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# The Evolution of Federal Drug Control Legislation\*

Thomas M. Quinn\*\*

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## INTRODUCTION

### PART I—FEDERAL REGULATION OF NARCOTIC DRUGS PRIOR TO 1970

- A. Federal Narcotic Legislation to 1922
  - 1. Opium Tariff Statutes
  - 2. Pure Food and Drug Act
  - 3. Import and Export Regulations
  - 4. Harrison Act
  - 5. The Narcotic Drug Import and Export Act
- B. Federal Narcotic Legislation from 1922 to 1970
  - 1. Porter Act of 1929
  - 2. Federal Bureau of Narcotics
  - 3. Informers Act of 1930
  - 4. Marihuana Tax Act
  - 5. Vehicle Seizure Act of 1939
  - 6. Opium Poppy Control Act
  - 7. Drug Legislation of 1946
  - 8. Increased Penalties 1951 and 1956

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9. Narcotics Manufacturing Act
10. Narcotic Addict Rehabilitation Act

**PART II—FEDERAL REGULATION OF DANGEROUS DRUGS  
PRIOR TO 1970**

- A. Definition of Dangerous Drugs
- B. Acts Forbidden
- C. Registration, Records and Enforcement

**PART III—THE CONTROLLED SUBSTANCES ACT OF 1970**

- A. Jurisdiction to Legislate
- B. Controlled Substances
- C. Requirements for Individual Registrants
  1. Manufacturers
  2. Distributors
  3. Dispensers
- D. Import and Export Regulation

**PART IV—SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVEN-  
TION AND OFFICE FOR DRUG ABUSE LAW ENFORCE-  
MENT**

- A. Special Action Office for Drug Abuse Prevention (SAODAP)
- B. Functions of Director
- C. Relation to HEW
- D. Office for Drug Abuse Law Enforcement (ODALE)

**PART V—HISTORICAL DEVELOPMENT AND PRESENT STATUS  
OF FEDERAL DRUG PENALTY PROVISIONS**

- A. Pre-1970 Narcotics Penalties
  1. Early Pattern
    - (a) Import-Export Penalties
    - (b) Harrison Act Penalties
  2. Unified Penalties of 1951
  3. Amendments of 1956
- B. Pre-1970 Dangerous Drug Penalties
- C. Present Federal Penalty Provisions for Narcotic and Dangerous Drug Offenses
  1. Unlawful Manufacture, Trafficking and Similar Offenses
  2. Possession
  3. Continuing Criminal Enterprise
  4. Dangerous Special Drug Offender
  5. Import and Export Penalties
- D. Interrelationships Between Penalty Provisions

**CONCLUSION**

The federal government entered the field of drug control in response to the growing incidence of addiction in the United States at the turn of the 20th century. The reasons for the increased number of addicts are not hard to find. First, morphine was freely dispensed to the wounded during the Civil War. It was estimated at the time that thousands of veterans were becoming addicted to the drug,<sup>1</sup> and after the war began to pass on the "pleasures" of morphine to friends and relatives. Second, opium smoking was quite popular among Chinese immigrants imported to help build the American railroads.<sup>2</sup> As they settled in the Western states, the practice began to spread beyond their ranks.<sup>3</sup> Third, in 1898 heroin was introduced to the medical world as the cure for morphine addiction.<sup>4</sup> Far from being a cure, however, heroin was soon found to cause even greater problems of addiction. Fourth and most important, opium and cocaine were common ingredients in various patented medicines and sodas which were marketed widely throughout the country prior to the early 1900's.<sup>5</sup>

The actual number of addicts at the turn of the century is a subject of debate. The first reported attempt to determine the extent of drug addiction in the United States was undertaken in 1878 by O. Marshall. In a report entitled "The Opium Habit in Michigan," Marshall estimated that there were 7,763 drug addicts in the state.<sup>6</sup> Six years later, J. M. Hull estimated that there were 5,732 addicts in Iowa.<sup>7</sup> If these figures reflected a national pattern, there were approximately 180,000 to 250,000 addicts in the country at that time. A Vermont study in 1900 indicated that approximately 3,300,000 doses of opium were sold monthly, enough to supply each Vermont adult, with 1½ doses per day.<sup>8</sup>

Early studies in the twentieth century showed no appreciable decrease in addiction. In 1913, Dr. Charles Perry conducted an exhaustive study of

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1. T. DUSTER, *THE LEGISLATION OF MORALITY* 6 (1970), citing TERRY & PELLENS, *THE OPIUM PROBLEM* 66 (1928).

2. R. KING, *THE DRUG HANG-UP* 10 (1972) [hereinafter cited as KING]. See also Cabinet Committee on International Narcotics Control, *World Opium Survey* 1972 p. 1. For a brief discussion of the opium problem among Chinese imported to build railroads in Panama, see N. TAYLOR, *NARCOTICS, NATURE'S DANGEROUS GIFTS* 52 (1966).

3. The use of opium by the Chinese led to specific statutory controls. For instance, the importation of opium into the United States by "any subject of the Emperor of China" was forbidden by ch. 210, 24 Stat. 409 (1887).

4. T. DUSTER, *THE LEGISLATION OF MORALITY* 8 (1970).

5. TERRY & PELLENS, *THE OPIUM PROBLEM* 66 (1928).

6. MARSHALL, *THE OPIUM HABIT IN MICHIGAN*, 1878 MICH. STATE BD. OF HEALTH ANN. REP. 61-73; cited in Bonnie and Whitebread, *The Forbidden Fruit and the Tree of Knowledge: An Inquiry into the Legal History of American Marijuana Prohibition*, 56 VA. L. REV. 971, at 981-82, n.31 (1970) [hereinafter cited as Bonnie].

7. HULL, *The Opium Habit*, 1885 IOWA STATE BD. OF HEALTH BIENNIAL REP. 535-45, cited in Bonnie, *supra*, note 6, at 981-82, n.31.

8. Grinnel, *A Review of Drug Consumption and Alcohol as Found in Proprietary Medicine*, 23 MEDICO-LEGAL J. 426 (1905).

drug addiction in Jacksonville, Florida. His report indicated that 541 persons, or .81 percent, of the city's population used opium in one form or another.<sup>9</sup> If Perry's sample in Jacksonville was representative of the rest of the country, there would have been approximately 782,118 addicts in the country in 1913—a staggering figure to say the least. Perhaps the most comprehensive early study, however—that done in 1924 for the United States Public Health Service by Laurence Kolb and A.G. Du Metz—estimated that the addict population of the United States “never exceeded 246,000.”<sup>10</sup>

Although these various reports disagreed on the actual number of addicts, they all seemed to agree on one point—drug addiction was a widespread phenomenon in the United States. This fact soon became apparent to the Congress and led to the passage of Federal laws aimed at controlling the drug problem.

In order to trace the development of Federal drug control legislation this paper will divide the topic into five parts:

Part I will treat pre-1970 Federal legislation dealing with narcotic drugs;

Part II will focus on pre-1970 legislation dealing with non-narcotic dangerous drugs, such as barbiturates and amphetamines;

Part III will discuss the Controlled Dangerous Substances Act of 1970;

Part IV will outline the structure of the Special Action Office for Drug Abuse Prevention and the Office of Drug Abuse Law Enforcement;

Part V will present separately an historical treatment of Federal penalties for drug offenses.

## PART I—*Federal Regulation of Narcotic Drugs Prior to 1970*

### A. *Federal Narcotic Legislation to 1922*

#### 1. *Opium Tariff Statutes*

The earliest mention of opium (or for that matter, any narcotic drug) in Federal legislation appears in the Tariff Act of 1832.<sup>11</sup> The Act—exempting opium from all import duties—attempted neither to interdict the flow of drugs nor produce substantial revenue. Ten years later in 1842, however, the narcotic was placed on the tariff lists for the first time and a duty of

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9. 1913 JACKSONVILLE, FLA., BD. OF HEALTH ANN. REP., cited in Bonnie, *supra*, note 6, at 981, n.31.

10. KOLB & DUMEZ, *The Prevalence and Trend of Drug Addiction in the United States and Factors Influencing It*, 1-20 (39 Public Health Reports No. 21) (May 23, 1924), cited in Bonnie, *supra* note 6, at 981-82, n. 31.

11. Ch. 227, § 3, 4 Stat. 590 (1832).

seventy-five cents per pound was levied on all imported opium.<sup>12</sup> In 1862, morphine was added to the tariff list and taxed at the rate of two dollars per pound.<sup>13</sup> The tariff rates on medicinal or raw opium and morphine fluctuated throughout the nineteenth century. Raw opium even reappeared on the duty free list in 1890.<sup>14</sup> This use of imported opium as a source of governmental revenue was consistent with the flourishing international opium traffic of the nineteenth century. British traffic in opium had led to the Opium Wars with China and generated a series of diplomatic concessions extorted from the Chinese, concessions which assured continuance of the lucrative opium trade.<sup>15</sup> For example, in an 1858 treaty between China and the United States, China agreed to remove opium from its list of contraband items, permitting American merchants to sell the drug at various Chinese ports.<sup>16</sup> With opium traffic so open and obvious, it was not surprising that the United States government should view opium as nothing more than another imported item to be taxed.

Smoking opium, however, was singled out for special treatment during this earliest period of federal concern. As previously mentioned, smoking opium was first associated with the Chinese immigrant but gradually, as the practice spread, it became a national concern. The response was an eighty per cent ad valorem tax on all imported smoking opium.<sup>17</sup> In succeeding years, it continued to be taxed at ever increasing rates, reflecting the growing fear with which the practice was regarded.<sup>18</sup> The magnitude of the problem is suggested by one commentator who observed that between 1860 and 1913 approximately \$27 million in revenue was collected from import duties on smoking opium alone.<sup>19</sup>

## 2. *Pure Food and Drug Act*

A second and quite different theme in federal narcotic drug control appeared

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12. Ch. 270, § 8, 5 Stat. 548 at 558 (1842).

13. Ch. 163, § 5, 12 Stat. 543 at 548 (1862).

14. Ch. 1244, 26 Stat. 567 at 608 (1890).

15. J. FAIRBANK, *TRADE AND DIPLOMACY ON THE CHINA COAST: THE OPENING OF THE TREATY PORTS 1842-1854* 151 (1953).

16. Convention with China, November 8, 1858. 12 Stat. 1069 (1858). Opium had been considered contraband under an earlier treaty between the United States and China. Treaty with China, July 3, 1844, 8 Stat. 592, 599, 605 (1844).

17. Ch. 163, § 5, 12 Stat. 543 at 548 (1862).

18. From 1864 to 1890 the tax on smoking opium rose from two dollars and fifty cents per pound to twelve dollars per pound. Ch. 171, § 11, 13 Stat. 202 at 212 (1864); ch. 255, Sec. 21, 16 Stat. at 265 (1870); ch. 121, § 2502, 22 Stat. 488 at 495 (1883); ch. 1244, 26 Stat. 567 at 569 (1890). In 1897, however, the tax on smoking opium was reduced to \$6 a pound. Ch. 11, 30 Stat. 153 (1897). Note also that, at the time the tax on smoking opium was twelve dollars per pound, raw opium (now called medicinal opium) appeared on the duty free list. *Id.* at 608.

19. W. ELDRIDGE, *NARCOTICS AND THE LAW: A CRITIQUE OF THE AMERICAN EXPERIMENT IN NARCOTIC DRUG CONTROL* 8 (1961).

on the scene in 1906.<sup>20</sup> It came in response to a growing national concern with the use of patent medicines. These commodities—heavily laced with opium, morphine and cocaine—were widely sold throughout the country and served as familiar preparations for such ailments as headaches, menstrual pains, cold symptoms, alcoholism, and general fatigue. What resulted from the heavy dependence on such patented medicines was a widespread pattern of national addiction. The federal response conceived of the patent medicine problem as one of consumer deception. Thus, to control the trade in these medicines, Congress enacted labelling regulations in 1906, the idea being that an informed consumer could protect himself if he chose to do so.

