No. 20-71433

In the United States Court of Appeals for the Ninth Circuit

SUZANNE SISLEY, M.D.; SCOTTSDALE RESEARCH INSTITUTE, LLC; BATTLEFIELD FOUNDATION, DBA FIELD TO HEALED; LORENZO SULLIVAN; KENDRICK SPEAGLE; GARY HESS,

Petitioners,

v.

U.S. DRUG ENFORCEMENT ADMINISTRATION; WILLIAM BARR, ATTORNEY GENERAL; TIMOTHY SHEA, ACTING ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION,

Respondents

EXCERPTS OF RECORD
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Matthew C. Zorn
Shane Pennington
YETTER COLEMAN LLP
811 Main Street, Suite 4100
Houston, Texas 77002
(713) 632-8000
(713) 632-8002
mzorn@yettercoleman.com
spennington@yettercoleman.com

ATTORNEYS FOR PETITIONERS SUZANNE SISLEY, M.D.; SCOTTSDALE RESEARCH INSTITUTE, LLC; BATTLEFIELD FOUNDATION D/B/A FIELD TO HEALED; LORENZO SULLIVAN; KENDRIC SPEAGLE; AND GARY HESS

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Mr. INGERSOLL. For example, the State of Indiana just this week is embarking on a program to reach all of its uniformed personnel. We have trained about 1,000 Baltimore police officers and about 1,000 police officers in Washington, D.C., in a program that has as its objective the training of all uniformed personnel in those departments.

Mr. BYRNES. I was trying to get at whether or not this a pretty general application. My next question was going to be whether or not there are areas that just do not take advantage of it. It seems to me a program such as this could prove most beneficial if it were of general application. But if it is very spotty, and we are doing the work for Philadelphia or New York but most other communities are not taking advantage of it, we had better gear in on something that has more universality to it.

Mr. INGERSOLL. I think these programs have reached every State in the Union, Mr. Byrnes, although some more intensively than others, because of demand and the availability of our resources.

I might add to this, also, that we are presently completing 14 conferences being held throughout the United States with the chief law enforcement executives of municipalities and counties of more than 2,500 population at the President's direction; again, this time to establish a definition of division of responsibility between the Federal agency and the State and local agencies and to set up a system not only to enhance our training or intensify our training assistance to these areas, but also to establish a better two-way flow of information.

Mr. BYRNES. Let me ask about the uniform State law.

Can you give me any information as to how many States have the uniform law today?

Attorney General MITCHELL. Mr. Sonnenreich has been directly involved in this program and it is an intensive one where our personnel go out and meet with the Governor and other people of interest in the State. He has been working on this and I would like to have him respond.

Mr. BYRNES. First, was this developed by the Department of Justice or the group that is normally engaged in uniform statutes?

Attorney General MITCHELL. This was developed by the Department of Justice.

Mr. BYRNES. This is Department of Justice-proposed legislation, and this bill is geared into that, at least to some degree?

Attorney General MITCHELL. The problem is to mesh it with our statute, and we obtained the help of the Intergovernmental Relations Committee which has been assisting us in this area.

Mr. SONNENREICH. The original drafting of the bill was performed by the Department of Justice. At that time, we recognized that the National Conference of Commissioners on Uniform State Laws was also working toward a similar goal, so the Attorney General directed members of the Department to work with that committee after we had drafted our bill to make certain that we could join the bills together and reach one result.

I might point out, as a result of that, we had excellent cooperation with them and we are attending their annual meeting. They are holding their national conference on August 1 through 5 in St. Louis, Mo., and they will be considering the Department's bill, which they have reworked and accepted as their proposal.

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I am referring to their Special Committee on Hallucinogenic and Dangerous Narcotic Drug Act.

Mr. BYRNES. Have they accepted a uniform State law proposal?

Mr. SONNENREICH. Yes, sir; the last Uniform Narcotic Act was in 1934 and the last model State Drug Abuse Control Act was in 1965. As to the Uniform Narcotic Act, 48 out of the 50 States accepted it and the other two States, California and New York, have something very similar to it.

As to the act that would touch on the hallucinogens, the amphetamines and other dangerous drugs, some 39 States have some sort of uniform law.

The fact of the matter is that there was a recognition of a need by the Attorney General to update these acts and there happened to be, correspondingly, a similar recognition by the National Conference of Commissioners on Uniform State Laws.

At the White House conference, held on December 3, 1969, with the Governors, the Attorney General did mention we were working with the conference and that we did have this model act ready to discuss with them.

Mr. BYRNES. As I understand it, a good number of the States have enacted and have, for some time, been operating under a uniform act as far as narcotics are concerned and a uniform act for—what is the term you use?

Mr. SONNENREICH. Dangerous drugs.

Mr. BYRNES. But those are of a vintage that is some years back, and just as we here in the Federal Government have tried to bring our laws up to date in keeping with current problems and changes, the act that you now are proposing is a new uniform State act that would replace the other two uniform acts; namely, the uniform State acts on narcotics and the uniform act on dangerous drugs.

I am trying to get a picture of where we are as between the States and the Federal Government, because of the overlapping that is bound to exist.

Mr. SONNENREICH. This was recognized by the President in his message. The first point in his message concerned new Federal legislation and the second point stressed the need for a model act. The States that have passed the model act so far are the States of Maryland, South Dakota, and Louisiana.

Mr. BYRNES. That is what I wondered, how many had enacted the most recent proposal.

Mr. SONNENREICH. Those three States have. We believe that the territory of Guam has also done so but we are not certain. There are some 14 other States that are presently considering the bill actively, among them being States such as New Jersey and Pennsylvania.

Attorney General MITCHELL. There has been some reluctance on the part of the States to go ahead with the uniform legislation until they are assured of Federal passage.

Mr. BYRNES. I would assume there are some showing reluctance, if they see a reluctance at the national level, and they wonder why, and maybe, therefore, they should go slow.

But is it a committee or commission on State laws and has it focused in and given approval, or is that what you hope will be coming up within the next month?

Mr. SONNENREICH. Their committee that had to draw up the bill worked with the Department. We felt there was no conflict of interest and they approved a draft on April 4, 1970.

As a matter of fact, today we are putting the final technical touches on it so it will be ready for presentation before the full conference on August 1.

Mr. BYRNES. It is anticipated that out of that conference hopefully will come an approved uniform law for the States?

Mr. SONNENREICH. Yes, sir; I would like to point out that the Attorney General just made a very valid point. In talking to the State Governors and we have visited some 42 States now, one of their great concerns is they want to be certain that before they move forward with the model law, that we do have a new Federal law, because most of the regulatory provisions and the technical provisions dealing with forms and keeping of records and inventories are tied to the Federal law.

Mr. BYRNES. I thought we should work toward a combined system of Federal and State law that was in conformity and not in confusion and not inconsistent, which has been the case to some degree, at least as I understand the situation, in recent years, and which could very well contribute to the problem.

Attorney General MITCHELL. We believe that is so. If you will address yourself to the first points in the President's message, you will see the recognition at the Federal level and we are trying to implement it.

Mr. BYRNES. This proposal sets up four different categories of dangerous drugs as I understand it. Has there been any tentative allocation of the currently known drugs as between the four categories?

Mr. INGERSOLL. All of the drugs that are presently under control, Mr. Byrnes, have been allocated in those four schedules, and the Senate added some others that were not under control at the time of their addition, one of which is now presently under control.

Mr. BYRNES. Is it specifically in the legislation? I understood that the categories were intended to be somewhat flexible in that the Attorney General would determine which one of the four categories drug A was to be considered in, at any point in time, but that this could be changed from time to time.

What did the Senate do? Did they list it in their report or did they list it in the bill? In other words, where is there a listing?

Mr. INGERSOLL. The listing appears in the bill, Mr. Byrnes. However, under the terms of the bill, the Attorney General can move a substance from one schedule to another on his own motion through administrative action, except in the case of either delisting or removing a schedule I substance to another schedule.

In this case, he must either have congressional approval, or he can remove it to schedule II on his own action, but he can't remove it beyond schedule II in the first instance.

Mr. BYRNES. I am not sure I followed you. Can he move them from IV up to I, but not from I down?

Mr. INGERSOLL. He can move any drug up providing the schedule criteria are met. He can move any drug from schedule II down to schedule III or down to schedule IV and any drug from schedule III down to schedule IV. But if he is going to move down a schedule I

drug, that can be moved only down to schedule II, unless the Congress acts to move it to another schedule or out of the scheduling all together.

Mr. BYRNES. I think you qualified this was the list of the ones that are now under control?

Mr. INGERSOLL. Yes, sir.

Mr. BYRNES. Are there some you know of that would be included in one of the four categories?

Mr. INGERSOLL. Yes, there are some other drugs that are undergoing review at the present time under present administrative procedures which would be brought in under this system of control either at such time that they are controlled under the present procedures or under the provisions of the new law.

Mr. BYRNES. I suppose they are being examined, really, under the present procedures, but also fundamentally under the procedures that you would follow which are established in the new bill or in the new legislation.

Mr. INGERSOLL. The criteria of the new legislation are being considered in examining these drugs.

Attorney General MITCHELL. I think some of the confusion arises out of the fact that the bill does not become effective for 6 months and we have to proceed with our current administrative processes in the meantime.

Mr. BYRNES. Whether or not the legislation passes you ought to know where we are, anyway. I would think this places you in a posture to put the new law into effect without any time gap for something that can be done well and serve of value ahead of time.

One of the areas that concerns all of us, of course, is the importation. I suppose that is mostly in the area of narcotics. Am I right in that?

Attorney General MITCHELL. Also dangerous drugs and marihuana.

Mr. BYRNES. We do have a great deal of that being imported?

Attorney General MITCHELL. Yes, sir.

Mr. BYRNES. What success have we had, Mr. Attorney General, in getting the cooperation of foreign governments? I am under the impression there are some areas where the governments themselves are not too concerned about drugs as a problem, or narcotics as a problem, and the dollars that are involved may outweigh their being cooperative in assisting us. Do we have some problem areas in foreign cooperation with us in this area?

Attorney General MITCHELL. We do and have had more in the past. I think we are finding that these countries that were noncooperative in the past are now beginning to realize they now have this problem. Consequently, they are cooperating more than they have in the past.

This is certainly true of our friends south of the border. They are beginning to recognize they have a local problem as well as a problem of export. We have undertaken negotiations and agreements and implementations of these agreements which I think is a very, very constructive move.

We know because our people see the marihuana burned and the heroin destroyed. We know they have devoted more of their public health and public services to these problems and I personally believe they will continue to do so.

As has been said, 80 percent of the marihuana and 20 percent of the heroin comes in from Mexico so if we make a big dent in those areas, it will be an important step forward.

In addition, as Mr. Ingersoll stated, many of the dangerous drugs that are manufactured in this country are shipped into Mexico and find their way back across the border. Mexico is cooperating in this area through its health services, as well as through its police forces.

As to the situation on the other side of the Atlantic, we have undertaken an active cooperative effort with the French Government. We have an informal agreement to get at the source of heroin that flows from the Middle East through France. They have increased their police force. They are cooperating with us.

The Bureau in the Justice Department is training their agents as they come on and we feel this will continue to be even more meaningful in terms of better law enforcement.

In the Middle East, of course, you do have the economic problem to which you referred. While we feel we are making strides, we have not made the full strides we hope to and we are using every resource of the Government, whether it be the State Department, or NATO, or any other avenue we have to get at this problem. We have made inroads and we hope to continue to make more.

Mr. BYRNES. Is that also true in the Far East?

Attorney General MITCHELL. The Far East is a developing problem. Perhaps Mr. Ingersoll, who has spent so much time on this subject, and who knows more about it in detail, can answer that.

Mr. INGERSOLL. The Far East presently represents a relatively less significant problem than the Middle East or Europe or South America, although if the Middle East and South America become less of a problem, then we foresee that the Far East will become a relatively greater one. We have agents stationed in the Far East, including Vietnam and Thailand, Hong Kong, Singapore, and Tokyo.

The basic problem there, and one which is going to be very difficult to surmount, is that opium which is cultivated and in plentiful supply is grown in areas of these countries—Burma, Laos and Thailand—which are beyond the firm control of the central government. They are in areas that are sometimes occupied by forces that are unfriendly to the central government and of course the opium traffic is a method of supporting some of their activities.

At the present time, all but a very small portion of this opium is consumed in the Far East and relatively little of it comes into the United States. We are doing an intensive evaluation of this observation at the present time to be sure that it is still holding up, and we will be monitoring it very closely to be sure that once the problem on one side of the world is reduced, that it does not pop up in the other area.

But we recognize that there is a definite problem. We are trying to anticipate it and lay the proper groundwork to deal with it when it arises.

Mr. BYRNES. If I understand you correctly, you are suggesting in Southeast Asia there is the use of opium as sort of a strategic, subversive device to undercut the local government and the local population; is that true?

