS instead focused on studies related to marijuana generally. *Id*. at 209:18-210:17. This was error. Indeed, the FDA, responding to "an uptick in adverse event reports to the FDA and the nation's poison control centers" involving Δ8-THC, noted that "Δ8-THC products likely expose consumers to much higher levels of the substance than are naturally occurring in hemp cannabis raw extracts," so that "*historical use of cannabis cannot be relied upon* in establishing the level of safety for these products in humans." TBI Ex. 27 (emphasis added).

These "delta-8 products can be purchased almost anywhere," Day 8 Tr. 1844:14-21, and are increasingly used. As NIDA has observed, a recent survey by Monitoring the Future determined that around 11% of 12th-graders had used a Δ8-THC product in the past year. *See* Nat'l Inst. on Drug Abuse, *Delta-8-THC use reported by 11% of 12th graders in 2023*, TBI Ex. 28 at 1. Similarly, the FDA has had "an uptick in adverse event reporting" involving regarding Δ8-THC. TBI Ex. 27 at 3. TBI has also observed increased use of Δ8-THC in young or school-aged children. Day 8 Tr. 1844:14-21.

HHS's failure to study Δ8-THC products renders HHS's entire analysis deficient, as marijuana is being redefined to include Δ8-THC and other THC products. At the time HHS did its analysis, cannabis plants and products with high levels of THC other than Δ9-THC were legally defined as hemp. ALJ Ex. 1, at 2. HHS considered this change in the legal definition of marijuana as an "important difference" "relative to the HHS 8FAs for marijuana in 2015" because it "narrowed the scope of what is considered marijuana under the CSA." *Id*. But in November 2025, Congress passed a law redefining hemp to exclude any cannabis plant with more than 0.3% potency of total THC, including Δ8-THC. *See* Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, PL 119-37, November 12, 2025, 139 Stat 495. Accordingly, strains of cannabis or cannabis products that contain high potency Δ8-THC and other forms of THC will fall under the definition of marijuana again. *Id*. Dr. Chiapperino testified he did not know whether HHS would recommend rescheduling marijuana under this new definition. Day 1 Tr. 227:18-24.

It would be at best imprudent to reschedule marijuana based on an HHS analysis that used a legal definition of marijuana that excluded increasingly used—and increasingly dangerous—products that will no longer be in effect within months. For this reason as well, marijuana should not be moved to Schedule III.

D. Factors 4 & 5: Children are increasingly exposed to marijuana.

Finally, children are being exposed to marijuana at alarmingly growing rates as marijuana becomes more available through decreased regulation. The DEA itself has reported that cannabis use disorder among kids aged 12-17 "has almost doubled" from 2.7% in 2014 to 4.7% in 2024. Drug Enforcement Administration, *Weed Addiction Has Almost Doubled Among Kids, Says National Drug Survey* (Aug. 5, 2025), TBI Ex. 32 at 1. And National Poison Control Center Data

shows that from 2019 through 2025, reports regarding exposure of children (0-19 years of age) to edibles increased from approximately 150 per month to over 600 per month, and many months there were close to 900 exposures. *See* America's Poison Control Centers, *Marijuana Edibles Tracker*, TBI Ex. 29, at 3. This increase includes small children. For example, in 2017 there were 207 reported exposures to edible marijuana involving children under 6. TBI Ex. 30 at 3. By 2021, that number had climbed to 3054 cases, an increase of 1375%. *Id.* Similarly, Poison control centers have reported a substantial increase in child exposures to Δ8-THC. The Tennessee Poison Control Center reported an "alarming" increase to 110 Δ8-THC exposures to children from February 2022 to 2023, up from 32 in the year prior. TBI Ex. 26 at 1. Notably, many marijuana products, especially those with high levels of Δ8-THC are widely available and marketed in child-friendly packaging that can easily be mistaken for cookies or snack foods, especially by children. Day 8 Tr. 1816:24-1817:9; *see also* 2025 NDTA at 58 (Figure 45); 2023 Cannabis Impact Report, TBI Ex. 3 at 10 (Figure 8). As DEA itself has observed, this packaging "increases the potential for children or unsuspecting adults to consume a product that contains delta-8 THC without realizing it." 2025 NDTA at 57.