The Pure Food and Drug Act of 1906 prohibited the interstate shipment of misbranded or adulterated food and drugs.<sup>21</sup> An article of food or drugs was considered to be misbranded if it contained any alcohol, morphine, cocaine, heroin, or any derivatives or preparations of these substances where such ingredients were not clearly marked on the label. Similarly, confectionaries were considered to be adulterated if they contained any narcotic drug as an ingredient. The Act also provided that food would be considered adulterated if it contained any added poisonous or deleterious ingredients which might be injurious to health. By requiring labelling of medicines which contained opium and cocaine, and by prohibiting outright the interstate shipment of food containing deleterious substances, the Act exposed to public view the dangerous and addictive capacities of non-prescription medicines and sodas being marketed in the country. It should be noted, however, that this legislation was entirely consistent with a legitimate domestic traffic in opium, morphine, heroin, and cocaine. Indeed, heroin was sold by one pharmaceutical company under the heroin trade name and widely touted; morphine could be purchased over the counter along with opium or cocaine.<sup>22</sup> While the Pure Food and Drug Act alerted consumers to the presence of narcotic drugs in various products, the sales of these drugs continued to flourish. For example, a 1910 pharmaceutical journal reported that one drug store earned a profit of \$60 a day from sales of cocaine alone.<sup>23</sup>

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20. At one earlier point, the narcotics menace seemed to be viewed as an educational problem by the federal government. In 1886, a law was enacted to include the study of narcotics in the curriculum of federal schools. Ch. 362, 24 Stat. 69 (1886).

21. Ch. 3915, 34 Stat. 768 (1906). Many states had adopted narcotic control laws prior to the federal government. This article does not attempt to study these various state regulations. For a good synopsis of early state drug legislation, see U.S. Treasury Department, *State Laws Relating to the Control of Narcotic Drugs and the Treatment of Drug Addiction* (1931).

22. See Cabinet Committee on International Narcotics Control, *World Opium Survey* 1972, at 2. For an early report of how easily cocaine could be purchased, see 75 AM. J. PHAR. 474, 486 (1903).

23. 81 AM. J. PHAR. 35 (1910).

### 3. *Import and Export Regulations*

In 1909 the federal government shifted from its earlier pattern of taxing opium to outright suppression of the traffic in the drug. In response to the Shanghai Opium Conference in 1909, the United States banned the importation of all smoking opium and restricted the importation of all other opium except for limited amounts authorized by the Secretary of the Treasury for medical purposes.<sup>24</sup> This had the effect of closing the United States ports of entry to the legal flow of opium except in controlled quantities for regulated purposes. Since the Act also forbade any person from receiving or selling illegally imported opium knowing it to be illegally imported, the Act represented the first serious federal attempt to use the criminal law to curtail domestic trafficking in opium.

Five years later, the United States took a second major step in the border control of opium traffic when it set controls on the export of opium. With these controls, Congress effectively took the United States out of the international drug traffic by prohibiting the use of its ports for either the import or export of opium and other harmful drugs. Controls on export, like the earlier controls on import, came in response to international pressures. At the Hague International Opium Conference in 1912, the signatory powers, including the United States, had agreed to place various restrictions on prepared opium, cocaine, and morphine—one of these restrictions was to align export controls with the import controls of other nations.<sup>25</sup> Consequently, Congress enacted the Narcotic Drug Export Act,<sup>26</sup> absolutely prohibiting any smoking opium from being admitted into the United States for transshipment to another country and, more importantly, banning the export of cocaine and opium—other than smoking opium, the export of which was absolutely forbidden—to any country which did not regulate the importation of these drugs. On the very same day that it passed the Narcotic Drug Export Act, Congress also adopted a statute which levied a prohibitive tax of \$300 per pound on all opium manufactured in the United States for smoking purposes.<sup>27</sup> Thus, Congress had now forbidden the import or export of smoking

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24. Ch. 100, 35 Stat. 614 (1909). Early attempts at combatting drug addiction in the United States were doubtlessly influenced by the American experiences handling the drug situation in the Philippines. After the Spanish-American War of 1898, the United States took control of the Islands and faced a growing drug epidemic. For a brief discussion of the American experiences with the drug situation in the Philippines, see KING, *supra* note 2, at 10-14.

25. International Opium Convention, The Hague, Jan. 23, 1912. 38 Stat. 1912 (1915). On the early international opium conferences, see W. WILLOUGHBY, *OPIMUM AS AN INTERNATIONAL PROBLEM, THE GENEVA CONFERENCE (1925)*.

26. Ch. 9, 38 Stat. 275 (1914).

27. Ch. 10, 38 Stat. 277 (1914).

opium, heavily taxed its domestic manufacture, and severely restricted the import of other forms of opium.

#### 4. *Harrison Act*

With the Harrison Act the federal government interjected itself decisively into the domestic traffic in narcotic drugs.<sup>28</sup> This statute was by far the most significant of all the early federal drug control laws, setting the main lines for domestic narcotic control and regulation which persisted until 1970. The thrust of the Harrison Act was twofold. First the Act sought to expose to federal surveillance the legal traffic in narcotics from its point of entry or manufacture to its point of consumption. Second, the Act provided criminal penalties for any trafficking in narcotics outside the legally established patterns. The stage was thus set for the regulation of the legal narcotic flow and the suppression of the illegal flow.

To achieve such broad purposes, the actual legislative scheme of the Harrison Act might be considered cumbersome to say the least. Congress chose to assert jurisdiction through its revenue powers rather than through its power to regulate interstate commerce. This rather curious approach was justified, however, since in 1914 the interstate commerce clause was still read rather restrictively by the courts. In all probability, that clause would not have supported any congressional controls over local drug manufacturers or distributors.<sup>29</sup> Of course, Congress' decision to use its revenue powers placed the domestic control of narcotics in the hands of the Internal Revenue Service, then deeply involved in the enforcement of the newly created federal income tax, and later the Prohibition laws. Contrary to certain state patterns of narcotic control, this placed enforcement of the Harrison Act in the hands of a special enforcement unit rather than in the hands of general law enforcement officers.

By its terms, the Harrison Act required registration with the local Internal Revenue Collector and payment of a special occupational tax by every person, with certain exceptions, who produced, imported, manufactured, compounded, dealt in, dispensed, sold, distributed, or gave away opium or coca leaves or any compound or preparation of these drugs.<sup>30</sup> The Act also stipu-

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28. Ch. 1, 38 Stat. 785 (1914).

29. Manufacturing was considered a subject for local rather than national regulation. *See, e.g.,* *Kidd v. Pearson*, 128 U.S. 1 (1888); *Parker v. Brown*, 317 U.S. 341 (1943). The constitutionality of the Harrison Act was upheld in *United States v. Doremus*, 249 U.S. 86 (1919).

30. The Harrison Act did not apply to the sale, distribution or possession of preparations containing minimal amounts of narcotic drugs, *i.e.* less two grains of opium,  $\frac{1}{8}$  of a grain of heroin. Ch. 1, § 6, 38 Stat. 785 (1914).

lated that any sale, exchange, or transfer of these drugs must be pursuant to the *written order* of the person to whom the drugs were to be transferred. Written orders could only be executed on forms specially provided by the Commissioner of Internal Revenue and the forms themselves could only be purchased by a registered person. Everyone in the drug distribution system was subject to stringent record-keeping. Finally, it was unlawful for any unregistered or unpaid person to possess or control any restricted drug; such possession or control was presumptive evidence of failure to register and pay the occupational tax.

The Harrison Act was amended in 1919 by increasing the rate of the annual occupational tax and by imposing a new commodity tax of one cent per ounce on all opium or coca leaves produced in or imported into the United States.<sup>31</sup> This commodity tax was in addition to any existing import duties. The 1919 amendments made it unlawful for any person to purchase, sell, dispense or distribute any of the aforementioned drugs or their compounds except in the original stamped packages or from the original stamped packages. The absence of appropriate tax-paid stamps became *prima facie* evidence of a violation of the Harrison Act.

From the viewpoint of federal law enforcement officers, there was one glaring gap in the coverage of the Harrison Act—the medical profession. Section 2 of the Act specifically exempted from its coverage the dispensing or distribution of drugs “to a patient by a physician . . . in the course of his professional practice only.”<sup>32</sup> With narcotics tightly regulated, the physician represented the sole legitimate source of supply open to the addict. For the unscrupulous doctor, this presented a lucrative opportunity to push drugs legitimately under the guise of practicing medicine. Huge profits could be made. The “script doctor,” as he came to be called, became a prime concern of the early Internal Revenue Service personnel charged with enforcement of the Harrison Act. For the responsible physician, the Harrison exemption was not a source of new income; if anything, it was a source of unexpected problems. As long as an addict was not confined to a hospital for treatment, a doctor could minister to him in one of two ways—either by personally administering the drug to the addict in his office or by prescribing the drug for the addict to administer to himself at home. If he treated the addict in his office, the physician could minimize possible drug diversion into the illicit market but at the expense of turning his office into a drug clinic with long lines of addicts awaiting treatment.<sup>33</sup> If he prescribed drugs for self admin-

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31. Ch. 18, § 1006, 40 Stat. 1057, at 1130 (1919).

32. Ch. 1, § 2(a), 38 Stat. 785 at 786 (1914).

33. See LINDESMITH, *THE ADDICT AND THE LAW* 142 (1965) [hereinafter cited as

istration, the doctor created serious problems of illegal diversion. The dilemma was real and with no apparent solution. Because of the possibility of diversion, law enforcement officials soon began to move to curtail the medical profession's freedom to prescribe narcotics in the treatment of addicts. The unfortunate consequence of this policy was to drive from the field of drug treatment not only the unethical "script doctor" but the legitimate doctor as well.

At the outset, the Harrison Act was not interpreted as interfering with the physician's medical treatment of the addict, whether by prescription or otherwise. Thus, for example, providing an addict with morphine in the treatment of his addiction was considered valid medical treatment to the extent that it suppressed and alleviated withdrawal symptoms. In 1919, however, with the Supreme Court's decision in *Webb v. United States*,<sup>34</sup> a series of cases maintained otherwise. Although *Webb* was a "script doctor," the Court was asked to decide whether a practicing physician's order for morphine was exempt as a physician's prescription within the meaning of section 2 where the order was not in the course of professional treatment in an attempt to cure the addict but solely to keep the addict comfortable by maintaining his customary use? The Court said no:

[T]o call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required.<sup>35</sup>

One year later, in *Jin Fuey Moy v. United States*,<sup>36</sup> the Supreme Court was faced with another case involving a "script doctor." In elaborating on its holding in *Webb*, the Court stated that the Harrison Act's immunity for physicians dispensing or distributing drugs in the course of their professional practice did not

include a sale to a dealer or a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug. A "prescription" issued for either of the latter purposes protects neither the physician who issues it, nor the dealer who knowingly accepts and fills it.<sup>37</sup>

The most controversial decision in this area, however, was neither *Webb*

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LINDESMITH]. For a brief discussion of the drug clinics which were operated in various parts of the country, see KING 33-39; LINDESMITH 135-161.

34. 249 U.S. 96 (1919). For a further discussion of this series of cases, see KING 40-58; R. King, *The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick*, 62 YALE L. REV. 736-749 (1953); LINDESMITH 5-17.

35. 249 U.S. at 99.

36. 254 U.S. 189 (1920).