Mr. INGERSOLL. I am not sure that is what I said, Mr. Byrnes. What I am trying to say is that this is a source of income in areas that have traditionally been beyond tight central government control.

Mr. BYRNES. You mentioned that parts of these areas are under control of groups unfriendly to the basic government of the area, and that

they undercut any attempt by the basic government to control opium and its use.

I was wondering whether you were suggesting that there is evidence of that happening, for instance, in Vietnam or Cambodia, or in Laos by the North Vietnamese.

Mr. INGERSOLL. I think it is more a mutual accommodation than using it to undercut. I think the central government is in that kind of a position rather than being undercut or being subverted by opium flow.

In Vietnam, marihuana of course is a significant problem and the government there is making an effort to eradicate sources of marihuana.

Mr. BYRNES. I am sure that you have, not only with narcotics but with dangerous drugs, been in contact with governments around the world. I am wondering whether the problem that probably concerns us more than anything else in this area is the gravitation of young people to the use of drugs.

Is that happening worldwide or is that more a peculiarity of this country?

Mr. INGERSOLL. I think it is more of a worldwide phenomenon, particularly in the developed nations. It is a very serious problem. For example, in Scandinavia where the government has taken drastic steps to control the use of amphetamines, some of the amphetamines have been completely banned for legitimate medical use.

It is a problem in France and throughout Europe. I have been to Europe almost every month for the last 8 or 9 months in dealing with our office there and each time we observe an increasing concern on the part of the governments of countries like France, Germany, England, the Benelux countries, as well as the Scandinavian countries.

I was in Spain not too long ago and it was apparent that marihuana and hashish are moving into and through Spain in great quantities. I just spent a session with the Minister of Interior of Germany who has expressed great concern and has met with us to discuss joint cooperative efforts in this area.

In Australia we have very close relations with a newly established organization that is similar to ours. Until just a few years ago, drugs were hardly known among Australian youth but drug use has spread very significantly in recent years.

I think that in most of these places the primary drug of choice at the present time is cannabis or its derivatives and the synthetic drugs I mentioned before are almost epidemic in Scandinavia and to a lesser degree in Italy and Spain.

Heroin is showing signs of increased consumption in Europe. Sometime last summer two young people were found dead of overdoses of heroin on the French Riviera and this caused great concern throughout the country.

I think this is one reason why the French realized they too are susceptible to this kind of problem and that is why they are mounting a greater effort to curtail it, in addition to having concern for our problem.

The Middle East drug problem has not seemed to have changed a great deal over the last 20 years as far as I can determine. Iran changed from opiate addiction to heroin addiction as its most significant drug problem when it ceased the production of opium in 1966.

It has since returned to opium production and the problem elsewhere in the Middle East again seems to revolve mostly around the cannabis products and the use of opium in its more raw or unrefined form.

Mr. BYRNES. As we have what I think is really a problem of crisis proportions, and since the use of drugs among younger people is prevalent as you point out in the industrialized countries, have any of them had singular success in coping with it and keeping it from getting out of proportion?

Mr. INGERSOLL. In Europe I would say that Sweden is the only country that has really had any length of experience in attacking a single drug problem intensely and that was against the amphetamines. They are still just as concerned as we were a couple of years ago about this problem.

Japan felt that it had a growing amphetamine problem before 1960 and that it was able to curtail it through a combination of more effective, and stricter law enforcement, and an intensive educational campaign. Their statistics indicate that the problem has declined. However, there still is a drug problem among young people in Japan as well.

As far as the other countries are concerned, I think they are in the position we were 10 years ago. They are just beginning to address themselves to it and it is a problem that is growing and growing significantly. We have conferred with the NATO countries very recently who have expressed a great interest in together making an effort to deal with it.

It is obvious they know very little of the nature and the causes of the drug problem. They have come to us consistently to learn from our experience which has not been too good except that we have had a lot of it.

Mr. BYRNES. Do you find that the production of drugs in this country is flowing into those areas and contributing to their problems or is it domestically produced?

Mr. INGERSOLL. To a limited degree we are becoming a source of the problem in other countries. LSD is a case in point. LSD is produced only clandestinely in the United States, and there is some evidence of traffic in LSD between here and Europe. We don't know how much we contribute to the amphetamine and barbiturate problems in other countries except as in Mexico where, as the Attorney General described, the flow of drugs from the United States to Mexico, which does not control the nonnarcotic dangerous substances at the retail level, makes it very easy for them to get into the hands of the people in Mexico and also to come back across the border. So, to that extent, we are a source of supply to them and also there are U.S. firms manufacturing these drugs in Mexico itself.

We are probably a source of supply of some drugs to Canada as well, but there is movement in both directions across the border there.

Mr. BYRNES. The reason I pose these problems is that we might look to some areas of greater cooperation than we received in the past in controlling the international movement of dangerous drugs and narcotics. I guess in the past our concern was with narcotics and in a good share they came from outside this country.

Our big problem is in getting cooperation in that area.

Now, you have added to it the other drugs. I know I have at least heard there was a problem in obtaining appropriate cooperation from

other governments in our program. We have read in the paper of some cooperation from Mexico.

I would gather, from what you say, that is the case. Let me ask you: Do we have a problem as far as Mexico is concerned? Is the Mexican Government cooperating with us in attempting to stop these flows either from this country into Mexico or in the case of marihuana from Mexico into this country?

Attorney General MITCHELL. If I can answer that, Mr. Byrnes, we have met with the officials of the Mexican Government at the highest levels and I am happy to report that the gentleman who has just been elected to the Presidency of Mexico has confirmed those undertakings.

I believe they are perfectly willing to undertake all of these obligations. They do have, of course, the problem of resources since many of these materials are grown in high places and wilderness and this is why we have provided light aircraft and helicopters to them in order for them to ascertain where these crops are grown and to get people in to destroy them.

Since our negotiations with them that took place just about a year ago and were implemented early last fall, they have shown every desire to cooperate and they are implementing them to the extent of their resources.

Mr. BYRNES. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Vanik will inquire.

Mr. VANIK. I would like to ask, Mr. Chairman, what the production is of the very, very dangerous drugs. I am talking about the ones in title I, opium and heroin. What is the source of that drug in the United States? I think you said that 20 percent of it came from Mexico.

Attorney General MITCHELL. That is a rough estimate, and outside of the Asian countries that Mr. Ingersoll referred to, I would believe that you could say the balance of it had its origins in the Middle East.

Mr. VANIK. If it comes from the Middle East, is it a substance which comes principally from Turkey and Iran?

Attorney General MITCHELL. Yes, sir, through the opiums which are made into the heroin.

Mr. VANIK. Many state that the great dangers are the transitions from the milder preliminary drugs and into heroin and opium. Now, if these quantities are coming substantially from the Middle East and from these two countries, Turkey and Iran, why not try to stop production at the source?

Attorney General MITCHELL. I think we have to put it in the perspective that at least theoretically these poppies are grown and opium is derived for medical purposes and they are supposed to be under a controlled crop production and controlled use, but they don't stay under control. They get into the illicit market. That is the problem.

Mr. VANIK. If this is the great problem that we are having with the highly dangerous drugs, what would be wrong with taking some more drastic action? Why should we not consider economic sanctions or an embargo on trade or commerce with a government that seems to let this go on to increase its flow of dollars or increase its trade balance?

Why not an embargo? This was first suggested by my colleague Congressman Peter Rodino of New Jersey, and I thought he had a pretty good idea. If governments are not cooperating in meeting this problem, why not consider this approach in addition to those you have suggested?

Attorney General MITCHELL. Mr. Vanik, I think your position or point is well taken. There have been intensive negotiations with these countries. I don't believe I should comment on it further, because this is really a matter for the State Department who has been working and cooperating with us on the subject matter.

It involves our foreign relations which are not conducted out of the Justice Department, but through the State Department.

Mr. VANIK. Certainly it would seem to me that regardless of what agency of Government may try to work out negotiations, if negotiations fail, would it not be a really strong tool if the President had the authority to order an embargo in commerce and trade with countries that fail to meet either the U.S. standards or what we expect.

I think the United Nations has taken some action in this area also, has it not?

Attorney General MITCHELL. The United Nations does have a problem with which we are involved and with which we work. We felt we could get along better on a unilateral basis. We are not sure this is working to the fullest extent we would like. We have started, as the people in the Foreign Service say, a new initiative with NATO, where we thought we could get at it quicker. To get directly to the point of your question, if our endeavors along the lines of these negotiations do not work out, I would feel we ought to take whatever sanctions are necessary to stop the flow.

Mr. VANIK. We are not yet through with the trade bill. If this authority was placed in the bill, would it not be a useful tool in providing some better cooperation from governments that are failing to control the production and the trafficking in drugs. There are some governments that are involved in the trafficking of opium. Would that be a powerful tool in your shop?

Attorney General MITCHELL. I don't think it should rest in our shop because it involves policy in relation to foreign policy and commerce. It should be directed in those areas because they have to deal with that overall problem.

Mr. VANIK. Mr. Attorney General, this new bill has the effect of repealing all of the existing laws in these four categories, does it not? It is a substitute for existing law?

Attorney General MITCHELL. That is our intention particularly with respect to the classifications of drugs.

Mr. VANIK. I would like to address your attention to title V which deals with offenses and penalties. On page 58 in this section of your bill—I will direct your attention to the language which begins on page 57, subsection 2 of V:

> To import or bring into the continental United States, State of Hawaii, or Puerto Rico from any insular possession or other place subject to the jurisdiction of the United States, or to import or bring into the United States, as defined in subsection 102(z) from any place, a controlled dangerous substance classified in schedules III or IV.

As I understand schedules III or IV those are the milder drugs.

Now, doesn't your language in this bill actually exempt and overlook the importations of the dangerous drugs that are in schedules I and II?

Attorney General MITCHELL. Mr. Sonnenreich advises me that this particular print has a typographical error in it and that it is intended to cover all of them.

Mr. VANIK. In its present form it would exempt the most dangerous drugs, is that correct?

Attorney General MITCHELL. If the reference to these schedules were finite and correct, that would be so, but that is not the intention of the bill.

Mr. VANIK. I would hope not. Permitting the importation of all of the dangerous drugs while we try to clean up the administration of the law internally would seem to be creating a more dangerous set of laws than we presently have on our books.

Attorney General MITCHELL. Mr. Vanik, I would point out that this particular subsection is contained in Senate bill S. 3246. It does contain all of the schedules in that prohibition.

Mr. VANIK. I was dealing with the administration bill 17463. I would assume that you would certainly want this section amended to prohibit the importation of the dangerous drugs in title I and II.

Attorney General MITCHELL. You are absolutely correct, sir.

Mr. VANIK. I have just another question or two. Your bill treats the possession of a first offender as a misdemeanor. Does this apply to both the user and the seller who is a first offender?

Attorney General MITCHELL. It does with respect to the user. The seller, of course, can have possession and be brought in under some of the other penalties contained there, particularly in the conspiracy aspect of it.

Mr. SONNENREICH. The intent of that provision, sir, is to cover simple possession for one's own use. It does not cover the possession with intent to sell.

Mr. VANIK. Without any further legislative history, if we were to take the proposal you have in your bill, would it not have the effect of giving the Federal authorities the right to treat the seller who is a first offender just exactly like the user? It would provide the option, and I am always concerned about the options that are available because that makes the law flexible where perhaps it should not be.

Mr. SONNENREICH. The section you are referring to, I think, is section 507(a) and it refers only to those offenses listed on page 60 of the bill, which is 501(e), which is the simple possession offense. It is restrictive.

Mr. VANIK. You feel that language would prevent its use in the case of a seller?

Mr. SONNENREICH. It only applies, on lines 14 and 15 on page 65, to subsection 501(e) which only deals with the person who is in simple possession. So it would be restrictive.

Mr. VANIK. The bill does something else. In reducing the penalties, and I understand the argument that is made here, you provide for a reduction of penalty for first offenders but you don't distinguish between offenders who are involved in LSD and marihuana or those involved in opium or heroin.

Now, should we treat people who are involved in the heavy drugs and who most probably have already gone through the course of the lighter drugs—should we give them the same option or chance for a lighter sentence that we give the people who are starting into the drug habit?

Mr. SONNENREICH. If I may, I would like to explain some of the philosophy behind this. As you are aware, section 507 does not intend

to give the same treatment to everybody, but places it in the sentencing discretion of the court. There are penalty prohibitions involved, too.

The major emphasis at the Federal level is not at the simple possession stage. It is a useful tool and we do have to use it at times, but in looking over the statistics of arrests, we discovered that of the people who were arrested for possession, and the best statistics we have are the Uniform Crime Reports of the FBI, approximately 98 percent were first offenders for simple possession.

This is not true with all of the other offenses. Therefore, we felt that there had to be some latitude, some flexibility within the law that would allow the court to make the penalty fit the individual that is before it. If it is a situation where you are dealing with a professional criminal, or if you are dealing with somebody who should get the full impact of the law, the judge can do so.