Figure 45. Delta-8 THC-Infused Products

Source: U.S. Food and Drug Administration

Figure 8 Common THC Products

TBI has seen the impact of this availability. For example, Agent Stephens testified about a recent incident where a teenager on a school bus passed out immediately and required hospitalization after taking a vape. Day 8 Tr. 1816:8-14. Testing of the vape cartridge determined that the vape oil was 99.9% Δ9-THC. *Id.* These are exactly the types of incidents that must be avoided, but will predictably increase if marijuana is moved to Schedule III.

CONCLUSION

For the reasons stated above, DEA has not met its burden, and marijuana should remain in Schedule I.

Dated: August 17, 2026

RESPECTFULLY SUBMITTED:

/s/ *Reed N. Smith*

REED N. SMITH (BPR #040059)
Office of the Tennessee Attorney General
P.O. Box 20207
Nashville, Tennessee 37202
(615) 741-3491
Reed.Smith@ag.tn.gov

Counsel for Tennessee Bureau of Investigation

CERTIFICATE OF SERVICE

I, the undersigned, that on August 17, 2026, a copy of the foregoing TBI Posthearing Brief was sent via email to the DEA Office of Administrative Law Judges at ECF-NPRM@dea.gov and caused a copy to be delivered to all designated participants of record, as noted herein:

(1) The Government, via email to the DEA Government Mailbox at dea.registration.litigation@dea.gov;

(2) Drug Enforcement Administration, via email to James J. Schwartz at James.J.Schwartz@dea.gov, Jarrett T. Lonich at Jarrett.T.Lonich@dea.gov, Alexis B. Attanasio at Alexis.B.Attanasio@dea.gov, Kayla L. Kreinheder at Kayla.L.Kreinheder@dea.gov, David C. Maley at David.C.Maley@dea.gov, Lisa K. Man at Lisa.K.Man@dea.gov, Stacy R. Race at Stacy.M.Race2@dea.gov, and Mack J. Swan ant Mack.J.Swan@dea.gov;

(3) National Drug & Alcohol Screening Association, via email to (A) M. Jo McGuire at jomcguire@ndasa.com and (B) David Evans, Esq., at thinkon908@aol.com; (C) Patrick D. Kenneally, Esq. at Patrick.Kenneally@burkegroup.law; (D) Connor W. Mighell at connor.mighell@burkegroup.law.

(4) Smart Approaches to Marijuana, via email to (A) Patrick F. Philbin, Esq., at pphilbin@torridonlaw.com; (B) John M. McNichols, Esq, at jmcnichols@torridonlaw.com; and (C) Chase T. Harrington, Esq., at charrington@torridonlaw.com;

(5) The States of Nebraska, Idaho, Indiana, and Louisiana, via email to (A) Zachary Pohlman, Esq., at Zachary.pohlman@nebraska.gov; (B) Michael Zarian, Esq., at Michael.zarian@ag.idaho.gov; (C) Blake Lanning, Esq., at blake.lanning@atg.in.gov; and (D) Zachary Faircloth, Esq., at faircloth@ag.louisiana.gov;

(6) DUID Victim Voices, via email to (A) Ed Wood, at edwood27@icloud.com; (B) Patrick D. Kenneally, Esq. at Patrick.Kenneally@burkegroup.law; and (C) Connor W. Mighell at connor.mighell@burkegroup.law

(7) Kenneth Finn, M.D., (B) Patrick D. Kenneally, Esq. at Patrick.Kenneally@burkegroup.law; and (C) Connor W. Mighell at connor.mighell@burkegroup.law.

(8) Phillip A. Drum, PharmD, *pro se*, via email at phillipdrum@comcast.net.

/s/ Reed Smith
Reed Smith
Counsel for Tennessee Bureau of Investigation