37. *Id.* at 194.

nor *Jin Fuey Moy*, but *United States v. Behrman*,<sup>38</sup> decided in 1922. Behrman, a physician like Webb and Jin Fuey Moy, dispensed drugs indiscriminately. At one time, for instance, he had given an addict prescriptions for 150 grains of heroin, 360 grains of morphine and 210 grains of cocaine.<sup>39</sup> The Government, however, grounded its indictment on a holding that "prescribing drugs for an addict was a crime regardless of the physician's intent in the matter."<sup>40</sup> Although the Supreme Court stressed the large amount of the drugs dispensed by Behrman, the decision could be read by nervous physicians as prohibiting all doctors from prescribing, in good faith, even small quantities of narcotics for self-administration in an attempt to treat an addict. After *Behrman*, it seemed that a physician could only prescribe narcotics for conditions such as ulcers or cancer, but not for relief of addiction itself.<sup>41</sup>

The *Behrman* holding was soon tested in *Linder v. United States*.<sup>42</sup> Dr. Linder had personally dispensed to one of his patients one tablet of morphine and three tablets of cocaine. Limiting the *Behrman* rationale, the Court stated:

[The Harrison Act] says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction.<sup>43</sup>

The Court further asserted that *Behrman* could not be interpreted as precluding a physician, acting in good faith and according to fair medical standards, from ever giving an addict moderate amounts of drugs for self-administration in order to relieve the conditions incident to addiction.

Although the language in *Linder* could be read to repudiate *Behrman*, doctors were genuinely afraid to treat addicts. This fear increased as lower federal courts seemingly disregarded the clear intent of the *Linder* rationale.<sup>44</sup> Now the addict could no longer turn to the medical profession for help: he was forced to turn to a new source of supply—the growing illicit

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38. 258 U.S. 280 (1922).

39. *Id.* at 288-89; KING 42.

40. KING 42.

41. *Id.* at 43.

42. 268 U.S. 5 (1925).

43. *Id.* at 18.

44. *Teter v. U.S.* 12 F.2d 224 (7th Cir. 1926); *Bush v. U.S.*, 16 F.2d 709 (5th Cir. 1927); *DuVall v. U.S.*, 82 F.2d 382 (9th Cir. 1936); *Hawkins v. U.S.*, 90 F.2d 551 (5th Cir. 1937).

drug market. As Rufus King remarks: "The addict-patient vanished; the addict-criminal emerged in his place."<sup>45</sup>

On the whole the Harrison Act has been criticized as an unenlightened approach to a difficult social problem. One European commentator summarized the situation in this way:

The Harrison Narcotic Law was passed in 1914 by the Federal Government of the United States with general popular approval. It placed severe restrictions upon the sale of narcotics and upon the medical profession, and necessitated the appointment of a whole army of officials. In consequence of this stringent law a vast clandestine commerce in narcotics has grown up in that country. The small bulk of these drugs renders the evasion of the law comparatively easy, and the country is overrun by an army of peddlers who extort exorbitant prices from their hapless victims. It appears that not only has the Harrison Law failed to diminish the number of drug takers—some contend, indeed, that it has increased their numbers—but, far from bettering the lot of the opiate addict, it has actually worsened it; for without curtailing the supply of the drug it has sent up the price tenfold, and this has had the effect of impoverishing the poorer class of addicts and reducing them to a condition of such abject misery as to render them incapable of gaining an honest livelihood.<sup>46</sup>

##### 5. *The Narcotic Drug Import and Export Act*

In 1922, Congress passed the Narcotic Drug Import and Export Act<sup>47</sup> which continued the existing ban on opium importation while adding cocaine to the list of drugs which were forbidden entry into the country. Limited amounts of crude opium and coca leaves, however, were permitted to be imported for medical and other legitimate needs. It is interesting to note that, for the first time, all restricted drugs were classified under the generic category of "narcotic drugs." A Federal Narcotics Control Board (composed of three Cabinet members) was created to administer various provisions of the Act. For instance, the Board was empowered to determine exactly what amounts of crude opium and coca leaves were needed to be imported for legitimate and medical purposes.<sup>48</sup>

1924 saw one important amendment to the Act. Although a certain amount of crude opium could be legally imported for medical or other legiti-

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45. KING 43.

46. H. Campbell, *The Pathology and Treatment of Morphia Addiction*, BRITISH JOURNAL OF INEBRIETY, 147-48 (1923), cited in Lindesmith, *Dope Fiend Mythology*, 31 J. CRIM. LAW & CRIMINOLOGY 199, 204 (1940-41).

47. Ch. 202, 42 Stat. 596 (1922).

48. This function was later transferred to the Surgeon General of the United States. Ch. 488, § 4(b) 46 Stat. 585 at 587 (1930).

mate uses, Congress now prohibited the importation of any crude opium for the purposes of manufacturing heroin.<sup>49</sup>

There is one provision of the Narcotic Drugs Import and Export Act, however, which merits close scrutiny. Under the Act, possession of narcotics gave rise to a two-fold statutory presumption—namely, that the narcotics were illegally imported and that the defendant had knowledge of their illegal importation.<sup>50</sup> This presumption has been the subject of a vast amount of litigation, culminating in the recent cases of *Leary v. United States*<sup>51</sup> dealing with its applicability to marihuana, and *Turner v. United States*,<sup>52</sup> dealing with its applicability to heroin and cocaine.

In *Leary*, the Supreme Court refused to reach the question of the validity of the inference but held unconstitutional that part of the presumption which related to defendant's knowledge of illegal importation. The Court reasoned that inasmuch as some of the marihuana consumed in the United States is domestically grown, it would be no more than speculation to say that even a majority of possessors knew the source of their marihuana.<sup>53</sup> Consequently, absent proof that the particular possessor had actual knowledge of illegal importation, the statutory presumption was not sufficient to uphold a conviction. In effect, the Court found no rational connection between the fact proved—possession—and the fact to be presumed—knowledge of illegal importation.

In *Turner*, the Court upheld the entire presumption as applied to heroin but declared it unconstitutional as applied to cocaine. As for heroin, the overwhelming evidence showed that heroin consumed in the United States is illegally imported and that anyone in possession of such heroin is aware of the "high probability" that it had originated in a foreign country.<sup>54</sup> In the case of cocaine, on the other hand, it was determined that more cocaine is lawfully produced in this country than is smuggled into the country.<sup>55</sup> Hence, the Court could not be sure whether the cocaine that the defendant possessed came from abroad or that the defendant knew of its illegal importation. In such a situation, the presumption of illegal importation could not be applied.

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49. Ch. 352, 43 Stat. 657 (1924).

50. Ch. 202, § 2(f), 42 Stat. 596 (1922).

51. 395 U.S. 6 (1969). For a further discussion of this case and statutory criminal presumptions see Note, *The Unconstitutionality of Statutory Criminal Presumptions*, 22 STAN. L. REV. 341 (1970); Comment, *Statutory Criminal Presumptions: Reconciling the Practical with the Sacrosanct*, 18 UCLA L. REV. 157 (1970); and 83 HARV. L. REV. 103 (1969).

52. 396 U.S. 398 (1970). For a further discussion of this case as well as *Leary*, see Comment, *Statutory Criminal Presumptions: Reconciling the Practical with the Sacrosanct*, 18 U.C.L.A. L. REV. 157 (1970).

53. 395 U.S. 6, 46 (1969).

54. 396 U.S. 398, 416-418 (1970).

55. *Id.* at 423-24.

## B. Federal Narcotic Legislation From 1922 to 1970

### 1. Porter Act of 1929

By the late twenties, the federal government was faced with a new problem—large numbers of addicts in its prison system. As the patterns of addiction grew and became associated with domestic crime, it was perhaps inevitable that the addict population in prisons would increase. Congress responded to the problem by enacting the Porter Act in 1929.<sup>56</sup> The Act established two United States Narcotic Farms designed to provide care and treatment of convicted addicts. The first was opened in Lexington, Kentucky in 1935; the second at Fort Worth, Texas in 1938.

### 2. The Federal Bureau of Narcotics

The growing narcotic problem also led to the emergence of a new federal agency within the Treasury Department. Enforcement of the Harrison Act of 1914 was entrusted to the narcotics division of the prohibition unit of the Internal Revenue Service.<sup>57</sup> In 1927 this division was incorporated into the newly created Prohibition Bureau of the Treasury Department.<sup>58</sup> In 1930 law enforcement in the federal narcotics field was further developed and consolidated into its own separate agency, the Federal Bureau of Narcotics.<sup>59</sup> Of equal importance with the establishment of the agency was the appointment of Harry J. Anslinger as the new agency's first commissioner. Anslinger had risen through the diplomatic service and established himself later at the Department of the Treasury as Assistant Commissioner of Prohibition.<sup>60</sup> With the establishment of the Bureau of Narcotics, Anslinger shifted his main concern from prohibition to narcotic law enforcement. Under his vigorous leadership the Bureau of Narcotics was shaped and developed into a powerful law enforcement agency.

### 3. Informers Act of 1930

While the Harrison Act was cast in terms of a regulatory statute designed to publicly expose the legitimate narcotic drug flow on the domestic scene, its collateral and less obvious goal was to interdict the domestic flow of illegal narcotics. This latter purpose obviously led to heavy criminal law enforce-

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56. Ch. 82, 45 Stat. 1085 (1929).

57. See King, *The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick*, 61 YALE L.J. 736, 737, n.9 (1953).

58. Ch. 348, 44 Stat. 1381 (1927). King, *The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick*, 61 YALE L. J. 736, 737 n.9 (1953).

59. Ch. 488, 46 Stat. 585 (1930).

60. See KING 70.

ment work. To facilitate this effort the Commissioner of Narcotics was empowered by Congress in 1930 to pay informers for information concerning violations of the drug laws.<sup>61</sup>

#### 4. *Marihuana Tax Act*

Although early federal legislation was mainly concerned with controlling opium and cocaine, a new "drug menace" had appeared by the 1930's—that "menace" was marihuana.<sup>62</sup> In 1937, under the prodding of the newly created Federal Bureau of Narcotics, Congress passed the Marihuana Tax Act—which was similar, in many respects, to the Harrison Act.<sup>63</sup> The Marihuana Tax Act required those in the chain of marihuana distribution to register and pay an occupational tax. A commodity tax of \$1.00 per ounce was levied on transfers of marihuana to persons registered under the Act. Unlike the Harrison Act where transfers could only be made to registered persons, the Marihuana Tax Act allowed transfers to non-registered persons but provided ample deterrents to such transfers by a prohibitive tax of \$100 an ounce. To effect a legal transfer both registered and non-registered persons were required to file special order forms. Increasing federal control over marihuana distribution even further, various reports and record-keeping requirements were mandated. In short, Congress placed virtually identical controls over marihuana as over the narcotic drugs.

#### 5. *Vehicle Seizure Act of 1939*

Like the Informers Act of 1930, the Vehicle Seizure Act of 1939<sup>64</sup> attested to the continuing efforts of the Bureau of Narcotics to extend its control over the growing black market in illegal drugs. By its terms, the Act made it unlawful to transport, carry, or convey any contraband article in, upon, or by means of any vessel, vehicle, or aircraft. A contraband article was defined as any narcotic drug which has been or is possessed with intent to sell or offer for sale in violation of the law, or which is sold in violation of the law, or which does not bear appropriate tax paid Internal Revenue Stamps. Any vessel, vehicle, or aircraft (with certain exceptions) which has been or is being used in violation of the Act was subject to seizure and forfeiture.

#### 6. *Opium Poppy Control Act*

The outbreak of World War II disrupted the flow of opium to the United

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61. Ch. 829, 46 Stat. 850 (1930).

62. It seems that Mexican immigrants and West Indian sailors introduced the practice of marihuana smoking into the border and Gulf states during the decade following the Harrison Act. See MARIHUANA: A SIGNAL OF MISUNDERSTANDING, FIRST REPORT OF THE NATIONAL COMMISSION ON MARIHUANA AND DRUG ABUSE 13 (1972).