But we are concerned about the fact that you are dealing in one of the largest state offense categories other than drunkenness, and that most of the people who come before the courts are young people with an average age of 20 years and have never come into a confrontation with the criminal justice system before.

So, we did feel there was a need for latitude and discretion. That is why there was not a differentiation as such between the hard drugs and what we call the dangerous drugs, because you are dealing with different types of people. The possesser of the narcotic normally is your addict and there are provisions for the treating of the addict in the one law not repealed which is the Narcotic Rehabilitation Act of 1966. We want the court to have latitude in dealing with that person who was arrested for possession of an amphetamine or possession of marihuana.

We felt that by having a uniform penalty structure at a given level, and the level being the misdemeanor level with these offender provisions, the court could, if it felt it best from the point of view of rehabilitation, to do something other than incarcerate the person.

Mr. VANIK. Does that not disregard what we know about the problem, that the person moves from the lighter substances to the heavy drugs? Are we wrong in assuming that someone who is addicted or is found in the possession of opium or heroin is someone who should be distinct, separate and apart and treated under the statute separately?

Mr. SONNENREICH. We do. There are two possession offenses built into this act. One is simple possession which is treated as a misdemeanor and the other is for distribution.

Mr. VANIK. It may be heroin for his own use. Under that situation, you lighten the penalty and you treat that person the same way. Here is a person whom you apprehend and he has in his possession heroin and you are going to treat him the same way you might treat some youngster at a school who has an amphetamine or is involved in LSD.

It does not seem rational. You will admit that the person who is on heroin or opium has already gone the heavy route. He has traveled the long road. He is well beyond and far beyond the other person.

Mr. SONNENREICH. We are talking only in terms of the first offense; and with the first offense, the problem that you have with an LSD,

or cocaine, or a heroin user, while the drug is different, is many times the same.

What we are trying to do here is to build some of this credibility back into the system because a person who is physically addicted should be treated in a different way through another mechanism which is the Narcotic Addict Rehabilitation Act.

But when we are talking about the kind of person that I think at the Federal level we are most concerned about, and that is the distributor or someone who possesses with intent to distribute the drug, then we feel the felony sanctions should apply to him and we have provisions for that.

Mr. VANIK. You don't feel there should be any modification of that? Do you concur in that, Mr. Attorney General?

Attorney General MITCHELL. I believe I do, Mr. Vanik. It is a close question. I think your observation is perfectly correct, but I would believe that the overwhelming concept is that, on a first possession offense, regardless of whether they have gone this route, that rehabilitation is the more important point than incarceration.

There is the other side of the coin. If he has gone this route, it is quite conceivable that by the time he gets to the hard stuff he is not a first offender for possession. He would be a second or otherwise, and then of course the penalties that apply to the second offender would come into play in the matter.

Mr. VANIK. Before I close my questioning, I would like to have in the record some estimate from probably the Bureau of Narcotics and Dangerous Drugs. And I want to express my gratification to you, Mr. Sonnenreich, for your participation in a crime control discussion in my community. Your office was very, very helpful.

I would like to have an idea of how much or the extent of the import of the highly dangerous drugs into the United States, coming from countries where there is government laxitude.

What percentage of our opium and derivatives come from Turkey and Iran?

Mr. INGERSOLL. Are you addressing the question to me, Mr. Vanik?

Mr. VANIK. Either to you or the Attorney General.

Attorney General MITCHELL. If we knew the answers with any specificity we would be well ahead, but we will endeavor to provide you with the information we have or at least our best judgment on it.

Mr. VANIK. Would I be in error to estimate that over 60 percent of the heavy drugs came in from those two countries? Would that be in error?

Mr. INGERSOLL. I think it is in error as far as Iran.

Mr. VANIK. I combined the two countries, Turkey and Iran.

Mr. INGERSOLL. To my knowledge, the Iranian opium production is not diverted at this time. They have only been back in it for a year or so now. Of course, it might in the future. The major problem is Turkey and their opium is produced ostensibly for legitimate purposes. However, the internal controls are not adequate to prevent much of this production from being diverted into illicit traffic channels.

Mr. VANIK. Turkey is a strong government.

Mr. INGERSOLL. Turkey is a signatory to international conventions but it has not legislated internally.

Mr. VANIK. If we were to determine how much of the opium and heroin gets into this country from these and hospitals and doctors' offices, what would be the percentage?

Are we not entitled to a breakdown as to how these things get into the country?

Mr. INGERSOLL. Opium is imported legitimately into the United States only in its crude form. Once it gets into the legal channels, very little is diverted into the illegal channels.

Mr. VANIK. What percentage would you estimate?

Mr. INGERSOLL. I would guess of the amount produced, and I would like to correct this if it is necessary later on, but of the amount of narcotic drugs produced in this country from raw opium that is imported, and narcotics can be imported only in the form of raw opium at this time, the only diversion which occurs is from theft and that mainly occurs at the resale drugstore level.

Mr. VANIK. What percentage that gets into the American market gets in through theft?

Mr. INGERSOLL. Less than 2 percent of the narcotics that are abused in the United States. The rest of the narcotics that are abused in the United States are illicitly brought in.

Mr. VANIK. Through illicit import.

Mr. INGERSOLL. Yes.

Mr. VANIK. That would address itself to 99 percent of the problem. If we deal with opium and heroin, how much of that comes from Mexico?

Mr. INGERSOLL. Somewhere in the neighborhood of 15 to 20 percent of the heroin that comes into the United States originates in Mexico.

Mr. VANIK. Any other South American countries?

Mr. INGERSOLL. There is no indication that any significant amount comes from any other South American country.

Mr. VANIK. This accounts for 15, 16, 17 percent. Where would the balance be coming from?

Mr. INGERSOLL. About 75 to 80 percent from the Middle East and about 5 percent from the Far East so far as we know.

Mr. VANIK. That gives us 80 percent of our supplies coming from the Middle East, principally two countries.

Mr. INGERSOLL. Principally, one of those two countries.

Mr. VANIK. If that is contributing 80 percent of the problem, then it seems to me the law ought to have 80 percent of its thrust addressed to that problem and economic sanction would seem to be the best tool. If that takes care of 80 percent of it, it seems to me it is not a tool we can overlook. It looks to me as if we are overlooking a really effective approach.

It seems to me, Mr. Attorney General, we can address ourselves to this approach within this committee and it is proper within our jurisdiction. It seems to me there ought to be some legislative way of making a determination that one or two countries in this world are not good neighbors, are violating the accord that they have, or should have, and consideration they should have for their fellow neighbors and, perhaps, we ought to set up a system that would provide for an embargo, or suspension of trade, or even suspension of relationships until

they can bring under check and under control the problems which threaten our Nation and the rest of the world.

Attorney General MITCHELL. Mr. Vanik, I quite agree with your concept. As you know, the Bureau of Narcotics and Dangerous Drugs has spent a good deal of its efforts in stopping these dangerous drugs and narcotics from getting out of their source, or at least the source where they are refined. I say again that this, however, is a matter of implementation of what we have been trying to do for the past year through negotiation, aid, and other approaches.

The implementation of it, I think, has to be considered through the State Department and the Commerce Department and not the Justice Department. We are all for cutting off the source in any way that is in the best interest of this country.

Mr. VANIK. This committee has just reported out, tentatively, a trade bill, the ostensible purpose of which is to bring about an agreement in the area of textiles and shoes. If we can pass legislation to provide for so-called orderly trade by forcing other countries in the world to reduce their export to the United States to the degree that they do in certain items, it seems to me that the tool would be equally available and very effective to control the import of dangerous drugs.

We could give them time for adjustment, but it seems to me that such a tool in the hands of the Federal Government could take care of 80 percent of the input of these dangerous items. It seems to me we are losing a good bet in not moving in that direction.

Attorney General MITCHELL. Turkey has moved quite far down the road in this direction, starting off with a substantial number of its Provinces where this crop is grown, and they are now down to six Provinces . The concept of it is that the opium grown in those six or seven Provinces will be under controlled harvesting and processing for legitimate uses.

They have also undertaken to provide additional personnel and equipment this year to try to bring this under control. We don't believe that it will solve all of our problems, but they are moving in that direction. This does not, however, remove my desire to have whatever is appropriate, by way of negotiation leverage or otherwise, to bring it under control so that we don't have this flow because the quantities produced are enormous in connection with the ratio of the amount that is necessary to bring it into our country to cause the problems we have.

Mr. VANIK. If such language could be written into the trade bill or in a subsequent bill and if the machinery for implementing it were established and carried out, would you consider that a helpful tool or a tool you would not need?

Attorney General MITCHELL. As far as the Justice Department is concerned, any legislation or administrative action that can cut down the production and the introduction into the illicit traffic of opium products that produce heroin, be the country Turkey or another, we, at the Justice Department, would be in favor of it because that is just what our activities overseas address themselves toward.

I would point out the national interest in this area should be considered by the State and Commerce Departments and whatever other interests of Government are involved.

Mr. VANIK. I thank the chairman.

The CHAIRMAN. Mr. Betts will inquire.

Mr. BETTS. Mr. Attorney General, to me your presentation has brought out the seriousness and complexity of this problem and I want to compliment you and your colleagues here at the table for indicating your interest in trying to solve it. I appreciate your appearance and your presentation.

Attorney General MITCHELL. Thank you, sir.

Mr. BETTS. You did mention that about 31 States have the no-knock provision in their laws.

Attorney General MITCHELL. That is correct.

Mr. BETTS. I presume that has been in the law in the individual States for some time; is that correct?

Attorney General MITCHELL. The powers in most of these States exist under the case law as distinguished from statutes. I would point out, in connection with that, that most of them are exercised by the police departments and the State law enforcement agencies without the requirement of the warrant that we have provided for in our bill.

Mr. BETTS. In other words, most of the States have a more severe no-knock provision than you are presenting to us in this bill; is that correct?

Attorney General MITCHELL. Yes, sir; there is no question about it. I would point out this is also true of the District of Columbia here, so far as the powers of the police that presently exist.

Mr. BETTS. To your knowledge, has there been any outspoken criticism of these practices in the 31 States that you have mentioned?

Attorney General MITCHELL. I believe you would have to look at that from two sides. As far as the criminal justice system and law enforcement is concerned, they have always felt it was a necessary tool they have to carry out law enforcement activities. I am sure there have been criticisms of it from certain segments of the community, in general, and, perhaps, as to an isolated application, but it is a well accepted part of the criminal justice system in those States.

Mr. BETTS. And it has been accepted by the judicial systems of those States?

Attorney General MITCHELL. Yes, sir.

Mr. BETTS. Would you assume, as far as these 31 States are concerned, this provision has been successful in fighting this problem; is that correct?

Attorney General MITCHELL. It has been successful in their criminal justice system and in their law enforcement.

The CHAIRMAN. Mr. Corman will inquire.

Mr. CORMAN. Thank you, Mr. Chairman.

Mr. Attorney General, the changes in penalties you recommend on first offense, simple possession is very badly needed. The great dilemma in prosecution has been that problem of literally destroying a young man or young woman's life for an offense of which a great many young men and women are guilty and I think that part of the bill is a big step forward.

As I understand it, people may legally possess quantities of those drugs listed in schedules II, III and IV if they get them legally through prescription; is that correct?

Attorney General MITCHELL. That is correct, because those are the drugs that have some medical benefits to them. The schedule I drugs do not.

Mr. CORMAN. How do you ascertain what is probable cause for arrest for simple possession in those categories?

Attorney General MITCHELL. I think Mr. Sonnenreich can put this in a better frame than I might.

Mr. SONNENREICH. The standard that is used is the same standard under existing law, Congressman. Normally these drugs are prescribed in prescription bottles and normally the requirement is that the drug must be in a prescription bottle. The usual practice with many people is that they take them out of their bottles. If a person is confronted with a possession situation, especially in a commonly used type of drug such as barbiturates, normally what happens in that case is that that person has only to show he did get it by prescription, or he or she could have gotten it directly by a doctor without a prescription by way of a sample or something of that nature.

Although it is a hypothetical problem, it is not too much of a problem for us.

Mr. CORMAN. Are you familiar with the lady who was arrested in Operation Intercept for having amphetamines and was subsequently acquitted in a California court? That is the reason I was concerned about it. She was arrested with the bottle of common diet pills that her doctor had given her. Subsequently she submitted an affidavit from the doctor, but she was still prosecuted in the State court after it was referred by the Federal authorities. Although she was subsequently acquitted it was a terrible experience for her and cost her some $2,000.

That is the reason I wondered about enforcement. I would assume an officer would take into account the character of the person, whether or not that is the kind of person who might have diet pills in her possession.

That was such a harsh case that I was really confused about how you enforce that part of the law.

Attorney General MITCHELL. I would assume from the description you have provided that that was probably a customs case and not a Bureau of Narcotics and Dangerous Drugs case.

I would hope the U.S. attorney to whom that was referred would have had a better insight into the situation and examined it further before proceeding with it. That is where the responsibility lies.