63. Ch. 553, 50 Stat. 551 (1937).

64. Ch. 618, 53 Stat. 1291 (1939).

States. There were those who decided that profit could be made by growing the opium poppy domestically—ostensibly to provide necessary opium for medical needs. A 1942 Act, however, prohibited any person who was not the holder of a license authorizing him to produce the opium poppy, duly issued by the Secretary of the Treasury, to produce or attempt to produce such poppies.<sup>65</sup> The Secretary, it should be noted, has never issued such a license.<sup>66</sup>

#### 7. *Drug Legislation of 1946*

The increased availability of *synthetic* opiates—such as methadone—led Congress to bring these drugs within the ambit of federal controls in 1946.<sup>67</sup> Specifically, any drug which was found to have an addiction forming or addiction sustaining potential similar to morphine or cocaine came within the purview of the federal statutes governing natural opium.

#### 8. *Increased Penalties—1951 and 1956*

The unintended effect of the Harrison Act and its subsequent enforcement was the closing of legitimate sources of supply to the addict, resulting in the rise to a flourishing black market in illegal drugs. With the repeal of Prohibition, organized crime in turn became more involved with the illegal distribution of drugs. The inevitable result was an expanding drug problem. The years between 1946 and 1960 were times of a rising drug trade in the United States and, equally important, times of growing fears regarding the drug problem.<sup>68</sup>

Not the least of these fears was that drug use was reaching epidemic proportions among minors. In 1951, for example, a Special Senate Committee on Organized Crime became concerned with the increasing number of drug addicts among young people. The Committee found that, in 1946, only three percent of the patient-addicts at the United States Public Health Service Hospital at Lexington, Kentucky, were below the age of 21, while just five years later the percentage had increased to eighteen percent.<sup>69</sup> Congress responded with the escalation of penalties for narcotic violations, first in 1951<sup>70</sup> under the vigorous leadership of Congressman Hale Boggs, and again in 1956.<sup>71</sup>

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65. Ch. 720, 56 Stat. 1045 (1942).

66. H. ANSLINGER & W. TOMPKINS, *THE TRAFFIC IN NARCOTICS* 137 (1953).

67. Ch. 81, 60 Stat. 38 (1946).

68. See Note, *Narcotics Regulation*, 62 *YALE L. REV.* 751 and n.1 (1953).

69. SEN. REP. NO. 725, 82d Cong., 1st Sess. 27 (1951).

70. Ch. 66, 65 Stat. 767 (1951).

71. Ch. 629, 70 Stat. 567 (1956).

The Harrison Act and subsequent statutes established the basic approach to drug control by the federal government. The legislation of the 1950's did not alter that approach. What prompted this legislation was the belief that tougher penalties would deter involvement in the traffic by severely punishing those who did not heed the warning. To this end, penalties were sharply increased. Mandatory minimum sentences were instituted to prevent "soft" judges from ameliorating the harshness of these strictures. In addition, a drug offender's right to a suspended sentence or probation was curtailed. These statutes will be discussed in greater detail in Part V of this article.

#### 9. *Narcotics Manufacturing Act*

In 1960 the federal government once again broke new ground in the field of narcotics control. For approximately forty years, the United States had closed its ports of entry to the import and export of narcotic drugs and then regulated and controlled the internal distribution processes with the Harrison Act. However, the Act exercised no direct control over the quantities of narcotic drugs legally manufactured within the country itself. The Narcotic Manufacturing Act of 1960 sought to remedy this.<sup>72</sup> Under this Act the Secretary of the Treasury was empowered to license manufacturers of narcotic drugs and to set an individual quota for each drug classification. The Government could not be assured that only those quantities of narcotic drugs actually required for legitimate needs would be domestically manufactured.

This Act was significant in another respect. Before 1960, licensing was always viewed as a peculiarly local concern left to the several states.<sup>73</sup> Now Congress asserted jurisdiction over licensing and, interestingly enough, based its power—at least in part—on the interstate commerce clause, an approach which had been rejected in 1914 when the Harrison Act was enacted. The cumbersome fiction of a tax statute to justify local control over drug distribution was no longer needed.

#### 10. *Narcotic Addict Rehabilitation Act of 1966 (NARA)*

Still more new ground was broken with the Narcotic Addict Rehabilitation Act of 1966.<sup>74</sup> This Act, patterned on state legislation found in California<sup>75</sup> and New York,<sup>76</sup> was based on two existing approaches to drug rehabilitative

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72. Pub. L. No. 86-429, 74 Stat. 55 (1960).

73. For example, see the Uniform Narcotic Drug Act, §§ 3, 4 which provided for state licensing. The Uniform Act was eventually adopted by almost every state.

74. Pub. Law No. 89-793, 80 Stat. 1438 (1966).

75. CALIFORNIA WELF. & INST'NS CODE §§ 3000-3305 (West, 1966) as amended, (West Supp. 1968).

76. L. 1962, c.204, § 1. As codified in Article 9, MCKINNEY'S CONSOL. LAWS OF NEW YORK, MENTAL HYGIENE LAW, as amended L. 1966, c.192.

treatment. The first, embodied in the Porter Act of 1929, had led to the creation of federal hospitals at Lexington and Fort Worth as places for confinement and treatment of the addict-criminal. The second was the long-standing concept that the mentally ill, the alcoholic, and the addict could be legally confined and treated even in the absence of overt criminal behavior. NARA was designed to funnel accused and convicted criminals out of the court and prison systems and into rehabilitative confinement. Even where no overt criminal conduct was involved, the Act provided rehabilitative confinement for addicts who voluntarily committed themselves or who were involuntarily committed by relatives.

## PART II—*Federal Regulation of Dangerous Drugs Prior to 1970*

Dangerous drugs are not to be confused with narcotic drugs which have been previously discussed in Part I. Dangerous drugs include basically three categories of drugs—depressants [including barbituates and tranquilizers], stimulants, and hallucinogens.

When compared to narcotics, dangerous drugs became subject to federal regulation rather late in time. It was not until 1965—with the amendments to the Federal Food, Drug and Cosmetic Act—that Congress imposed controls on the distribution of these drugs comparable to those in the Harrison Act.<sup>77</sup> Before this time, individuals who unlawfully dispensed dangerous drugs could only be prosecuted through certain misbranding provisions of the Food, Drug and Cosmetic Act.<sup>78</sup>

The 1965 amendments cover all dangerous drugs—whether in interstate or intrastate commerce. Unlike the Harrison Act which was based on federal taxing powers, Congress justified intrastate regulation of dangerous drugs on interstate commerce theories. In the findings and declaration preceding the amendments, one finds the following language:

The Congress hereby finds and declares that there is a widespread illicit traffic in depressant and stimulant drugs moving in or otherwise affecting interstate commerce; that the use of such drugs, when not under the supervision of a licensed practitioner, often endangers safety on the highway (without distinction of interstate and intrastate traffic thereon) and otherwise has become a threat to the

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77. Drug Abuse Control Amendments of 1965, Pub. L. No. 89-74, 79 Stat. 226 (1965). For an excellent general discussion of these amendments, see Rosenthal, *Dangerous Drug Legislation in the United States*, 45 TEX. L. REV. 1037 (1967) [hereinafter cited as Rosenthal].

78. 21 U.S.C. §§ 331, 352, 355 (1970). Rosenthal, *supra* note 77, at 1051 n.86. The government was required to prove "that the drug was introduced or received into interstate commerce, delivered for introduction into interstate commerce or misbranded in interstate commerce." *Id.* This is no longer necessary under the 1965 amendments since they apply to drugs in interstate commerce.

public health and safety, making additional regulation of such drugs necessary regardless of the intrastate or interstate origins of such drugs; . . .<sup>79</sup>

For purposes of discussion, the 1965 amendment can be conveniently outlined in the following fashion:

#### A. *Definition of Dangerous Drugs*

The amendments categorize dangerous drugs as either depressants or stimulants. Depressant drugs include all drugs containing "any quantity of barbituric acid or any of the salts of barbituric acid" (a definition which does not encompass many common tranquilizers); stimulant drugs are those containing "any quantity of amphetamine, any of its optical isomers, or any salt of amphetamine."<sup>80</sup> The definition of a depressant or stimulant drug, however, includes the following significant language:

any drug which contains any quantity which the Secretary, after investigation, has found to have, and by regulation designates as having, a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect. . .<sup>81</sup>

This language is the authority for controlling hallucinogens and nonbarbituric tranquilizers under the amendments. The Secretary of Health, Education, and Welfare is granted discretion to exempt certain drugs from the coverage of the amendments.

#### B. *Acts Forbidden*

With certain exceptions the 1965 amendments forbade the manufacture of depressant or stimulant drugs.<sup>82</sup> Permitted to manufacture, however, were manufacturers who were properly registered and who produced drugs for use in research, teaching, medicine or for chemical analysis.<sup>83</sup> Sales were prohibited except by those legitimately in the chain of distribution and only in the ordinary and authorized course of their business. Finally, possession (a) other than for personal use of the possessor or a member of his household or (b) for administration to an animal owned by him or by a member of his household, was forbidden.<sup>84</sup>

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79. Pub. L. No. 89-74, § 2, 79 Stat. 226 (1965).

80. Pub. L. No. 89-74, § 3a; Rosenthal 1052.

81. Pub. L. No. 89-74, § 3a.

82. *Id.*, § 3(b).

83. *Id.*, § 3b; Rosenthal 1056-57.

84. *See generally* Pub. L. No. 89-74, § 3b; Rosenthal 1057-57. In 1968 possession of dangerous drugs for personal use was made a crime. Pub. L. No. 90-639, 82 Stat. 1361 (1968). This change in the law was largely occasioned by the growing use of LSD.

### C. Registration, Records and Enforcement

The federal law was changed in 1962 to prescribe annual registration with the Food and Drug Administration for those manufacturing *any* drug, no matter what its type or character.<sup>85</sup> The 1965 amendments, however, further required manufacturers to include in their registrations whether they were manufacturing or processing any dangerous drugs.<sup>86</sup> In addition, the amendments demanded registration for wholesale distributors of dangerous drugs.<sup>87</sup> With certain exceptions, however, pharmacies, hospitals, clinics, and physicians did not have to register.

Registration was not the only requirement of the 1965 amendments. Individuals who manufactured or disposed of dangerous drugs had to prepare a record of each drug on hand when the amendments went into effect and continue to keep future records of the manufacture and handling of such drugs. These files were subject to inspection and copying by the appropriate officials of the Food and Drug Administration.<sup>88</sup> Again, with certain exceptions, licensed physicians were exempted from all record-keeping provisions contained in the amendments.

It is interesting that enforcement of the dangerous drug laws was first placed in the hands of the Food and Drug Administration in the Department of Health, Education, and Welfare—an agency responsible for the general health and not particularly involved with law enforcement. In 1968, however, jurisdiction over dangerous drugs was transferred from the FDA to the Justice Department.<sup>89</sup>

These amendments were the final piece of legislation which preceded the Comprehensive Drug Abuse Prevention and Control Act of 1970, with Title II of that Act otherwise known as the Controlled Substances Act.

### PART III—*The Controlled Substances Act of 1970*

The Comprehensive Drug Abuse Prevention and Control Act of 1970<sup>90</sup> repealed almost all prior federal drug legislation and created a new and comprehensive scheme for federal drug control. For the first time, one statute governed both narcotics and dangerous drugs. Enforcement of all drug laws was placed in the hands of the Bureau of Narcotics and Dangerous Drugs (BNDD)—an agency created in the Justice Department in 1968 to combine

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85. Drug Amendments of 1962, Pub. L. No. 87-781, Title III, § 302, 76 Stat. 780 at 795 (1962), 21 U.S.C. § 360(b) (1970); Rosenthal 1055.

86. Pub. L. No. 89-74, § 4. Rosenthal 1056.

87. Rosenthal 1056.

88. See generally Rosenthal 1058-59.

89. Reorganization Plan No. 1 of 1968, § 2(a), 28 USC § 509 (1970).

90. Pub. L. No. 91-513, 84 Stat. 1236 (1970), 21 USC §§ 801 et. seq. (1970).

the enforcement powers of the Bureau of Narcotics in the Department of Treasury and the Drug Abuse Control Bureau of the FDA in the Department of Health, Education, and Welfare.<sup>91</sup> Although the 1970 Act totally revamped the existing pattern of drug control, a great deal was borrowed from prior legislation—a fact that will become apparent as the provisions of the Act and the federal regulations implementing it are analyzed.

#### A. *Jurisdiction to Legislate*

As had been forecast by the Narcotics Manufacturing Act of 1960 and the 1965 amendments to the Federal Food, Drug and Cosmetic Act, authorization for the new legislation was found in the interstate commerce clause and not in Congress' power to collect revenue. The cumbersome system of taxes established by the Harrison Act and the Marihuana Tax Act was thus abrogated.

#### B. *Controlled Substances*

The Act establishes five schedules of controlled substances which include all of the substances previously defined as either narcotic or dangerous drugs.<sup>92</sup> Because the schedule I substances have a high potential for abuse, have no currently accepted medical use for treatment in the United States, and cannot be used safely even under medical supervision, they are subject to rigid controls. Drugs in schedule I include certain opium derivatives—such as heroin and hallucinogens—such as LSD, marihuana, and mescaline. Schedule II substances are also rigidly controlled since they too have a high potential for abuse and may lead to severe psychological and physical dependence. Unlike schedule I substances, however, they do have a currently accepted medical use in this country. In this schedule are included, among others, the synthetic opiates such as methadone, the opium poppy and poppy straw, coca leaves, and their derivatives, and any injectable liquid containing methamphetamine.

Substances in schedule III have a potential for abuse less than the substances in the first two schedules and a currently accepted use in medical treatment. Abuse may lead only to moderate or low physical dependence or high psychological dependence. This schedule includes stimulants, depressants, nalorphine, and substances containing certain limited quantities of specific narcotic drugs.

Schedule IV substances also have a currently accepted medical use for

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91. Reorganization Plan No. 1 of 1968, 28 U.S.C. § 509 (1970).

92. 21 U.S.C. § 812 (1970).

treatment, but they have a low potential for abuse in comparison to those substances in schedule III. That is not to say that the use of schedule IV substances cannot lead to limited physical or psychological dependence. Schedule IV contains such drugs as phenobarbital and chloral hydrate.

Schedule V substances, like substances in the prior three schedules, have a currently accepted medical use for treatment in the United States; but when compared to any of these other substances, those in schedule V have an even lower potential for abuse. This schedule consists of substances which, even though they may contain small quantities of specific narcotics, also contain enough non-narcotic medicinal ingredients to confer upon the compound or mixture valuable medicinal qualities other than those possessed by the narcotic content alone. Thus, paregoric or cough medicines containing small amounts of codeine would presumably be considered a schedule V controlled substance.

The 1970 Act also includes detailed criteria for the classification of controlled substances into schedules. It gives the Attorney General rule-making power to add a substance to a schedule or transfer substances between schedules if, after making the appropriate findings prescribed for each schedule, he determines that any substance has the requisite potential for abuse.<sup>93</sup> Conversely, the Attorney General may remove a drug from all schedules if his findings do not warrant inclusion of the drug in any of the five schedules. Proceedings to make such determinations may be initiated by the Attorney General on his own motion, at the request of the Secretary of HEW or on the petition of any interested party.

Before initiating such proceedings, however, the Attorney General must request scientific and medical evaluations and recommendations from the Secretary of HEW. The Secretary will recommend whether or not the substance should be controlled, and, if so, in what schedule it should be included. In making his decision, the Secretary will consider, among other things, the state of current scientific knowledge regarding the drug, scientific evidence of its pharmacological effects, the risks to the public health, and its psychic or physiological dependence potential. Although the ultimate decision on control lies with the Attorney General, he is bound by the findings of the Secretary of HEW. For instance, if the Secretary recommends that a substance not be controlled, the Attorney General may not control it.

The above described procedure is slightly modified when United States international obligations existing on the effective day of the Act require that a substance be controlled. In that case, the Attorney General may control a

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93. 21 U.S.C. § 811 (1970).

substance under any schedule he deems appropriate without first consulting the Secretary of HEW.

Before concluding this discussion, two final points should be mentioned. First, the Secretary of HEW must inform the Attorney General whenever a new drug application for a stimulant, depressant, or hallucinogenic drug is presented and the drug appears to have an abuse potential. Second, although the distinctions between narcotic and dangerous drugs have been somewhat blurred by the 1970 Act, certain of its provisions continue to distinguish between them, resulting in the need to define a "narcotic drug." Unfortunately, the definition provided by the Act is not sound from a pharmacological viewpoint. It encompasses not only true narcotics such as opium and its derivatives, but also cocaine, a drug which cannot be classed as a narcotic under any medical definition of that term.<sup>94</sup>

### C. Requirements for Individual Registrants

Although registration requirements may sometimes be waived, those who manufacture, distribute or dispense substances controlled by the Act must register annually with the Bureau of Narcotics and Dangerous Drugs in accordance with the regulations of that agency.<sup>95</sup>

A separate registration must be filed for each principal place of business or professional practice where the applicant manufactures, distributes, or dispenses controlled substances. To assure proper registration, the BNDD is empowered to conduct administrative inspections of the "controlled premises"—the physical plant of a registrant or applicant—to see that the statutory standards are being met. The Bureau may also conduct investigations to verify or copy various records required to be kept by the Act. In most cases, an administrative warrant is required.<sup>96</sup>

In certain respects, however, the provisions of the Act differ slightly with regard to manufacturers, distributors and dispensers. Accordingly, each category of registrant must be separately analyzed.

#### 1. Manufacturers

The 1970 Act repealed the Narcotics Manufacturing Act of 1960, which pre-

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94. A narcotic drug is defined, at least pharmacologically, as one that depresses the central nervous system producing stupor, insensibility or sleep. Upton, *Narcotics and Other Drugs Susceptible to Abuse and Their Regulation*, 10 N.H.B.J. 264, 265 (1968). Cocaine is a stimulant, not a depressant.

95. 21 U.S.C. §§ 821-24 (1970). The Attorney General delegated his authority under the Act to the Bureau of Narcotics and Dangerous Drugs. BNDD acts under the general supervision of the Attorney General, however, see 28 C.F.R. Sec. 0.100. Procedure governing the registration of manufacturers, distributors and dispensers of controlled substances are set forth in 21 C.F.R. Part 301.

96. 21 U.S.C. § 880 (1970).

viously governed the licensing of manufacturers and the setting of manufacturing quotas. According to the 1970 Act, the term "manufacture" means:

. . . the production, preparation, propagation, compounding, or processing of a drug or other substance, either directly or indirectly or by extraction from substances of natural origin, or independently by means of chemical synthesis . . . and includes the packaging or repackaging of such substance or labeling or re-labeling of its container; except that such term does not include the preparation, compounding, packaging or labeling of a drug or other substance in conformity with applicable state or local law by a practitioner as an incident to his administration or dispensing of such drug or substance in the course of his professional practice.<sup>97</sup>

With respect to controlled substances in schedules I and II, BNDD will register a manufacturer-applicant only if it finds that registration is *consistent* with both the public interest and any international obligations of the United States. In determining the public interest, certain factors must be considered, among which are.

- a) the maintenance of effective controls against diversion of controlled substances by limiting the importation and bulk manufacture of these substances to the number of establishments which can produce an adequate supply for legitimate medical, scientific, research, and industrial purposes;
- b) an applicant's prior conviction record under federal and state drug laws; and,
- c) an applicant's past experience in the manufacture of controlled substances.

Registration requirements for the manufacture of substances in schedules III, IV and V are somewhat less stringent. These manufacturers will be registered *unless* it is determined that it would be *inconsistent* with the public interest. This places the burden of proof with respect to the public interest on the applicant who wishes to manufacture controlled substances in schedules I or II, but shifts the burden to BNDD with respect to applicants who wish to manufacture substances in the last three schedules.

In addition to meeting stringent registration requirements, manufacturers of substances in schedules I and II must obtain an individual production quota before they can manufacture.<sup>98</sup> Each year BNDD determines the total quantity of each basic class of schedules I and II substances required to be manufactured in order to provide for estimated domestic, export, and reserve needs. Based on this overall production quota, individual production quotas are set so that the aggregate of individual quotas will not exceed

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97. 21 U.S.C. § 802(14) (1970).

98. 21 U.S.C. § 826 (1970). For detailed requirements, see 21 C.F.R. Part 303.

the total amount of the substances needed annually. The Act specifies the requisite factors which BNDD should consider in setting individual quotas. Quotas are not required for substances in schedules III, IV and V.

Once he is registered and, if necessary, has received his manufacturing quota, the Act requires that a manufacturer make a biennial inventory of his stock of controlled substances on hand. Additionally, every registrant must currently maintain a complete and accurate record of each controlled substance manufactured, received, sold, delivered, or otherwise disposed of by him. All such inventories or other records must be kept available for two years for copying and inspection by BNDD officials. In the case of controlled substances which are also narcotics, the records must be kept separate from all other records; in the case of non-narcotic controlled substances, the records need not be separate but must be in such form that information is readily retrievable from the ordinary business records of the registrant. Finally, manufacturers are required to make periodic reports to BNDD of every sale, delivery, or other disposal of any controlled substance.<sup>99</sup>

## 2. Distributors

According to the Act, the term "distribute" means the delivery of a controlled substance, other than by dispensing or administering.<sup>100</sup> Distributors are thus to be considered as wholesalers of controlled substances.

The requirements for registration are essentially those for manufacturers of schedules III, IV and V controlled substances. With respect to a distributor of any controlled substance, BNDD will register him unless the agency determines that the registration is *inconsistent* with the public interest.

Once registered, a distributor may not distribute a controlled substance in a commercial container unless such container bears a label with the proper identifying symbol.<sup>101</sup> A different symbol is required for each *schedule* of controlled substances. In addition, if a substance is included in schedules II, III or IV, the label must contain a clear concise warning that it is a crime to transfer the drug to any other person. With exceptions, distributions of controlled substances in schedules I and II may only be lawfully made pursuant to the written order of the person to whom the substance is distributed.<sup>102</sup> The written order must be on a form provided by BNDD and can only be issued to persons validly registered (or exempt from regis-

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99. 21 U.S.C. § 827 (1970). 21 C.F.R. Part 304 sets the detailed requirements for records, reports and inventories.

100. 21 U.S.C. § 802(11) (1970).

101. 21 U.S.C. § 825 (1970).

102. 21 U.S.C. § 828 (1970).

tration) under the Act. Like the Harrison Act before it, the 1970 Act envisions a distribution system which is regulated by BNDD at every step.

By and large, a distributor must take biennial inventories and keep adequate records just as the manufacturer. His reporting requirements are slightly less burdensome, however. He is required to make periodic reports only with respect to narcotic controlled substances and not with respect to all controlled substances.

### 3. Dispensers

The 1970 Act also applies to those who dispense controlled substances. The term "dispense" means:

. . . to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery.<sup>103</sup>

In effect, dispensers are the retailers of controlled substances.

As with distributors and manufacturers, each dispenser of controlled substances must annually register with BNDD. The four largest groups of dispensers or practitioners, as they are called, are physicians, pharmacists, researchers, and hospitals.