Mr. CORMAN. In fairness to the Justice Department, it was handled by the State of California and the county's district attorney. As you pointed out earlier, normally the Federal Government does not prosecute simple possession cases.

If we could turn a moment to the continuing criminal enterprise, page 68 of the bill. As I understand it, penalties may be substantially increased if there is established continuing criminal enterprise on the part of the defendant and that does not require any prior convictions; is that correct?

Mr. SONNENREICH. That is correct, sir. The intent was also to reach at the first offender because experience has shown that in many cases you only get some of the professional criminals once.

Mr. CORMAN. I cannot quarrel with your objective. On the other hand, it seems to me that it is a rather substantial departure from present administration of criminal law.

Does the continuing criminal enterprise have to be connected in any way with narcotics?

Mr. SONNENREICH. No, sir; not with narcotics as such, but I should point out the caveat is there must be a felony for which the man is convicted, so this automatically eliminates the simple possession offenses from it.

Mr. CORMAN. The second possession offense is a felony.

Mr. SONNENREICH. Yes, sir.

Mr. CORMAN. On a second possession conviction a man may receive life imprisonment because of continuing criminal enterprise and it has nothing to do with narcotics and for which he has never been convicted. It seems to me we have to look closely at what it is we are going to prove to raise the gravity of the offense to that severity and what guarantees there are for the protection of the individual's rights.

Mr. SONNENREICH. If I could comment on that, Congressman, on page 71, with that kind of person, the Government would have to prove that he has played a continuing role in criminal enterprise involving any violation of this act in concert with at least five other persons and he had to occupy a position of organizer or supervisor or other position of management; or the second category is the category that is used in the income tax evasion cases.

The language is the same until page 72, which talks about he has or had under his own name or under his control substantial income or resources not demonstrated to have been derived from lawful activities or interests.

The burden in both of these tests, in addition to the substantive offense which must be proven to a jury and of which the jury must find him guilty, is argued before the court which has to consider those two factors and we have to go forward with our burden of proof.

Mr. CORMAN. The jury finds him guilty of the first offense which must be a felony. The jury does not make a determination about his being involved in the continuing criminal enterprise, does it?

Mr. SONNENREICH. No, sir; that is done by the court.

Mr. CORMAN. Must he fall under (f) to come within continuing criminal enterprise? Are those all limited to a defendant who qualifies under (f)?

Mr. SONNENREICH. He must qualify under (f) to be found guilty of being involved in a continuing criminal enterprise.

Mr. CORMAN. Back on 69 it says:

> If it appears by a preponderance of the information, including information submitted during the trial of such offense and the sentencing hearing and so much of the presentence report as the court relies upon, that the defendant is involved in a continuing criminal enterprise, the court shall sentence him * * *

and then sets out the more severe penalty.

Where does that bring (f) in as a requirement?

Mr. SONNENREICH. That is talking about what is, in effect, a second trial before the court. The intent of this provision is that the actual offense would be tried by the jury. Whatever information came out during the trial could also be added to the proof that the Government would have then have to proceed with before the judge as to proving that the individual is involved in a continuing criminal enterprise. The use of the term "preponderance of the information" was to bring forward the fact that what you are involved with here is really a sentencing determination.

The intent of our provision was to isolate these people via the sentencing structure from other people who are involved in primarily

the trafficking offenses that might not have this much culpability in terms of assessing a penalty.

We feel it is necessary to take whatever information the jury has found or has been adduced at trial and add it and present it also to the judge when he must consider the factors under (f), but (f) is the controlling factor before this person can be adjudged guilty of this particular offense of continuing criminal enterprise.

Mr. CORMAN. Is continuing criminal enterprise a separate offense?

Mr. SONNENREICH. Yes, sir; we have made it so from the viewpoint of sentencing.

Mr. CORMAN. What is the reason for reducing it from beyond reasonable doubt to preponderance of evidence if it is a separate offense?

Mr. SONNENREICH. The reasoning behind that is that the standard of "beyond a reasonable doubt" as to the substantive offense has been made by the jury in finding that he is guilty of that offense. The thrust here is that we are involved in a sentencing determination. In most of the cases that go before a judge, when you have very wide penalty limits, say, from five to life, which would apply to anybody who was convicted of a criminal offense such as narcotic trafficking, the judge then must take into account extenuating circumstances, mitigating circumstances and other factors in reaching his final sentencing determination as to what the exact penalty will be.

At that stage, he does not have to be satisfied "beyond a reasonable doubt." He goes by a preponderance of the information. This, I might point out, is not something that was created new to life by the Department. We did look at the Model Penal Code. We did look at other philosophies along this line. This has been discussed by the National Committee to Reform the Federal Criminal Laws.

Mr. CORMAN. Is this provision in some other proposals before the Congress now?

Attorney General MITCHELL. It is substantially the same as the one in S. 30, now before the House Judiciary Committee, on organized crime.

Mr. CORMAN. If either that bill or this one passes, they would have the same effect? In other words, if a person is convicted of a felony and he falls in the category of this continued criminal enterprise, does it matter what kind of a felony?

Attorney General MITCHELL. This is limited to the purposes covered by this act and of course the organized crime bill is related to the participants in organized crime.

Mr. CORMAN. Do I understand correctly then that you are just asking for it in relation to narcotics offenses. For instance, it would not apply in bank robbery or other kinds of felonies.

Attorney General MITCHELL. No, sir, except insofar as it may be under consideration by the Commission that is rewriting the Federal penal statutes. That, of course, is not under the Department of Justice and I am not sure what the status of it might be there.

Mr. CORMAN. Back on 69, paragraph (b) there is a provision that the judge may withhold from the defendant information on which he is basing his decision. I wonder if you could comment on that.

First of all, am I readying the law right?

Mr. SONNENREICH. Yes, sir, you are. Once again, this is a sentencing type of situation and many of the factors that the court considers are

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not factors that they normally inform the defendant of. Also, this provision has an impact on confidential informants who might be divulging information and whose identities we would like to remain anonymous but not anonymous to the judge because at that point, he must know the source of the information.

In point of fact, he will make a determination as to the relevancy of the information just as he does during a jury trial.

Mr. CORMAN. I would like to listen to some more of what you have to say and other witnesses, but it seems to me we have a radical departure. We are talking about an offense where a fellow could go to jail for 2 years, with all of the constitutional protections that we give him, but we say in your case we find that you have committed a second offense, different from this.

You have engaged in continued criminal enterprises. To ascertain whether you are quilty of that offense which may put you in jail for the rest of your life, we are not going to let you confront the witnesses who testify against you, we are not going to prove beyond a reasonable doubt these offenses—this disturbs me.

Mr. SONNENREICH. A judge can do this in a preliminary hearing or jury trial also. You can withhold the identities and the right to cross examine confidential informants and in *McCray* v. *Illinois*, the Supreme Court held this to be true.

We are following the limits of what the court has so established. Where information is obtained from a confidential informant and which the Government need not be compelled to have him testify or be identified, at the discretion of the court.

Mr. CORMAN. Do you have a citation on that?

Attorney General MITCHELL. The Department, needless to say, has prepared a memorandum on this subject matter which, if it will help your consideration of it, we will be glad to provide to you. It shows that these provisions have been recommended by such bodies as the National Crime Commission, the American Bar Association Project on Minimum Standards for Criminal Justice, and so on down the line.

This is not a new thought or a new consideration in connection with this bill. If it would be helpful, we would be glad to provide you with such a memorandum.

Mr. CORMAN. I would appreciate it.

The CHAIRMAN. How voluminous is that memorandum, Mr. Attorney General?

Attorney General MITCHELL. It is a memorandum that contains other subject matters which we would reduce and I imagine it would be 3 or 4 pages.

The CHAIRMAN. Without objection the memorandum will appear at this point in the record.

(The information referred to follows:)

SECTION 509 OF H.R. 17463 (CONTINUING CRIMINAL ENTERPRISES)

INTRODUCTION

Section 509 of H.R. 17463 is designed to deal with the organized criminal elements trafficking in narcotics and dangerous drugs. Set out below is a discussion of the historical antecedents for such a provision, analysis of the section itself, and a discussion of the reasons why the Administration favors such a provision.

HISTORICAL ANTECEDENTS

The Advisory Committee on Sentencing and Review of the American Bar Association,[1] the Model Penal Code,[2] and the Model Sentencing Act[3] all favor special treatment for professional criminals. The National Commission on Reform of Federal Criminal Laws included a professional criminal section in its revamping of Title 18.[4]

The professional criminal provision is an example of providing special treatment for the exceptional case. In discussing the merits of providing for exceptional treatment, the ABA's Advisory Committee stated:

"It is common for the legislature to specify in advance the outer limits of the sentence which can be imposed for each offense. These limits will then control, no matter how aggravated the particular offense nor how depraved the individual offender. The natural result is that authorized sentences are fixed with the worst cases in mind, and . . . tend to be considerably higher than are necessary for the average case. The practical consequence of this is that sentences imposed in the average case tend to get pushed up, even though they may still remain far below the authorized maximum.

"In view of this tendency, the Advisory Committee is persuaded that it would be better for the legislature to approach the problem in a slightly different fashion. The suggestion, derived from the efforts of the Model Penal Code and the Model Sentencing Act, is that the legislature address the more typical case when engaged in the process of fixing sanctions, and that the basic limits be geared to this far more numerous class of offenders. Explicit increases should then be permitted based on the existence of factors which seem to call for a more severe disposition. Most cases, perhaps as many as ninety percent, could then be handled within the confines of more realistic and satisfactory limitations, while there would still remain appropriate authority for the case where more severity is needed." [5]

The Advisory Committee cites as an additional reason for this approach that it will tend to eliminate severe disparities in the disposition of comparably situated offenders. Also, such a scheme will protect society by providing the capacity to identify the exceptional cases so that they can be eliminated.

Some states have adopted this pattern of sentencing. The Minnesota sentencing statutes,[6] for example, provide that additional sentences may be imposed if the court finds that the defendant is disposed to the commission of criminal acts of violence and extended terms of imprisonment are required for the public safety. Likewise, a Pennsylvania proposal would provide for extended sentences where the criminal is an exceptional case.[7]

ANALYSIS

Section 509(a) provides that an attorney assigned to prosecute a violation of the act shall notify the court of his reason to believe that an adult defendant is involved in a continuing criminal enterprise involving violations of the act and, upon conviction, should be subject to the penalty provisions of Section 509. Additional provision is made that the continuing criminal enterprise allegation not be an issue at trial nor disclosed to the jury.

Subsection (b) of this section provides that upon a finding of guilty and before imposition of sentence, the court shall set a hearing date to determine whether the person has been involved in the continuing criminal enterprise charged in the notice. Prior to that hearing the court shall inform the defendant and the United States as too the substance of the presentence report on which it intends to rely. The right to counsel, to present evidence, to confront and cross-examine witnesses shall be afforded the offender. If the court in fact finds that the convicted person has been involved substantially in a continuing criminal enterprise, then the court shall sentence him to a term of imprisonment for life, or for not less than five years, a fine of $50,000, and forfeiture of any profits and interests acquired or maintained in violation of the act.

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1 Standards Relating to Sentencing Alternatives and Procedures, Advisory Committee on Sentencing and Review of the American Bar Association, p. 94.
2 Model Penal Code, (1962), § 7.03, (2).
3 Model Sentencing Act, (1963), § 5.
4 Study Draft of a New Federal Criminal Code, (June 8, 1970), Section 3203.
5 *Supra,* footnote 2, p. 83.
6 Minn. Stat. Ann. 609.155, (1964).
7 Joint State Government Commission, Proposed Criminal Code for Pennsylvania. 803–606, pp. 85–87, (1967).

Subsection (c) of this section provides that upon conviction of a second or subsequent offense under this section, the defendant may receive a term of imprisonment for life, or for not less than 10 years, a fine of $100,000 and forfeiture of any profits and interests acquired or maintained in violation of the act.

Subsection (d) provides further that the sentence shall not be suspended nor probation granted. Parole provisions of the Federal law shall not apply.

Subsection (e) of this section confers jurisdiction on the district courts of the United States to take such actions as may be necessary and appropriate in connection with any property or other interest subject to forfeiture under this section.

Subsection (f) of this section sets out the criteria which must be met before a defendant can be deemed involved in a continuing criminal enterprise. The court must find by a preponderance of evidence that the defendant acted in concert with or conspired with at least five other persons engaged in a continuing criminal enterprise involving violations of the act. The defendant must also have occupied a position of organizer or assumed a management role. In the alternative, a court can find a person was engaged in a continuing criminal enterprise if it finds he played a substantial role in a continuing criminal enterprise involving violations of the act and has in his own name, or under his control, substantial amounts of income or resources which he cannot account for as having been derived through lawful activities.

Subsection (g) of this section provides that for purposes of sentences imposed under this section, the time for taking an appeal from a conviction is to be measured from the time of imposition of the original sentence.