In order to dispense or conduct research with controlled substances in schedules II, III, IV and V, practitioners will be registered if they are authorized to dispense or conduct research under the laws of the state in which they practice.<sup>104</sup> As for research with schedule I controlled substances, an application must be referred to the Secretary of HEW who determines (a) the qualifications and competency of each research applicant and (b) the merits of each research proposal. Even if the Secretary of HEW approves, BNDD may deny the request for specified reasons.<sup>105</sup> Pharmacies—as distinguished from pharmacists—engaged in commercial activities, must be registered to dispense controlled substances in schedules II to V if they are authorized to dispense under state law. Each location must be registered separately, except that a practitioner need not obtain a registration for an

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103. 21 U.S.C. § 802(10) (1970).

104. 21 U.S.C. § 823(f) (1970).

105. Even though drug abuse is a centuries old problem, there is a serious lack of information about how drugs work and their long term effects on the body. In the past there have been strong federal policies against certain types of research. See DEALING WITH DRUG ABUSE, A REPORT TO THE FORD FOUNDATION 14-15 (1972). In the past there has been little federal money spent on drug research, *see id.* at 13. There are recent indications, however, that the federal government is encouraging increased drug research.

office at which he does not dispense or administer controlled substances, but where he only prescribes them and where no supplies of these substances are kept.<sup>106</sup>

Like manufacturers and distributors, dispensers have the obligation to make biennial inventories and keep continuing records of all controlled substances received, sold, delivered, or otherwise disposed of. There are various exceptions to this rule, however, one of which will be discussed here.<sup>107</sup> Under the Harrison Act, a physician was required to keep records of narcotic drugs dispensed showing the amount dispensed, the date, and the person to whom the drugs were dispensed. The physician did not have to keep these records with respect to drugs dispensed to a patient whom he "personally attended."<sup>108</sup> The new law substantially changes these rules. With respect to narcotic drugs in schedules II, III, IV and V, a practitioner need not keep records if he prescribes or administers such drugs in the lawful course of his professional practice.<sup>109</sup> What is significant about the section is the use of the words "in the lawful course of his professional practice." This is the same type of ambiguous language used in the Harrison Act as a qualification of physicians' exemptions from using the special order forms and which led to the *Webb-Linder* line of cases.<sup>110</sup> Whether the 1970 Act exemption will cause an equal amount of litigation remains to be seen. It should be noted that the section does not grant an exemption for dispensing schedule I substances or for anything other than prescribing or administering narcotic substances in schedules II, III, IV or V. Thus, a pharmacist who fills a prescription for such drugs must keep adequate records.

Finally, dispensers, unlike manufacturers and distributors, are not required to make periodic reports to BNDD. Except in an emergency or when dispensed by a doctor, the Act also requires that no schedule II controlled substance which is a prescription drug may be dispensed without the doctor's

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106. 21 C.F.R. 301.23(h)(3).

107. 21 U.S.C. § 827(c) (1970). See also 21 C.F.R. Part 304.

108. Ch. 1, § 2(a), 38 Stat. 785 (1914).

109. Under the new law, it would seem that there is no requirement for methadone maintenance programs to maintain records of the amount of the drug dispensed and the recipients of the drug, since the methadone would be administered in the lawful course of medical practice. An argument could be made, however, that records might have to be kept if the methadone is given to the patient for self-administration—such treatment might not be considered "prescribing or administering" methadone under the meaning of the Act. See Whitford, *The Physician, The Law, and The Drug Abuser*, 119 U. PA. L. REV. 933, 956 and n.96 (1971). In any event, the Food and Drug Administration separately requires methadone maintenance programs to maintain records on patients treated in order to be allowed to use methadone, a drug which has not yet been approved as fully safe and effective. *Id.* at 954-57.

110. See discussion *supra*, and accompanying text.

written order.<sup>111</sup> Schedules III and IV substances may be dispensed pursuant to either oral or written prescriptions.

#### *D. Import and Export*

Title III of the 1970 Act—known as the Controlled Substances Import and Export Act—deals with the export and import of controlled substances.<sup>112</sup> Prior federal law, including the Narcotic Drug Import and Export Act of 1922, prohibited the importation of narcotics such as opium and coca leaves except for limited amounts needed for medical or scientific uses. The new Act forbids the importation of all substances in schedules I and II and narcotic drugs in schedules III, IV and V. The Attorney General, however, may allow the importation of such amounts of crude opium and coca leaves as he finds necessary to provide for the medical, scientific and other legitimate needs of the country. In an emergency when domestic supplies are found inadequate or when there is inadequate competition among domestic manufacturers, the Attorney General may also permit the importation of other prohibited drugs if he finds it necessary to provide for the country's legitimate needs. Crude opium, may not, however, be imported for the manufacture of heroin.

To import a non-narcotic controlled substance in schedules III, IV and V, it must be shown that the drug is imported for a legitimate purpose and pursuant to various requirements prescribed by BNDD.

The export of a narcotic drug in schedules I, II, III and IV is forbidden unless the destination country is a party to certain international conventions on narcotics, maintains a system to control narcotics importation which is deemed adequate by BNDD, the person to whom the narcotic is delivered is licensed by the country of importation, and a proper export permit has been issued.<sup>113</sup> Similarly, BNDD must be satisfied that the narcotic drug is to be applied to medical or scientific uses within the country of import or that there is an actual medical or scientific need for the drug in that country. The statutory provisions governing the export of non-narcotic substances and the transshipment of all controlled substances are less rigid than the export restrictions placed on the export of narcotics.

As in Title II, there are annual registration requirements for importers and exporters.<sup>114</sup> With respect to controlled substances in schedules I or II, an

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111. 21 U.S.C. § 829 (1970). *See also* 21 C.F.R. Part 306.

112. 21 U.S.C. § 951 (1970). The authority and functions of the Attorney General under Title III were delegated to the Director of BNDD under the Attorney General's supervision. 21 C.F.R. Sec. 0.100. Regulations are to be found in 21 C.F.R. Part 312.

113. 21 U.S.C. § 953 (1970).

114. 21 U.S.C. §§ 957-58 (1970).

importer or exporter will be registered if such registration is *consistent* with the public interest and with the international obligations of the United States. Such registration, however, only authorizes import or export of the substances specified in the registration. Alternatively, an importer of a controlled substance in schedules III, IV, or V or an exporter of a controlled substance in schedules III or IV will be registered unless it is *inconsistent* with the public interest. As with manufacturers, distributors, and dispensers under Title II, separate registration is required for each principal place of business where the applicant imports or exports controlled substances.

Title III makes it unlawful for a person to manufacture or distribute a schedule I or II substance with the intent or knowledge that it will be illegally imported into the United States.<sup>115</sup> This provision is intended to reach those who manufacture or distribute these substances outside the United States intending that they ultimately reach the United States. The United States District Court at the point of the offender's entry into the United States has jurisdiction to hear the case.

#### PART IV—*Special Action Office for Drug Abuse Prevention and Office for Drug Abuse Law Enforcement*

On June 17, 1971, by Executive Order,<sup>116</sup> President Nixon established, in the Executive Office of the President, the Special Action Office for Drug Abuse Prevention, the Director of which was to be his official representative in matters concerning drug abuse prevention. In March of 1972, Congress gave the Special Action Office for Drug Abuse Prevention a statutory existence and expanded the responsibilities of its Director, Dr. Jerome H. Jaffe.<sup>117</sup>

##### A. *Special Action Office for Drug Abuse Prevention (SAODAP)*

The Special Action Office for Drug Abuse Prevention<sup>118</sup> is given jurisdiction over all federal programs in the area of drug *abuse*—as distinct from drug *traffic*—prevention. Drug abuse prevention includes programs relating to education, training, treatment, rehabilitation, and research in the field of drug abuse, while drug traffic prevention covers law enforcement activities and diplomatic or international efforts relating to drug traffic. Thus, since the Bureau of Narcotics and Dangerous Drugs primarily enforces federal drug laws, these law enforcement functions are not under the jurisdiction of

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115. 21 U.S.C. § 959 (1970).

116. Exec. Order No. 11,599, June 17, 1971.

117. Drug Abuse Office and Treatment Act of 1972. Pub. L. No. 92-255, 86 Stat. 65.

118. *See id.*, Title II, §§ 201-255.

the Special Action Office. BNDD's educational materials, however, are subject to the control of the Special Action Office.

Within the field of drug abuse prevention, the Special Action Office is charged with (a) focusing the comprehensive resources of the federal government on drug abuse with the immediate objective of significantly reducing the incidence of drug abuse within the shortest period of time; and (b) developing a comprehensive, coordinated strategy to combat drug abuse. One of its main tasks will be to eliminate duplication, overlap, or conflict among federal drug abuse programs and ensure that all federal drug abuse laws, guidelines, regulations, and standards are consistent with each other and with overall national policy. Congress has given the Special Action Office three years in which to accomplish its mission. As of June 30, 1975, the Office is abolished unless, of course, its life is extended by Congress. By that time, it is hoped, the separate federal agencies will be able to proceed in concert in the field of drug abuse prevention.

*B. Functions of the Director of the Special Action Office for Drug Abuse Prevention*

The Director of the Special Action Office for Drug Abuse Prevention is appointed by the President with the advice and consent of the Senate. The main responsibilities of the Director are briefly summarized below:<sup>119</sup>

1. The Director establishes the overall planning and policy objectives for federal drug abuse prevention efforts. He reviews all existing guidelines, regulations, procedures and criteria of federal agencies to insure that they are consistent with his policies, priorities and objectives. If necessary, the Director may recommend that an agency effect changes in its organization, management and personnel.

2. The Director reviews all federal laws relating to health, education, and welfare and assures that the agencies who administer these laws view drug abuse as a health problem.

3. The Director may review implementation plans and budget requests of any federal agency for all federal drug abuse programs. He also has the power to place someone from his office or from some other federal agency in any federal drug abuse program for a short period of time to evaluate the performance of that program.

4. The Director is to encourage certain research and to create, develop and test:

- i. non-addictive synthetic analgesics to replace opium and its derivatives in medical use;

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119. See generally, *id.* §§ 221-223.

- ii. long-lasting non-addictive blocking or antagonistic drugs or other pharmacological substances for the treatment of heroin addiction; and
- iii. detoxification agents which, when administered, will ease the physical effects of withdrawal from heroin addiction.

5. The Director may make recommendations to the President in connection with any federal *drug traffic program*. One of the Assistant Directors of the Special Action Office is to maintain liaison with respect to all federal drug traffic programs.

6. Before any controlled substance is transferred, added, or removed from any of the schedules under the Controlled Substances Act of 1970, the Attorney General must notify the Director. Similarly, the Secretary of HEW must notify the Director, as well as the Attorney General, of any new drug applications which may pose a potential for abuse.<sup>120</sup>

7. The Director is to give technical assistance to state and local agencies in the field of drug abuse, to maintain a clearinghouse for all information on drug abuse, and to draft model legislation for state and local purposes.

8. The Director must report to the President annually, specifying the objectives, activities, and accomplishments of the Special Action Office and accounting for all funds expended.

In carrying out his various responsibilities and functions, the Director has the authority to make grants and contracts with federal departments and agencies and with non-profit private agencies.<sup>121</sup> Similarly, the 1972 Act establishes a National Advisory Council for Drug Abuse to make recommendations to the Director with respect to overall planning and policy and the objectives and priorities of federal drug abuse prevention functions.<sup>122</sup> The Council is composed of the Secretaries of HEW and Defense, the Administrator of Veterans' Affairs and twelve individuals appointed by the President.

### C. *Relation to HEW*

In addition to creating the Special Action Office, the 1972 Act has important consequences for various programs administered by the Secretary of HEW.<sup>123</sup> For instance, the Secretary:

- 1. may not approve an application for a community mental health center grant unless the application provides for a treatment and rehabilitation program for drug addicts where such a program is feasible and needed;

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120. *Id.* § 209.