Subsection (h) of this section permits review to be taken to a court of appeals by either the defendant or the United States of any sentence imposed under this section.

Subsection (i) of this section provides that no limitation may be placed on information concerning the background, character, and conduct of a person convicted of an offense which a court of the United States may receive and consider for the purpose of imposing an appropriate sentence.

DISCUSSION

The advantage of such a sentencing structure is that it provides two different authorized sentences for each felony, the first available on the basis of the conviction and the second on the basis of a further demonstration that the defendant is engaged in a continuing criminal enterprise related to a violation of the proposed Act. The court is then able to apply the more severe sentence in dealing with the professional criminal, and yet cannot use the stricter sentence in cases which do not fit the statutory criteria. Protection is thus provided to the public while at the same time defendants are guarded against abusive and unwarranted terms of imprisonment.

The criteria provided in the proposed Act with respect to the defendant's age, relationship to an illegal organization, and criminal activities are sound standards. They are similar to those established in the Model Penal Code and those recommended by the ABA's Advisory Committee.[8] They will provide sentencing guidelines so that the judge can make an intelligent determination of the appropriate sentence in each case. This is a much more rational method of determining sentence than is currently provided under many of the existing Federal statutes. For example, a violation of the Federal Bank Robbery Statute, 18 U.S.C. 2113, carries with it a sentence ranging from one day to twenty years with no indication either in the statute itself or elsewhere what criteria ought to be employed in grading offenders on the scale provided. As a consequence, each judge is free to develop his own working rules. One judge may start with twenty years as the presumed term, thereafter reducing the sentence as mitigating factors suggest themselves. Another may start with probation, and work up in severity as factors appear which suggest the need for incarceration. The constitutionality of such sentencing is firmly established, and a similar pattern could have been adopted here. However, such a recommendation would have overlooked the obvious need for legislative reform in this area.

The proposed Act provides additional safeguards in the requirement for a hearing prior to imposition of sentence. There is no similar safeguard provided by the Federal Rules of Criminal Procedure for other Federal convictions. The courts

[8] *Supra,* footnote 2, s. 5 ; 5.5, and *supra,* footnote 3.

have consistently upheld the use of pre-sentence report information even where there was no such hearing and the defendant had no opportunity to rebut the contents of the report. See, for example, *Hoover* v. *United States*, 238 F. 2d 737; *Baker* v. *United States*, 323 F. 2d 862; *Booth* v. *United States*, 380 F. 2d 755, *cert. denied*, 390 U.S. 1015. Other decisions have permitted the courts to use in the sentencing process information which was gathered outside the realm of a formal report prepared by a Federal probation officer. For example, *United States* v. *Garfinkel*, 285 F. 2d 948, *cert. denied*, 365 U.S. 879 (use of information supplied to the court by the FBI); *Stephan* v. *United States*, 133 F. 2d 87, *cert. denied*, 318 U.S. 78, re-hearing denied, 319 U.S. 1143 (Judge conducted interviews with defendant's wife, defendant, a friend, representatives of the FBI, and others).

The hearing provided in the proposed Act would insure fairness and furnish the due process which was absent in *Specht* v. *Patterson*, 386 U.S. 605. That case involved the imposition of an indeterminate term of one day to life under the Colorado Sex Offenders Act following conviction for an offense which normally carried a ten year maximum. The defendant was examined by designated psychiatrists and a written report of their findings was returned to the sentencing court. The Supreme Court concluded that an indeterminate sentence might be imposed only after a hearing at which the defendant was present with counsel, and was afforded the opportunity to be heard and to offer evidence and to confront and cross-examine witnesses.

Present law would permit establishing severe minimum penalties, such as 25 years of imprisonment for all violations of the proposed Act, and including in the sentencing structure provisions whereby the court could sentence a defendant to a lesser term if certain criteria were met. The proposed method of establishing lower maximums for the ordinary case with provisions for higher sentencing of exceptional cases is accomplishing the same thing in substance by means of a different form.

In summation, Section 509 provides for a special sentencing provision whereby a convicted felon may, through established criteria, be singled out by the Government and approved by the court as a type of individual deserving of increased punishment. We believe the procedural safeguards provided are sufficient to avoid any constitutional infirmity, and we are convinced that this provision will be of substantial benefit to the courts and to the public.

The provision for special treatment of professional criminals is important from another point of view. It provides Federal law enforcement with a special point of reference towards which our efforts can be directed. By singling out the professional criminal and devoting the efforts necessary for his eradication, we can accomplish far more than would be done by exposing many lesser offenders to unduly long terms of imprisonment.

Mr. CORMAN. What are the limitations on withholding evidence in a normal criminal case? What is he told about secret informants?

Mr. SONNENREICH. This has always been a great problem area. That is why the Supreme Court has always said it rests with the discretion of the judge. If an informant has given information to a law enforcement agency and that informant was involved in the commission of a crime, for example, he was a person who actually went up to the person and asked him to sell the drugs to him, then that person would have to come forward and testify.

But if the person merely established the probable cause such as in the *McCrag* case where he informed the arresting officers this person was doing such and such and he was not involved in the actual commission of the offense, then that person at the court's discretion, need not be disclosed and he need not be compelled to testify and they held this not to be in violation of due process.

Mr. CORMAN. In that case he is not submitting evidence on which the jury decides the man is guilty. All of that comes from other evidence that his information may have led to, but there is different, distinct evidence I take it about which the defendant knows everything and has an opportunity to cross-examine. Is that what you are talking

about here in (b) where the judge may withhold particular information?

Mr. SONNENREICH. That is it in part, yes, sir.

Mr. CORMAN. What I am really trying to find out is this. Aren't you going further with this bill in refusing to disclose information to a defendant than in the cases permitted so far?

Mr. SONNENREICH. It always rests within the discretion of the judge as to what should be included and what should be excluded. We want to retain that since we are insuring the defendant due process, assistance of counsel and so on.

Mr. CORMAN. It sounds like you are treating this as a separate offense which I assume it really is.

Mr. SONNENREICH. We are treating it more as a sentencing determination, but we are affording him the rights to a sort of trial before the court.

Mr. CORMAN. In a criminal trial you can't let the jury consider something that the defendant does not know anything about, but in this case you can; is that right? The judge has information which he decides he must not disclose to the defendant. Based on that information he decides this defendant should not spend 2 years in jail, he should spend the rest of his life in jail.

Mr. SONNENREICH. This is very similar to when a court makes a determination between a normal offense and an aggravated offense. The court has other information that is not just related to the defendant when they make a sentencing determination. If the court could not withhold this kind of information, Congressman, then the court would have to go into an elaborate factfinding session every time they imposed a penalty or sentence on an individual.

We are not trying to deprive anybody of their due process rights. We are trying to allow discretion to remain in the judge as it does now because it is not just a question of withholding information on probable cause. There may be many factors, such as mitigating factors, that are considered by the court that the defendant himself brought forward.

Mr. CORMAN. The defendant knows about those.

Once you are convicted of a felony under this Act, you may go to prison for life, not because of what you have been convicted of by the jury, but rather because of an entirely unrelated enterprise and you may be in a real sense convicted of that unrelated enterprise on evidence of which you are never apprised.

It does seem to me with all due respect to the groups backing this, it is a rather substantial departure from the administration of justice.

Mr. SONNENREICH. It is related to the narcotic and dangerous drug offense that he has committed. He is apprised of the fact from the very moment he steps into the courtroom when he is indicted because the information is given to him immediately. It is not given to the jury so they will not be prejudiced.

Mr. CORMAN. I understand that. The continuing continual enterprise does not have to involve narcotics. It could involve counterfeiting?

Mr. SONNENREICH. It has to involve any violation of this act.

Mr. CORMAN. I understood you to say earlier it did not have to involve narcotics.

In other words, the only kind of continuing enterprise that he can be sentenced for under this section is one involving narcotics.

Mr. SONNENREICH. Or other dangerous drugs.

Mr. CORMAN. In other words, if he is guilty of continuing criminal enterprise of gambling or any other than drugs thing, that does not bring him within this?

Mr. SONNENREICH. Absolutely.

Mr. CORMAN. I misunderstood your earlier answer. That eases my mind a little bit. I would appreciate that memorandum.

The CHAIRMAN. There are no other questions. You have been very helpful to us in our thinking.

Attorney General MITCHELL. We are always available if you want any additional information from the Justice Department.

The CHAIRMAN. It appears that we may be able to complete the hearings at the close of business next Monday. We will then go into another subject matter on Tuesday and Wednesday. We will be back to this subject probably on Thursday. We will be in touch with you. We will expect you and your various staff members to be with us in executive session.

Attorney General MITCHELL. We appreciate that schedule no end.

The CHAIRMAN. Without objection, the committee will recess until 2 p.m. in this Chamber when Secretary Kennedy will be present.

(Whereupon, at 12:45 p.m., the committee recessed to reconvene at 2 p.m., the same day.)

AFTER RECESS

(The committee reconvened at 2 p. m., Hon. James A. Burke, presiding.)

Mr. BURKE. The committee will be in order.

Our lead off witness this afternoon is the Honorable David M. Kennedy, Secretary of the Treasury.

On behalf of the committee, we welcome you. We wish to apologize for our delay, but there is an automatic rollcall now taking place on the floor of the House. I am sure you understand. You may proceed.

STATEMENT OF HON. DAVID M. KENNEDY, SECRETARY OF THE TREASURY; ACCOMPANIED BY EUGENE ROSSIDES, ASSISTANT SECRETARY FOR ENFORCEMENT AND OPERATION; AND SAMUEL PIERCE, GENERAL COUNSEL

Secretary KENNEDY. On behalf of the Treasury Department, I wish to thank you for this opportunity to appear today to comment upon H.R. 17463 and further to discuss other matters of concern to this committee.

No genuine dispute exists concerning the dangerous dimensions of drug abuse in the United States. I am sure every member of this committee is fully informed on how the overall traffic in drugs has grown in recent years. From the viewpoint of Treasury's Bureau of Customs, which has responsibility for preventing illegal importations of drugs, this rapid escalation is confirmed by smuggling statistics.

In fiscal year 1969, Customs seized 141 kilograms of heroin at U.S. borders and ports of entry—this represents a growth of 300 percent

over fiscal year 1967, 25 percent over fiscal year 1968. Cocaine seizures rose from 18 kilograms in fiscal year 1967 to 44 in fiscal year 1968 to 90 in fiscal year 1969—and in the 1 month of June, this year, we seized nearly 12 kilograms of cocaine. Marihuana seizures are now more conveniently measured in tons—9 tons in June 1970 alone, plus 92 kilograms of hashish, which represents the concentration of 600 times that much marihuana.

No one is more aware of the magnitude of the drug problem than the President. Shortly after taking office, he sent a message to Congress on the control of narcotics and dangerous drugs. In it the President stated:

> The Department of the Treasury, through the Bureau of Customs, is charged with enforcing the Nation's smuggling laws. I have directed the Secretary of the Treasury to initiate a major new effort to guard the Nation's borders and protect against the growing volume of narcotics from abroad. There is a recognized need for more men and facilities in the Bureau of Customs to carry out this directive.

This directive was backed up with a request for a substantial supplemental budget to counter narcotics smuggling. The Congress cooperated fully by passing in late December of 1969 an appropriation of $8.75 million, which provided for 915 additional men and for improved equipment. This action demonstrated bipartisan concern and determination to combat drug abuse.

The House Appropriations Committee report, in part, stated:

> In order to deal with this problem, the Department proposes to substantially increase the law enforcement effort against smuggling. The whole problem is put into sharp focus by the following testimony from the Treasury Department:
>
> "Almost all of the marihuana, all of the hashish, all of the cocaine, and all of the smoking opium used in the United States is smuggled into this country."
>
> The committee strongly supports the Department's objective of reducing to a minimum the smuggling of this contraband into the United States. The committee specifically allows the 915 additional positions requested and urged the Department to move ahead on this project as rapidly as practicable.

Treasury has now fully implemented the supplemental appropriation and Customs has either on the operating line or in training all the authorized additional personnel. On June 1, as soon as the major portion of these resources became operational, we initiated an intensified enforcement program which has been cracking down on every avenue and mode of drug smuggling—by ship, by plane, by truck, and by car; in cargo, in mail packages, in baggage, and on the person of travelers. The transportation and other affected industries and labor unions are cooperating fully.

In our first month of operation under the intensified enforcement program, we made such seizures as 2 kilograms of cocaine at Baltimore on a vessel arriving from South America; 60 kilograms of hashish contained in air cargo at John F. Kennedy International Airport at New York; 23 kilograms of marihuana in air cargo at Buffalo; 25 kilograms of hashish taped to the bodies of a group of three airline passengers arriving at New York; 1 kilogram of cocaine at Miami concealed in the false bottom of an attaché case of an air passenger from South America; 25 kilograms of hashish concealed in an air cargo shipment of magazines at Miami; a ton and a quarter of marihuana concealed in the paneling of a truck trailer at Tecate; and 94,000 tablets of dangerous drugs concealed inside a spare tire and the fender walls of an automobile crossing the border at San Ysidro.

I think it is an interesting sidelight that one of our new recruits, on his first day of actual duty following graduation from Customs' training course, and on the second day of the intensified enforcement program, arrested in Buffalo, N.Y., a courier carrying 6 pounds of cocaine. This courier had traveled from Chile to Canada in order to enter the United States through the preclearance operation at Toronto. The team, of which this recruit was a part, was making selective personal searches on these precleared passengers who could not be so examined while on foreign territory. He was a proud young man and we are proud of him and the selection and training programs which put him into this battle against drug abuse.

Tremendous physical problems are encountered by Customs in intercepting contraband. More than 225 million travelers clear Customs entry procedures annually, and any individual might be concealing drugs on his person. Agents of the Bureau of Customs must also intercept illegal boat or aircraft entries along 20,000 miles of the U.S. border and coastline and at about 290 international ports of entry. Drug smuggling operations vary from individuals carrying a small supply for themselves and friends to organized crime syndicates with activities spanning oceans and continents. Cargo has become a primary means or vehicle for smuggling, and separate cargo entries into the United States exceed 2½ million annually.

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The bill under consideration represents a comprehensive system of controls over narcotics, marihuana and dangerous drugs. It would repeal the title 26 taxes on narcotics and marihuana on the ground that the Federal role in the control of dangerous substances can be satisfactorily founded on powers other than the taxing power. The Treasury Department supports this view and advocates the passage of this legislation. Certain technical changes which we wish to recommend will be conveyed to you by a supplemental report on the bill.

The administrative responsibilities of the Internal Revenue Service with respect to the narcotics tax (26 U.S.C. 4701 et seq.) have not been particularly burdensome. The aggregate revenue from taxes and $1 registration fees is largely offset by the costs of processing the registrations required for conducting legitimate transactions in narcotics. The bulk of narcotic tax receipts results from voluntary compliance with the laws by individuals engaged in legitimate narcotics activities and most are collected without IRS enforcement action. Elimination of the tax would neither impair the effectiveness of the regulatory aspects nor significantly reduce net tax receipts nationally.

Collection of the transfer tax on marihuana (26 U.S.C. 4741 et seq.) has been troublesome and the income so derived, when offset by the costs of administration, has been even less significant than that derived from narcotics taxes. Because of recent increased activity in the illegitimate use of marihuana, IRS has been obliged to make assessments in numbers and amounts where chances of collection are practically nil. For example, in one IRS region during calendar year 1968, there were 1,837 large marihuana transfer tax assessments made amounting to $62,921,170 and, at the close of that year, only $340,287 had been collected. During the year, $47,253,431, or 75 percent of the amount

assessed, was reported as uncollectible, and it is expected that a major portion of the balance will be declared uncollectible.

In the course of the subcommittee hearings on the supplemental appropriation to intensify the Bureau of Customs' antinarcotics smuggling campaign, concern was expressed by some of the members that certain repealers of existing legislation contained in S. 3246, the so-called Dodd bill, would have the effect of stripping customs of its investigative jurisdiction in enforcing the laws against the unlawful importation of controlled dangerous substances. Similar repealer provisions are found in section 103 of this bill.

During the months when the administration's bill was being drafted, the Treasury Department was consulted and offered its views to the Bureau of the Budget and the Department of Justice regarding the proposal. We did not object to the proposed repeals, because the Department of Justice draft proposal was not regarded as changing the role or modifying the authority of the Treasury Department with respect to its responsibilities regarding the importation of narcotics and dangerous drugs.

Neither that bill nor the present bill changes the Treasury Department's existing enforcement and investigative responsibilities—as exercised through the Bureau of Customs—to deal with offenses under customs and related laws, whether or not some or all of the merchandise involved may consist of narcotics and dangerous drugs.

Section 702(b) of the bill expressly so provides, stating:

> Nothing in this act shall derogate from the authority of the Secretary of the Treasury under the customs and related laws.

The basic "smuggling" statute is 18 U.S.C. 545. It was once part of the Tariff Act of 1930 and was transferred to the Criminal Code when that code was revised and enacted into positive law in 1948 as title 18, United States Code. That section, along with a number of others, is incorporated in chapter 27 of title 18 under the chapter heading, "Customs." Thus, section 545 is a "customs law."

The words, "and related" pertain to and embrace over 40 separate statutes that customs enforces or assists to enforce. Any law that controls or relates to the importation of anything into the United States is either a customs law or a law related to customs and is covered by the language, "Customs and Related Laws."

The proposed amendment of title 26, United States Code, section 7607, contained in section 104(r) of the present bill expressly preserves the existing authority of officers of the customs to make arrests without warrant for violation of any law of the United States relating to narcotic drugs and marihuana as defined in the bill.

Section 701(a)(5) of the bill authorizes the Attorney General to designate any officer or employee of the Bureau of Narcotics and Dangerous Drugs to "perform such other law enforcement duties as the Attorney General may designate." This provision permits the Attorney General to respond to requests from other agencies which may require the assistance of enforcement personnel.

For example, if the Post Office Department or the Treasury Department requested law enforcement assistance from the Attorney General, section 701(a)(5) would authorize him to designate BNDD agents to respond.

Thus, Mr. Chairman, as mentioned, we support and advocate the

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passage of this legislation. The technical changes which we wish to recommend will be conveyed to you by a supplemental report on the bill.

We can point to many accomplishments in suppressing drug abuse since the President's mandate. Many new programs and facilities have been set up to fight the illegal drug traffic—and these should eventually make drugs harder to obtain all across the Nation.

The great majority of the American people fully support this program. Enforcement officials cannot do the job alone. We need the cooperation of the Congress and the public on many fronts. With such cooperation and support we are confident we can succeed in our mission. We have no common objective more important than this.

Thank you, Mr. Chairman. I would be pleased to answer any questions the committee might have.

Mr. BURKE. Mr. Secretary, is it your opinion there is nothing in this proposal which will weaken or encourage the present problem we have, weaken the enforcement or encourage the acceleration or the use of drugs?

Secretary KENNEDY. We know of nothing in the bill that would cause any problem to the Customs Department in moving ahead. In fact, in any provisions will help us in this effort.

Mr. BURKE. I asked a question this morning on the training of the customs inspectors. I was wondering whether you or your associates could outline what has been done during the past year to increase personnel and whether you have begun any new training programs.

Secretary KENNEDY. I will ask Mr. Rossides to comment on that.

Mr. ROSSIDES. We have had a special training program for the customs inspectors so they would be trained in drug smuggling. This was a new program instituted last year. Teams would go around the country and work with the inspectors on the line to galvanize the efforts of the inspectors in examining travelers and cargo.

Mr. BURKE. Mr. Schneebeli?

Mr. SCHNEEBELI. Mr. Secretary, what do you do with the seized material? How do you handle the confiscated drugs?

Mr. ROSSIDES. That is worked in with the Bureau of Narcotics and Dangerous Drugs. Certain of the heroin is turned over to them for specific disposal in accordance with regulations. The marihuana we might actually burn.

Mr. SCHNEEBELI. Do the dangerous drugs enter into our health facilities for use?

Mr. ROSSIDES. No, it does not enter into our health facilities. At times, if HEW should want some of the material for research, arrangements could be worked out.

Mr. SCHNEEBELI. Some of this material is being used legitimately for health purposes in hospitals, et cetera, is it not?

Mr. ROSSIDES. The morphine and certain derivatives are being used.

Mr. SCHNEEBELI. Couldn't you use the confiscated material as well?

Mr. ROSSIDES. I am not sure if they do. I will find out and submit it for the record.

Mr. SCHNEEBELI. It would seem like a pretty cheap way of getting it for useful purposes.

Mr. ROSSIDES. I don't believe they do use it.

(The information referred to follows:)

A very small percentage of confiscated material is returned to legitimate use. All of the amphetamines, barbiturates, and hallucinogenic drugs are destroyed, and most of the marihuana and hashish are also destroyed. Drugs which are not destroyed are turned over to the Drug Disposal Section of BNDD. For example, in 1969 163.42 kilograms of heroin were seized by Customs and BNDD combined, and 60.03 grams which had been recrystalized and purified were turned over to doctors engaged in legitimate research. None was delivered to any hospital for use in treating patients. A number of research programs deal with marihuana and hashish, and 118, 278 grams of marihuana and 100 grams of hashish were released to doctors engaged in legitimate research programs.

Mr. SCHNEEBELI. Is there any estimate of the attempted smuggling taking place that is being intercepted? Is there any estimate of how much of the total is being caught at the border?

Mr. ROSSIDES. Congressman, they have made estimates from time to time and estimates I read when we first came on board indicated that Customs seizes 10 percent at the border. To me that is an absolute and pure guess. In my judgment, there is no solid figure as to how much is missed.

Mr. SCHNEEBELI. Certainly that percentage is increasing with the seizure during 1970 compared to 51 years ago.

Mr. ROSSIDES. Yes, we are seizing more, but you just can't tell. I think now the President's program highlighting enforcement in this area will take time, but we may see in a year or so a little more evidence of the fruits of that several-part program.

Mr. SCHNEEBELI. With the tremendous use apparently being made of this in the larger cities, particularly as we hear among the youths of the country, certainly we are intercepting a very small percentage of it, are we not?

Mr. ROSSIDES. That is correct.

Mr. SCHNEEBELI. Concerning the intercepts along the Canadian border—I presume the Customs clearance and investigations are a lot more comprehensive than they were a year or 2 ago? Do they do a spot check on this or do they inspect everybody or how do the inspections work?

Mr. ROSSIDES. You mentioned Intercept. During Operation Intercept, on the Mexican border there was a 24 hour a day 100 percent inspection of travelers and cargo. There is now a program of cooperation which is working very well.

As of June 1, along both borders there has been an intensified enforcement effort. The percentage of inspections has increased. Before, at John F. Kennedy International Airport we may have inspected four out of five travelers. Now, with the additional personnel, we will be able to inspect a greater percentage, but we are making spot and random checks. We are sending blitz teams to hit a certain area or perhaps an entire plane.

Mr. SCHNEEBELI. To what extent have the Mexican officials cooperated with you in trying to eradicate this trade?

Mr. ROSSIDES. Very fine cooperation. We have a fine on-going program with Mexico following Operation Intercept. It is now called Operation Cooperation. For the first time, as an example, the Mexican Customs Service is getting fully into the narcotics traffic. They were not before. We have an agreement between the two Customs Bureaus that will be of great help along the border.

Recently we turned over a number of airplanes and helicopters for Mexico's use. Starting June 1, we have a program which the Secretary referred to which involves Canada. The Royal Canadian Mounted Police and the Customs Service are cooperating with us.

Mr. SCHNEEBELI. What about the people who make a daily trip back and forth who work in one country and live in the other? How do you take care of this large group? I imagine between Detroit and Hamilton you must have a problem such as this.

Mr. ROSSIDES. We do. We work closely with the Canadians in trying to get advance intelligence. You would naturally move those people through more quickly.

Mr. SCHNEEBELI. Do you make a spot check at all to keep them on their toes?

Mr. ROSSIDES. Surely.

Mr. SCHNEEBELI. Suppose you found a person who has a regular job in Canada and lived in the United States and you found him transporting things back in his dinner pail. Would he be subject to loss of his job or would he be denied the privilege of returning to Canada in the regular employment or what penalties are dealt to a regular employee?

Mr. ROSSIDES. If he is found with drugs?

Mr. SCHNEEBELI. Yes.

Mr. ROSSIDES. He would be subjected to the civil and criminal sanctions.

Mr. SCHNEEBELI. In other words, he could continue his daily trips back and forth?

Mr. ROSSIDES. Unless he was incarcerated. It would be up to his employer as to what he would do, but he could go back and forth. There is no statute that I am aware of that would prevent him from traveling back and forth.

Mr. SCHNEEBELI. Thank you.

Mr. CHAMBERLAIN. Referring to page 5, the middle paragraph of your statement, would you comment a little further about the assessments that were made and why you are not able to collect them. What is the set of circumstances that gives rise to such a situation?

Secretary KENNEDY. I will ask Mr. Rossides to answer that, if it is all right with you.

Mr. CHAMBERLAIN. Surely.

Mr. ROSSIDES. Congressman, the circumstances are, if you have a transfer and you fill out the transfer form, it is $1 an ounce on marihuana but if you fail to file a form there is a tax of $100 an ounce; so the tax assessment can go high rather quickly.

Mr. CHAMBERLAIN. These are assessments against those who have been apprehended for making transfers and your assessments can not be collected.

Mr. ROSSIDES. That is right. These are judgment proof situations in large part.

Mr. CHAMBERLAIN. What are the penalties?

Mr. ROSSIDES. If they legally filled out a form it would be $1 an ounce on marijuana but it is $100 an ounce if you fail to fill out a transfer tax form. That is the penalty and you see if they have any assets that can be attached. Seventy-five percent of the $63-odd million have been found uncollectible.