121. *Id.* § 210.

122. *Id.* §§ 251-255.

123. *Id.* Title IV §§ 401-413.

2. must require that drug treatment and rehabilitation programs be established in appropriate Public Health Service facilities unless he determines that there is not a sufficient need for such a program in a particular institution;

3. is authorized to suspend Federal support to any private or public hospital which refuses to treat a drug abuser in need of emergency medical help;

4. is authorized to make grants to states which submit plans for establishing and coordinating projects for the development of more effective drug abuse prevention methods in the state; and

5. is authorized to make similar grants to public and private non-profit organizations to carry on training, education, research or rehabilitation programs in the field of drug abuse. In addition to his existing responsibilities, the 1972 Act confers additional drug abuse prevention responsibilities on the Secretary of HEW, such as operating an information center for drug abuse matters, publishing statistical data on drug abuse, etc. To assist the Secretary in carrying out his duties, the National Advisory Council on Drug Abuse makes recommendations to the Secretary on matters pertaining to drug abuse. Finally, effective December 31, 1974, the Act establishes, in the National Institute of Mental Health, a National Institute on Drug Abuse to administer the various HEW programs concerned with drug abuse prevention.<sup>124</sup>

Two final aspects of the 1972 Act are worth mentioning. First, in order to coordinate long term federal strategy in the areas of both drug abuse and drug traffic prevention, the Act establishes a high level Strategy Council comprised of the Director of the Special Action Office, the Attorney General, the Secretaries of State, HEW, and Defense, the Administrator of Veterans' Affairs, and other officials as the President may deem appropriate. Second, the 1972 Act recognizes the importance of the confidentiality of patients' records. Thus, records of the identity, diagnosis, prognosis, or treatment of a patient kept in connection with any drug abuse prevention function authorized or assisted under the provisions of the 1972 Act or any act amended by it must be kept confidential.<sup>125</sup>

#### *D. Office for Drug Abuse Law Enforcement (ODALE)*

On February 1, 1972 by Executive Order President Nixon created a new office within the Department of Justice to coordinate the drug law enforcement efforts of the federal government.<sup>126</sup> In a sense, the new office was the

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124. *Id.* Title III §§ 301-305.

125. *Id.* Title IV § 408.

126. Exec. Order No. 11,641, February 1, 1972.

counterpart on the law enforcement side of the Special Action Office for Drug Abuse Prevention. Myles J. Ambrose, former Commissioner of Customs, was appointed Director with a title of Special Assistant Attorney General.

By the terms of the Executive Order, the Director of the Office will advise the President on all matters relating to the more effective federal enforcement of laws relating to illegal drug traffic and on methods by which the federal government can assist state and local governments in strengthening the enforcement of their laws relating to illegal drug traffic. The Director is also mandated to recommend plans, programs, legislation, techniques, and other measures to maximize the country's war on drugs. Specifically, the Director is empowered to develop a concentrated law enforcement program in the federal government and cooperate with state and local governments in enforcing their drug laws.

In operation, the Office of Drug Abuse Law Enforcement has concentrated its efforts at the street level drug trade.<sup>127</sup> Before ODALE, there was little federal participation in enforcing drug laws against the ordinary street pusher. Under Mr. Ambrose's leadership, however, a nationwide network of prosecutors, investigators, and special grand juries has been created to assist state and local authorities in detecting, arresting, and convicting "hard drug" pushers. Presently the Office is operating in at least 33 cities throughout the country.

#### PART V—*Historical Development and Present Status of Federal Drug Penalty Provisions*

Over the past sixty years, Congress has constantly reacted to statistics showing increased drug abuse in America by increasing penalties for drug offenders. A review of the federal penalty provisions will show that the escalation has been consistent and, at times, even dramatic.<sup>128</sup>

##### A. *Pre-1970 Narcotic Penalties*

###### 1. *Early Pattern*

Prior to 1951, there were basically two patterns of penalties depending on the act violated. For convenience, the two patterns can be called import-export penalties and Harrison Act penalties.

a) *Import-Export Penalties*: When the importation of opium was pro-

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127. N.Y. Times, January 29, 1972, p.1.

128. See DEALING AND DRUG ABUSE, A REPORT TO THE FORD FOUNDATION, 300-328 for a discussion of federal expenditures on drug abuse control.

hibited in 1909, the offender was subject to fines "not exceeding five thousand dollars nor less than fifty dollars, or by imprisonment for any time not exceeding two years or both."<sup>129</sup> An identical provision was contained in the 1914 Narcotic Drug Export Act.<sup>130</sup> By 1922, there had been a dramatic increase in import penalties. For violations of the import provisions of the Narcotic Drug Import and Export Act, the penalty was a fine of not more than five thousand dollars *and* imprisonment for not more than ten years.<sup>131</sup> Where prior drug laws had cast penalties in the alternative, either a fine or imprisonment or both, this Act mandated *both* a fine *and* a prison term. The penalties for illegal *export*, however, were not increased.

b) *Harrison Act Penalties*: When it was enacted in 1914, violators of the Harrison Act were subject to a fine of not more than two thousand dollars *or* imprisonment for not more than five years or both.<sup>132</sup> Identical penalties were provided for violations of the Marihuana Tax Act of 1937.<sup>133</sup>

## 2. *Unified Penalties of 1951*

In 1951, however, Congress totally revamped the then-existing penalty structure under prodding from the Bureau of Narcotics.<sup>134</sup> First of all, penalties for all drug offenses were made uniform, no matter how trivial or serious the offense. Thus, the penalties for failing to register as a drug distributor or for illegally importing drugs were made identical. Second, the severity of the penalties themselves was increased by requiring *mandatory* minimum prison terms and by lengthening the possible maximum sentence. A first offense entailed a fine of not more than two thousand dollars *and* a prison term of not less than two nor more than five years. For a second offense, the fine remained the same but the prison term jumped to not less than five nor more than ten years. For a third or subsequent offense, the prison term was increased to not less than ten nor more than twenty years. Of equal significance was a provision which denied both a suspended sentence and any form of probation to a second or subsequent offender.

## 3. *Amendments of 1956*

By 1956, Congress had grown dissatisfied with its handiwork of five years

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129. Ch. 100, § 2, 35 Stat. 614 (1909).

130. Ch. 9, § 7, 38 Stat. 275 (1914).

131. Ch. 202, § 2(c), 42 Stat. 596 (1922).

132. Ch. 1, § 9, 38 Stat. 785 (1914).

133. Ch. 553, § 12, 50 Stat. 551 (1937).

134. Ch. 666, §§ 1, 2, 3, 4, 65 Stat. 767 (1951).

before and decided to increase penalties yet again.<sup>135</sup> At least this time Congress did differentiate between serious drug offenses and those less serious in nature. For illegally importing narcotics or for transferring them without the required order form, the prison term was now set at not less than five nor more than twenty years for a first offense; and at not less than ten nor more than forty years for a second or subsequent offense. The possible fine for first or second offenses was raised to twenty thousand dollars. Penalties for sales of drugs to minors were set even higher; indeed, for a sale of illegally imported heroin to a minor, there was a possibility of the death penalty. Consistent with the increased severity of these penalties, Congress denied the right to a suspended sentence, probation, or parole to even the first offender convicted of a serious drug offense.

Even for less serious drug offenses, such as failing to register and pay the occupational tax, Congress increased existing penalties, although, in doing so, it did not set them as high as for illegal importation or similar offenses. Thus, for a first offense, the penalty was set at a prison term of not less than two nor more than ten years and a fine of not more than twenty thousand dollars. For a second offense, the prison sentence jumped to not less than five nor more than twenty years; and for a third or subsequent offense, to not less than ten nor more than forty years. A suspended sentence, probation and parole, however, were still available to the first offender convicted of these less serious offenses.

#### B. Pre-1970 Dangerous Drug Penalties

As mentioned above, depressant, stimulant, and hallucinogenic drugs were regulated by the 1965 amendments to the Federal Food, Drug and Cosmetic Act and not by the narcotic laws.<sup>136</sup> First offenders were punishable by imprisonment for not more than one year, or a fine of not more than one thousand dollars or both. For a second offense, the penalty was increased to not more than three years or a fine of not more than ten thousand dollars or both.<sup>137</sup> Stiffer penalties, however, were provided for selling dangerous drugs to persons under twenty-one years of age. In such cases, the penalty was a prison term of not more than two years or a fine of not more than five thousand dollars or both.

Just as in the case of narcotic drugs, however, Congress became dissatisfied with these penalties and enacted tougher ones three years later in

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135. Ch. 629, § 103, 70 Stat. 567 (1956).

136. Pub. L. No. 89-74, § 7, 79 Stat. 226 (1965).

137. Ch. 675, § 303(a), 52 Stat. 1043 (1938). For a full discussion of the penalty provisions of these 1965 amendments, see Rosenthal, *supra* note 77 at 1058.

1968.<sup>138</sup> The unlawful manufacture, sale or possession with intent to sell of a dangerous drug was made punishable by up to five years in jail, a fine of up to ten thousand dollars, or both. For selling to someone under twenty-one, the penalty was set higher—imprisonment for not more than ten years, a fine of not more than fifteen thousand dollars, or both. It must be said, however, that Congress did not set mandatory minimum sentences as it did for narcotic violations, nor did Congress deny an offender eligibility for a suspended sentence or probation.

### C. *Present Penalty Provisions for Narcotics and Dangerous Drug Offenses*

The penalty provisions of the Controlled Substances Act of 1970 are complex and variegated, not lending themselves to easy analysis. Five different categories of penalties need be considered.

#### 1. *Unlawful Manufacture, Trafficking and Similar Offenses*<sup>139</sup>

The 1970 Act imposes identical punishment for illegally manufacturing, distributing, dispensing, possessing with intent to manufacture, distribute or dispense, or attempting or conspiring to do any of these acts. The severity of the penalties, however, depends on the type of controlled substance involved.

a) In the case of a controlled substance in schedules I or II which is also a narcotic drug, the person is subject to a jail sentence of up to fifteen years, a fine of not more than twenty-five thousand dollars, or both. Any prison term imposed must be accompanied by a special parole term of at least three years in addition to a prison term. If, for any reason, parole is revoked, the original term of imprisonment is increased by the period of the special parole term.

b) In the case of a controlled substance in schedules I or II which is not a narcotic drug, or a controlled substance in schedule III, the person is subject to a prison term of not more than five years, a fine of not more than fifteen thousand dollars, or both. A special parole term of at least two years is also imposed.

c) In the case of a controlled substance in schedule IV, the prison term is lowered further still to not more than three years; the fine, to not more

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138. Act of Oct. 24, 1968, Pub. L. No. 90-639, § 3, 82 Stat. 1361.

139. 21 U.S.C. § 841 (1970). It should be noted that the 1970 Controlled Substances Act permits search warrants to be served at any time of the day or night if the judge or United States magistrate issuing the warrant is satisfied that there is probable cause to believe that grounds exist for the warrant and for its service at such time. A judge or United States marshal may include a "no-knock" provision in the warrant. 21 U.S.C. § 879(a) and (b) (1970).

than ten thousand dollars. The special parole term is decreased to at least one year.

d) In the case of a controlled substance in schedule V, the prison term is lowered to not more than one year; the fine, to not more than five thousand dollars. No special parole term is imposed.

In each of these categories, the prison sentence, fine, and special parole term are doubled for a second offender. Penalties are also doubled for anyone eighteen years or older who distributes a controlled substance to someone under twenty-one.

These general penalty provisions applicable to manufacturing and trafficking offenses admit of many exceptions. These exceptions, however, fall into two basic categories. One scales down the criminal penalties; the other substitutes civil for criminal penalties.