Mr. CHAMBERLAIN. So, you just tell them goodbye and close the book.

Mr. ROSSIDES. They have been turned over to the Federal or State authorities and they are under indictment or they are under a criminal process.

Mr. CHAMBERLAIN. Do you have any information as to what happens as a result of the criminal process?

Mr. ROSSIDES. Surely. We know how many have been convicted and those that are acquitted.

Mr. CHAMBERLAIN. It would be well if you could supply some of that information for the record at this point. So we will not leave the idea that nothing is being done.

Mr. ROSSIDES. We will be pleased to supply that information, Congressman.

(The information referred to follows:)

The Supreme Court of the United States held on May 19, 1969, that the Fifth Amendment privilege against self-incrimination provides a complete defense to prosecution for failure to pay the marihuana transfer tax. *See: Leary* v. *United States*, 395 U.S. 6 (1969); *United States* v. *Covington*, 395 U.S. 57 (1969). Consequently, since that date no prosecutions have been instituted for violating the Marihuana Tax Act. However, possession of marihuana is a criminal offense under both federal and state law, and when an individual is arrested for possession of marihuana, the district office of the Internal Revenue Service is notified and the marihuana transfer tax is assessed. Then the account is turned over to a revenue officer to ascertain if the individual is able to pay the tax. If his investigation discloses that the taxpayer has no assets, the account will be treated as uncollectible. However, the assessment remains on the tax rolls for six years, until the statute of limitations has run out, and if during that period the taxpayer files a tax return, or information is obtained which indicates that he may have acquired a source of income, additional action will be taken to collect the tax. For example, all claims for refund are automatically checked by our data processing equipment against outstanding assessments for marihuana and other taxes; and the assessment will be set-off against the claim for refund. Outstanding marihuana tax assessments are reviewed on a regular basis, and very reasonable effort is made to collect them.

Mr. CHAMBERLAIN. Mr. Secretary, I was pleased to have your comments earlier as to the additional enforcement officers that you had. Are you requesting any more this year?

Secretary KENNEDY. No; we have now employed the ones we have the authority to hire and we are training them and they are going into the force now.

Mr. CHAMBERLAIN. Can we assume now you have adequate enforcement personnel?

Secretary KENNEDY. For the time being. We don't know for sure. We will take a look as we go along, but this is the program up to date.

Mr. CHAMBERLAIN. In the normal course of events when you requested these 915 additional positions, that no doubt went to the Bureau of the Budget for clearance and approval. Could I inquire as to whether or not you had requested more than the 915 when you submitted your request to the Bureau of the Budget, or was this the number you did in fact request of the Bureau of the Budget?

Secretary KENNEDY. My recollection is that it is what we requested. I am informed by Mr. Rossides that in the early stages we were talking about more than that number, but in the discussions back and forth this is what we arrived at.

When I saw it and it came up to my desk for the first time, this was the amount that was the recommendation.

Mr. CHAMBERLAIN. How many did Customs feel you needed to have?

Mr. ROSSIDES. We were talking in terms of a few hundred more when this supplemental was submitted originally to the Bureau in the summer of 1969. By the time it got up to the Congress and passed we were only talking about a 6-months period and it was refined downward to the number that could be economically trained and recruited by June 30, 1970.

Moreover, you might have been guessing, so give or take 50 would not have been significant in giving customs the numbers they could recruit and train.

Mr. CHAMBERLAIN. How many did you request?

Mr. ROSSIDES. I think it was about 1,100.

Mr. CHAMBERLAIN. Then you feel you requested some that you did not need and you say now you are satisfied but Mr. Secretary, you have 150 less than you originally wanted.

Secretary KENNEDY. When we were going into this program, I am sure in gearing up customs was taking a look at a long-range program. There was a time interval. As we came up for the supplemental appropriations——

Mr. CHAMBERLAIN. I can appreciate that, Mr. Secretary.

Secretary KENNEDY. At least when it came to my desk it looked to me like this was the amount that was about what we could recruit and train in the time frame and it would probably round out our program for the time being.

So, the official request that I signed and sent over was for this number.

Mr. CHAMBERLAIN. Have they been recruited and trained and are they on duty now?

Secretary KENNEDY. The answer is "Yes."

Mr. ROSSIDES. They are all on board and actively working and some may still be in training.

Mr. CHAMBERLAIN. Then I can conclude, Mr. Secretary, that you have no pending request for additional enforcement people and that you are satisfied with the force as it is at the present time?

Secretary KENNEDY. At the present time, that is precisely true. We continually review this and I am sure that customs will be taking a look at their performance, their needs, and their ability to recruit and train. I would not want to foreclose the possibility that there would be additional requests because we are up against a very serious and difficult problem here.

Mr. CHAMBERLAIN. People at the Bureau of the Budget have strong reasons for economy, and there are strong desires on the part of all of us to economize wherever possible, but we find that the Bureau of the Budget is sometimes a little over zealous. I would want you to feel that you would find a very sympathetic ear for requesting the numbers that you feel are necessary to do the job that must be done. I feel that the Congress will respond to your needs and that was why I wanted this record to be absolutely clear that you have what you feel in your judgment is necessary to do the job.

We are looking to you to see that it is done.

Secretary KENNEDY. I appreciate that very much and that same cooperative attitude was evidenced when we came up with the supple-

mental request. It was promptly approved. We went ahead immediately to implement it.

Mr. CHAMBERLAIN. This is most reassuring, Mr. Secretary. Thank you.

Mr. BURKE. Are there any further questions?

On behalf of the chairman and the committee, I wish to thank you very much, Mr. Secretary.

Secretary KENNEDY. Thank you very much, Mr. Burke.

Mr. BURKE. There being no further questions, the committee will stand adjourned until 10 a.m. tomorrow morning.

(Whereupon, at 3 p.m., the committee adjourned to reconvene at 10 a.m., Tuesday, July 21, 1970.)

48-551—70——18

CONTROLLED DANGEROUS SUBSTANCES, NARCOTICS AND DRUG CONTROL LAWS

TUESDAY, JULY 21, 1970

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witnesses this morning are Dr. Egeberg and Dr. Brown who are appearing for the Department of Health, Education, and Welfare.

Gentleman, will you please come to the witness table?

Dr. Egeberg will make the first statement and then will be followed by Dr. Brown. We appreciate having both of you with us and we are most anxious to hear your testimony. We are glad to recognize you, Dr. Egeberg.

STATEMENT OF DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; DR. SIDNEY COHEN, ACTING HEAD, BUREAU OF NARCOTICS AND DRUG ABUSE, NATIONAL INSTITUTE OF MENTAL HEALTH; AND NANCY WOLFF, OFFICE OF LEGISLATIVE COUNSEL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. EGEBERG. Thank you, sir. May I introduce Dr. Sidney Cohen who is the Director of the Division of Narcotics and Drug Abuse in the National Institute of Mental Health.

The CHAIRMAN. We are glad to have you with us also.

Dr. EGEBERG. He was a resident of Los Angeles and a neighbor of mine.

The CHAIRMAN. Don't overlook the ladies.

Dr. EGEBERG. Miss Wolf is going to keep us honest. She is from the General Counsel's Office.

The CHAIRMAN. I am glad you brought her along.

Dr. EGEBERG. Perhaps I should not have admitted that.

The CHAIRMAN. We appreciate having all of you here and you are recognized.

Dr. EGEBERG. Mr. Chairman, and members of the committee:

I appreciate the opportunity to discuss with you today H.R. 13742

and H.R. 17463 and the vitally important problem with which they deal—the problem of insuring that man's ever-growing knowledge of the properties of drugs of all kinds will be put to constructive use only.

I need not tell this committee that the misuse of drugs through their diversion into unauthorized channels has created a serious public health problem of major proportions. The media has published figures that indicate large numbers of persons—anywhere from 70,000 to 150,000, depending on whose survey figures are used, are opiate addicts.

The numbers of Americans who experiment with or regularly use marihuana and other dangerous drugs are estimated in the millions.

What is worse, the blight of drug abuse is afflicting an ever-growing number of young people under 21—young people from every walk of life and type of environment. More precise incidence figures, to the extent of the information now available, can be supplied to the committee for the record. The important question is, what can we do about it?

The answer to the drug abuse problem is multifaceted and requires a heroic national effort in the area of prevention and education, treatment and rehabilitation and lastly, control of the dangerous substances themselves.

Most recently, the President announced the creation of the National Clearinghouse for Drug Abuse Information to give the public one central office to contact for help. The first year budget is almost $700,000.

Grants to provide increased support for construction and staffing of community-based treatment and rehabilitation facilities were also provided by this Congress through Public Law 91–211, the Community Mental Health Centers Amendents of 1970. This act also provides for a program of training of specialized personnel to work in these facilities as well as authority to support surveys and field trials aimed at evaluating adequacy of prevention and treatment programs.

It is now time to turn our attention to the problem of devising a sound and effective regulatory scheme of control—a scheme based on a realistic and scientifically valid appraisal of our various kinds of drug abuse problems.

As you know, Mr. Chairman, the basic framework of legal controls over the use and abuse of narcotics, marihuana, and other dangerous drugs is a triple structure composed of international commitments, State and local police measures, and Federal laws which interact with and reinforce the others.

There is another tripartite division of controls according to the type of substance to be controlled. The laws which govern narcotics, marihuana, and the "dangerous drugs" are not consistent at present. They are a veritable patchwork of inconsistent controls, showing little knowledge of differences in abuse liability and in legitimate medical value from one substance to another.

The two bills before you today are designed to change the ill founded and inappropriate classification of drugs and punishment of those who abuse them.

H.R. 13742, which you introduced at the request of the administration on September 11, 1969, deals only with narcotics and marihuana.

Since that time, you have sponsored omnibus legislation which would apply to other drugs of abuse as well, and which contains important additions and modifications, especially with respect to penalties and to HEW participation in decisionmaking.

It is this latter bill, H.R. 17463, which the department recommends be enacted. As indicated by Mr. Ingersoll's testimony yesterday, we are continuing to work closely with the Department of Justice and other concerned congressional committees to develop effective legislation.

The control and regulation of certain medically useful drugs are both necessary and desirable. These include the narcotics, sedatives, and stimulants that are employed in the practice of medicine.

It should not be assumed, however, that intensified regulatory activity alone will solve our serious problem of drug abuse. Reducing the leakage of these lawfully manufactured agents will be helpful, but the bulk of the problem lies elsewhere and this should be explicitly recognized.

Heroin accounts for more than 90 percent of all narcotic addiction in this country. No heroin whatsoever is manufactured or imported legally into this country. It is estimated that 2 or 3 tons of heroin will supply the needs of all addicts for a year. Consider the enormous difficulties of preventing the entry of that small quantity from being introduced into the United States by land, sea, or air.

Most of the marihuana and all of the hashish used is illicitly introduced into the United States. Lesser quantities of American marihuana are consumed from wild, low-grade material which do not enter into legitimate commercial channels.

None of the hallucinogens listed in section 202, schedule I(c) of H.R. 17463, are licit items of commerce. When they are abused, items like LSD are illegally manufactured or smuggled into the country.

The amphetamines are drugs with some medical usefulness. They can, however, also be very easily manufactured in unlicensed laboratories from precursors which are not controlled under H.R. 17463. Methamphetamine, the amphetamine known as speed, is made for intravenous injection exclusively in clandestine laboratories when it is used by the so-called speed freak.

It is remarkable what a strange assortment of chemicals, poisonous solvents, and dangerous plants will be sought out by those who, for one reason or another, cannot tolerate sober existence. I suspect that mind-distorting chemicals will always be with us no matter how well we enforce the provisions in this bill. Nevertheless efforts must be made to diminish the availability of these substances.

As an example of the facility with which the purveyors of mind-shaking chemicals can provide new products, two hallucinogens are known to the National Institute of Mental Health that are now being actively abused, and they are not listed in H.R. 17463. Their manufacture, sale, and distribution is not now and will not be illegal despite the fact that they are just as dangerous as many of the drugs listed in section 202, schedule I(c). I am referring to MDA (3,4-methylenedioxyamphetamine) and TMA (3,4,5-trimethoxyamphetamine).

It would be easy to add these drugs to the existing list of hallucinogenic substances and I recommend that we do so. But the basic problem would still remain unresolved for we have long series of active hallucinogens which could make their appearance at any time.

They include dipropyltryptamine (DPT), 6-hydroxydimethyltryptamine, 2,5-methoxy, 4-ethylamphetamine (DOET), 2,4,5-trimethoxyamphetamine (TMA-2), 2,3,6-trimethoxyamphetamine (TMA-5), 2,4,6-trimethoxyamphetamine (TMA-6), 2,4,5-methoxymethylenedioxyamphetamine (MMDA-2), 2,5-dimethoxy-3, 4-methylenedioxyamphetemine (DMMDA), 2,5-dimethoxyamphetamine (DMA) and many others.