The first category includes such offenses as: 1) a registrant's knowing and intentional distribution of a controlled substance in schedules I or II in the course of his legitimate business without a proper order form; 2) the use of a fictitious or revoked registration number; 3) the acquisition of a controlled substance by fraud, forgery, or misrepresentation; and 4) the use of the mails, telephone, radio, and all other means of communication to commit or to facilitate the commission of a felony under the Act.<sup>140</sup> For such offenses, the penalty is imprisonment for not more than four years, a fine of not more than thirty thousand dollars, or both. There is no special parole term imposed. For a second offense, the fine and jail term are doubled.

Only civil penalties are provided for the second group of offenses—offenses which are considered only minor infractions of the 1970 Act.<sup>141</sup> Thus, for a registrant who manufactures a controlled substance in schedules I or II which is either not expressly authorized by his registration or is in excess of his assigned manufacturing quota, the penalty is a fine of not more than twenty-five thousand dollars. The same penalty is provided for someone who removes or obliterates required symbols or labels on packages or who fails to keep, make, or furnish any record or report required by the Act. However, if any of these offenses (for which a civil penalty is provided) is committed knowingly or after a prior offense against the drug laws, the person convicted becomes liable for imprisonment as well as for a fine.

## 2. *Unlawful Possession*<sup>142</sup>

For unlawful possession of a controlled substance in any one of the five

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140. 21 U.S.C. § 843 (1970).

141. 21 U.S.C. § 842 (1970).

142. 21 U.S.C. § 844 (1970). It should be noted that any person who distributes a

schedules the punishment is a prison term of not more than one year, a fine of not more than five thousand dollars, or both. Penalties double for a second offense.

A special procedure is available to the first offender. Where the offense is his first, the court is empowered to defer further legal proceedings and place the offender on probation. If he does not violate the conditions of his probation, the court will discharge the offender and dismiss the proceedings against him.

### 3. *Continuing Criminal Enterprise*<sup>143</sup>

For a person who engages in a continuing criminal enterprise, the 1970 Act changes its pattern somewhat, requiring (a) that a *mandatory* minimum sentence of ten years be imposed (life imprisonment is the maximum); (b) that a fine of not more than one hundred thousand dollars be assessed; (c) that a suspended sentence or probation not be granted; and, finally (d) that any profits garnered in the enterprise be forfeited to the United States. A person is considered to be engaged in a continuing criminal enterprise if he (a) commits a felony which is part of a continuing series of drug offenses; (b) acts in concert with at least five other persons to commit these offenses; (c) commands some organizational or supervisory position with respect to the group; and (d) obtains substantial income from the enterprise. The provision is clearly aimed at the importer and the high level dealer who commands a drug distribution network.

### 4. *Dangerous Special Drug Offender*

Special penalties are also singled out for the so-called "dangerous special drug offender."<sup>144</sup> A defendant who is over twenty-one years of age and has been convicted but not yet sentenced for a drug felony can be declared a dangerous special drug offender in a separate judicial hearing prior to sentencing. If he is determined to be such a dangerous special drug offender by a preponderance of the evidence, the court shall sentence the defendant to imprisonment for an appropriate term not to exceed twenty-five years and not disproportionate in severity to the maximum term otherwise authorized by law for the felony which he committed. In other words, for the sake of protecting the public from further criminal conduct, the period of confinement imposed on a dangerous drug offender can exceed the period of con-

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small amount of marihuana for no remuneration shall be punished under § 844 and not under § 841, 21 U.S.C. § 841(b)4 (1970).

143. 21 U.S.C. § 848 (1970).

144. 21 U.S.C. § 849 (1970).

finement otherwise provided for the particular offense committed. In order to be classified as a dangerous special drug offender, the defendant must meet certain statutory requirements: (a) the defendant must have been previously convicted in a state or federal court of two or more offenses involving dealing in controlled substances—offenses which were committed at different times but each punishable by more than one year in jail; (b) the defendant must have been imprisoned for one of these prior offenses and less than five years must have elapsed between the present felony and his release from prison or the commission of a prior drug offense; (c) the defendant must have committed the present felony as part of a criminal pattern of dealing in controlled substances which constitutes a substantial source of his income; (d) the defendant must have committed his present offense as part of a conspiracy with at least three other persons to engage in a pattern of dealing in controlled substances, and the defendant must have agreed to initiate, organize, plan, finance, direct, manage, gove or receive a bribe, or use force in connection with such dealing.

#### 5. *Import and Export Penalties*<sup>145</sup>

As in the case of unlawful manufacture, the penalties for unlawful import or export of controlled substances depends on the nature of the substance involved. Thus, if a narcotic drug in schedules I or II is illegally imported or exported, the penalty is severe—a prison term of not more than fifteen years, a fine of not more than twenty-five thousand dollars, or both. A special parole term of at least three years is also imposed. The penalties for illegal import of a controlled substance other than a narcotic drug in schedules I or II is imprisonment for not more than five years, a fine of not more than fifteen thousand dollars, or both. A special parole term is also imposed but the length of the term is determined by the type of controlled substance involved.

For a second offense, the statute generally provides double the penalty. Attempts and conspiracies are treated as if the offense attempted or planned had been committed. Finally, the 1970 Act provides civil penalties for transshipment of controlled substances to another country unless such offense was knowingly and intentionally committed, in which event criminal penalties are provided.

#### D. *Interrelationship Between Penalty Provisions*

For purposes of analysis, this article has separated penalties into varying categories, such as penalties for illegal importation, for illegal manufacture,

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145. 21 U.S.C. §§ 960-963 (1970).

for possession, etc. From this it should not be inferred that these categories are separate and distinct. Quite the contrary. Any single offense against the drug laws as often as not involves multiple violations. Take, for example, someone arrested for illegally selling heroin.

1. Under the Harrison Act, there would have been an automatic three-count indictment, charging the defendant with the following violations: (1) selling narcotic drugs not in the original stamped package or from the original stamped package;<sup>146</sup> (2) selling narcotic drugs without the proper written order form;<sup>147</sup> and (3) selling illegally imported heroin, knowing it to have been illegally imported.<sup>148</sup> Possession of a narcotic drug at any time created a presumption that the drug had been illegally imported and the defendant had knowledge of the illegal importation.

2. Under the Controlled Substances Act of 1970, there is a two-count indictment, charging possession with intent to distribute a controlled substance and illegal distribution of a controlled substance.

Although beyond the scope of this paper, interesting comparisons can be drawn between the penalty provisions under the Harrison Act as amended in 1951 and 1956 and the new Controlled Substances Act of 1970. Under the old law a minimum mandatory prison sentence was imposed, while under present law there is generally no minimum required sentence. It would seem that the prosecutor was in a stronger bargaining position under the old law than he is now. Since the 1956 amendments to the Harrison Act imposed harsher mandatory sentences for some offenses than for others, the prosecutor could threaten an offender with the more serious charge unless he cooperated. Under the present law, the prosecutor can never be sure what penalty will be meted out by a judge. As a result, the federal drug offender today may be less disposed to plea bargain and more prone to take the risks incident to a full trial.

### *Conclusion*

Until the turn of the century the basic federal attitude toward the distribution and use of narcotics by the general public was permissive. Narcotic substances and their use were regarded as a matter of personal choice not requiring the intervention of the federal government. This attitude was not inconsistent with a recognition that narcotics were far more dangerous than routine household items and that those who used them might be subject, per-

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146. Act of Aug. 31, 1954, ch. 1147, §§ 6-7, 68 Stat. 1003.

147. Act of Aug. 31, 1954, ch. 1147, § 8, 68 Stat. 1004.

148. Act of Nov. 2, 1951, ch. 666, § (c), 65 Stat. 767.

haps, to moral censure. This general approach was dominant until well into the 1900's.

After the turn of the century there was a shift from a posture of permissiveness to one of repression which was characterized by a federal effort to proscribe the distribution and use of narcotics except within narrow and tightly controlled channels for recognized medical purposes. This approach developed slowly. First, there were the ever increasing tariffs on imported smoking opium, then the outright ban on all imported opium not needed for medical uses, and, finally, there were the regulatory provisions of the Harrison Act, effectively forcing the addict to turn not to the medical profession but to the illicit drug market for his daily supply. This black market became the mechanism by which drugs were distributed in the world of the drug user. Attempts by law enforcement agents to control this market have led to even more repressive federal regulation. Penalties were escalated, informers paid, vehicles seized. When these tactics showed little apparent success, suspicion grew that perhaps it was the local law enforcement systems which were partly to blame. There was talk of "soft judges" who misguidedly coddled criminals. This led to mandatory minimum sentences, thus preventing judges from ameliorating the harshness of the penalties. Most recently, federal agents, in such programs as ODALE, have begun to work directly with local police to combat distribution of drugs at the street level. The end result of this process is a comprehensive federal criminal statute limiting the use of controlled substances and significant federal intervention through the BNDD and ODALE at every level of international, national and local drug distribution.<sup>149</sup>

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149. Still a third federal approach can be termed "medical," for want of a better word. It has not been developed in this article which is designed to focus on federal control of the distribution and use of drugs rather than on the rehabilitation of the addict. This third federal approach categorizes the drug addict not as a criminal but as a patient and looks not to his imprisonment but to his treatment. One of the earliest efforts along these lines was the use of narcotics by the medical profession to treat the addict. This led, in the wake of the Harrison Act, to the creation of the clinics of the 1920's and the dispensation by private physicians of morphine, heroin and cocaine to the drug addict. These early efforts were short-lived due to the vigorous use of the Harrison Act by federal drug enforcement personnel. The same theme emerged again, however, some forty years later, in 1963, with the work of Doctors Dole and Ny-swander. In this instance the narcotic substance was methadone but the medical concern was the same, *i.e.*, the use of a narcotic substance to treat the addict. Methadone treatment did not meet the fate of the clinics of the 1920's. Perhaps sobered by years of enforcement of the Harrison Act in the face of an ever-growing drug problem, methadone was accepted on an experimental basis. It rapidly became an important federal concern and found support in federal monies allocated under the NARA program of 1966 and later legislation. Its use is still technically "experimental" but it remains a strong national theme and is conceived by many as viable federal alternative to the use of the criminal law.

Another form of this medical approach has been to categorize drug addiction as a

Assessing the success of the repressive or drug suppression approach to the drug problem is not the object of this article which seeks only to describe. One observation, however, may be made by way of clarification. The use of criminal law sanctions in the suppression of narcotics operates in at least three different ways. For some, the presence of the law is enough to inhibit use of the interdicted item. The use of drugs is a crime and for many, indeed for most, that is enough.

A second effect of the law is to make drugs hard to obtain. The practical consequence of this is that drugs are not readily available—thereby reducing the possibilities of their use wholly apart from any moral or civic attitudes regarding either the law or the use of drugs. Here again the law succeeds.

The troublesome area of the law's operation is in its application to those in the drug subculture itself. In this area federal drug control legislation presents itself as an effort to prevent individuals who are strongly motivated and determined from buying and selling narcotics. Here the federal drug control legislation operates in much the same way as did prohibition legislation. The test of the effectiveness of the effort is only in part the law itself. Far more important are the national attitudes and infrastructures which apply the law to the problem—the police, the courts, the prisons. It is here that problems multiply, results discourage, and the urge to reassess takes its stand.

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type of character disorder. So conceived the drug addict found a place with the mental case and the alcoholic, all incapable of caring for themselves. This concept led to the authorization of Lexington and Fort Worth in 1929 and later came to full flower in the commitment provisions of the NARA of 1966. This same character disorder theme finds expression in the various therapeutic communities such as Synanon or Phoenix House, designed to get the addict to work through his "problem" in a supportive but drug free environment. This approach has also found federal support through the funding provisions of the NARA act of 1966 and later legislation.