The basic problem, of course, is that while external deterrents are needed, it is the internal deterrents which are crucial in solving this problem. When we have learned, through research and meticulous study, how to make drug taking irrelevant, then we will have begun to finally resolve the issue that concerns us here.

We are only beginning to learn how to develop attitudes in the very young which will make a be-drugged existence unnecessary and inappropriate. We have found that viable alternatives to drug taking are available for all age groups. These are not easily instilled, but some persons have been freed from chemical dependence by turning on to people and on to more genuine life experiences than the spurious drug experience. Some procedures have been learned which successfully deal with the chronic user who wants help.

It is in these areas of skillful prevention, of expert education, of devoted and innovative treatment that the definitive answer will be found. The problem, as we learn more about it, is not drugs; it is people. When people find suitable goals and values, drugs become meaningless and superfluous.

The determinations that have to be made in decisions to impose special controls on any drug must be based on scientific information on the nature of a given drug, its physiological and psychological effects, trends in its use among various segments of the population, its potential medical usefulness, and other factors in the province of health sciences, as well as practical questions of enforcement and the effect on organized crime.

We think the inclusion in H.R. 17463 of the requirement that the Attorney General seek in writing the advice of this Department and a committee of scientists before changing or modifying the schedules of controlled substances is a vitally important one.

You have my assurance, Mr. Chairman, that the Department will promptly and fully meet this responsibility so that the Attorney General will be able to base his determinations on the best possible scientific information we can provide.

As an example of the need for rapid input of information from the Secretary, a current example can be cited. We are all aware of the investigations which have been conducted during the past 5 years in which methadone maintenance is used in the treatment of certain heroin addicts. Methadone is in schedule II.

Recently, it has been found that alphaacetylmethadol can do as well as methadone for this purpose, and its effects last at least twice as long. If this finding is confirmed by additional studies, a difficult technical treatment problem will be overcome in that the patient will require three doses of medicine a week instead of seven. Alphaacetylmethadol might have to be shifted quickly from schedule I to schedule II since it is predictable that considerable therapeutic work will be done with it. When its medical usefulness is established, it will require

rescheduling. Its potential for abuse is even less than methadone's abuse potential.

We note with approval that the penalties for violations of the various strictures in the act have been considerably modified in H.R. 17463 along the lines developed and presented by the Department of Justice since the administration bills were first introduced. Mandatory minimum sentences for all drug violations, except in the case of the professional criminal whose traffic in drugs poses a real threat to society, have been abolished and the courts are given considerably greater flexibility in imposing sentence to make the punishment more nearly fit the crime.

Although the bill still classifies marihuana in schedule I for regulatory purposes, it establishes significantly lesser penalties for unlawful distribution of marihuana than for a similar offense involving narcotics drugs. We think this a very sound and useful distinction to make.

Perhaps I should say a few more words about marihuana and its active ingredient, delta-9-tetrahydrocannabinol (THC). Few drug-related topics trigger as intense emotional reactions as the proper controls for this ubiquitous substance.

The plant has been cultivated for its fiber since pre-Revolutionary days in the colonies. Introduced into this country around 1840 for medical purposes, its use as a medication reached a peak about the time of World War I and then gradually declined. Its use began to be regarded as a vice in 1927, when Louisiana passed the first restrictive law specifically directed toward marihuana use, and several other States followed suit.

Meanwhile, Federal narcotic enforcement officials who regarded marihuana as the "new" drug danger second to opiates in hazard (no clear scientific basis was ever given for this belief), asked for and received responsibility for its regulation at the Federal level, culminating in the Marihuana Tax Act of 1937.

Thus, marihuana became subject to almost the same controls as "hard" narcotics and it remains associated in the minds of a large segment of the public with more dangerous substances such as heroin, morphine, and other addicting drugs.

We know now that marihuana is not a narcotic, its use does not lead to physiological dependence under ordinary circumstances, and there is no proof that it predisposes an individual to go on to more potent and dangerous drugs. With respect to its short-term effects, marihuana can be described as a rather mild hallucinogenic drug.

What I have been talking about are the effects of short-term use. We are painfully aware of great gaps in our knowledge of the risks associated with regular and continuing long-term use of Marihuana. The National Institute of Mental Health is presently engaged in intensive research on all aspects of this problem.

The bill (H.R. 17463) before your committee today, in detailing the jurisdiction of the new Committee on Marihuana it would establish, clearly delineates the many unanswered questions to which we must have answers before we can take further socially and scientifically justified steps to change the control of marihuana.

Until these answers are in, I must point out to all the millions of Americans, young or old, who are experimenting with marihuana, that they are taking a significant risk in tampering with this substance.

Permit me to mention some of the advances in the field of cannabis, now that sufficient supplies of assayed marihuana and pure THC have become available to researchers.

1. We now know the first metabolic change that THC undergoes in the body. The chemical changes that accompany smoking marihuana are becoming better understood.

2. One of our contractors is, at last, able to detect extremely minute quantities of THC from smoked marihuana in body fluids.

3. A number of investigators have demonstrated a defect in very recent memory (the recall of events that happened moments ago) when average amounts of marihuana are smoked.

4. Studies of the genetic effects of THC and marihuana are underway, but no definite results can be reported at the time. It has been demonstrated that THC does cross the placenta.

5. Our planned studies with long-term users in countries where hashish consumption is traditional are underway.

6. Although we are receiving reports of acute marihuana panic and psychotic reactions, the number remains small in comparison to the total amount of marihuana consumed.

7. From the continuing survey reports that we receive, the general trend of marihuana indulgence seems to be on the increase. Experimentation is observed down to grade school levels and across all economic and social classes. The majority of marihuana users are "triers." They have smoked less than a dozen times and have no intention of indulging in the future.

A third of all users are occasional, "social" smokers. They will use marihuana intermittently when they regard the time and place as propitious. The remaining 5 to 10 percent are consistent, regular users, the "potheads."

It is this latter group that tend to go on to more potent hallucinogens, stimulants, and sedatives. In a few instantes they try opium and heroin, and some become addicted to these narcotics. On psychological studies the "potheads" are distinguishable from nonusers and infrequent users by their degree of emotional disturbance. They tend to have immature, inadequate, impulsive personality traits.

As I indicated, the Department is highly supportive of the mandate to the Committee on Marihuana established in this bill. I would just like to call your attention to the "Marihuana and Health Reporting Act", incorporated as title V of the recently passed "Hill-Burton Act" (P.L. 91–296) which, with respect to its reporting requirements particularly, overlaps the requirements of section 801(b) of this bill.

The "Marihuana and Health Reporting Act" designates the Secretary as the "authoritative source" for informing Congress about the health consequences of using marihuana to enable it to take further legislative and administrative action. In your bill this information is to come not from the Secretary but from an outside committee of experts selected jointly by the Secretary and the Attorney General.

The Reporting Act requires a preliminary report 90 days after enactment (on September 28, 1970), a first full report on January 31, 1971, and other reports annually on that date thereafter. H.R. 17463 asks for the same comprehensive report 2 years from the date of enactment on a one time basis.

I mentioned earlier the importance of research and education as part of the total comprehensive attack on the drug abuse problem.

H.R. 17463 recognizes the need for involvement in these activities by the Attorney General when such research or education is directly related to his law enforcement functions. The primary responsibility for comprehensive research into all medical, pharmacological, and social aspects of the use and abuse of drugs and the carrying out of information and educational programs to deter and prevent such abuse among our Nation's youth and other segments of the population remains with the Department of Health, Education, and Welfare.

The National Institute of Mental Health and this Department, as I have mentioned, are directing a comprehensive program of drug abuse and research and education.

We are recommending enactment of H.R. 17463, Mr. Chairman, because we feel that it represents significant progress in the achievement of effective and acceptable controls over the use and abuse of dangerous substances.

Dr. Brown and I will be happy to answer any questions you may have.

The CHAIRMAN. Dr. Brown, do you have a special statement?

Dr. BROWN. I have no special statement. Dr. Egeberg and I worked closely together on this statement and I will be glad to answer any questions.

The CHAIRMAN. We appreciate your fine statement. There are some words in your statement that I think I will have to go to a medical dictionary to understand fully.

Dr. EGEBERG. So will I.

The CHAIRMAN. Is that where I will find them or may we use an ordinary dictionary?

Dr. EGEBERG. You won't find many of those in a dictionary that is more than 6 months old.

The CHAIRMAN. Mr. Schneebeli.

Mr. SCHNEEBELI. Dr. Egeberg, on page 6 you refer to a long series of these hallucinogens. As they come onto the market, I assume the problem is one of whether to add them to the list of forbidden products.

Tell me how is this coordinated? As a product comes onto the market, how is it considered for being put on the list? Does the Attorney General ask your permission or ask your advice? Who calls it to the attention of the Attorney General?

Dr. EGEBERG. In the first place, if a request for a new drug comes to the agency of the Food and Drug Administration, and if they think it has hallucinogenic or habit-forming properties, they should notify both the Secretary and the Attorney General.

Mr. SCHNEEBELI. You say they should.

Dr. EGEBERG. It is in this proposed bill. Otherwise, the Secretary, if he feels some new attitudes have derived or if some new properties in drugs that are currently being used would make them appear to be habit forming or hallucinogenic and appropiate to come under control, he can recommend them to the Attorney General. The Attorney General does not have to take his recommendation because it has to be balanced against many social effects, its present popularity, the size of the import, and so on.

Mr. SCHNEEBELI. The pharmaceutical companies have to start with FDA.

Dr. EGEBERG. Yes, sir.

Mr. SCHNEEBELI. And they may suggest to you he may want to have them put on the restrictive list.

Dr. EGEBERG. Yes, sir.

Mr. SCHNEEBELI. Can this be done rather quickly?

Dr. EGEBERG. FDA is very sensitive to this and, I think, they would be very much alert to the possibilities. Many of these drugs are in categories. They change the numbers, but a lot of the names are quite similar and they would, I think, have their suspicions aroused rather early.

Mr. SCHNEEBELI. So the proposed legislation does implement it with procedures to cover it?

Dr. EGEBERG. To make it a living document.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. How is marihuana used for medical purposes?

Dr. EGEBERG. It used to be used as a sedative. Cannabis indica was in the pharmacopeia until recently. It supposedly has no useful medical purpose at the present time. I believe that somebody has raised a question of its having a good influence in lowering blood pressure.

But, otherwise, I don't know that it has any useful purpose.

Dr. COHEN. There are substances derived from THC which should be tested for blood pressure lowering effects as an antidepressant or as a sedative. These are variances of THC and not THC itself.

Mr. BROYHILL. In light of some of the statements you made about a lot of research yet to be done and about the lack of proof as to the ultimate harmful effects, I am wondering if we are not a little too severe in the proposed legislation about the simple possession of marihuana?

Dr. EGEBERG. Which way?

Mr. BROYHILL. Of course, it is quite severe now, and in the proposed legislation we would be lessening the penalty for simple possession of marihuana. In light of your lack of proof as to the harmful effects of marihuana and your statement that you had not completed your research in this regard, it would be questioned whether the penalty for simple possession, which is proposed, is still too great.

Dr. EGEBERG. As I understand the proposed penalty, and I think I will pass this to you, the first time it can be entirely erased if the judge wishes and will not appear in any record.

Dr. COHEN. The penalty for the first offense of simple possession is a misdemeanor, up to 1 year in jail or up to $1,000 fine. However, the judge has flexibility. If he imposes a sentence, it can be erased after 1 year.

So, there is no criminal record. In other words, the penalty in certain cases may be only a small fine if the judge feels this is a correct punishment.

Mr. BROYHILL. I have a question as to whether we should lower the penalty to that extent in light of what the doctor said. I think it is quite severe for just possession.

Dr. EGEBERG. At the present time, there is a mandatory minimum of 2 years which has caused judges to find that there was no real evidence that the man had it in his possession. This seems to denigrate the law.

Mr. BROYHILL. That is all I have, Mr. Chairman.

The CHAIRMAN. Mr. Conable.

Mr. CONABLE. I was under the impression, Doctor, that some hallucinogens are used to treat some types of schizophrenia, is that true?

Dr. BROWN. There have been some investigations as to whether they can be used for schizophrenia or alcoholism. They are not used as ordinary treatment, but that does highlight the use of these drugs in scientific investigation to find appropriate new uses for them. They are not regularly used for that purpose as of this time.

Mr. CONABLE. But marihuana or the derivatives are not among those used that way.

Dr. BROWN. The potential use would be the active use of marihuana for depression. This is being explored in other countries and may be an important outcome, although at this point, it is very much in the research arena.

Mr. CONABLE. We have been receiving some telegrams from doctors expressing concern about this legislation and saying that it represented a threat to their practice in some way. I wonder if there has been any direct contact between HEW and organized groups of doctors with respect to these allegations and if so, how serious they are. Is there a widespread feeling among the medical profession?

Dr. EGEBERG. I will start answering that. Doctors hate to be policed. I think for a long time they felt that if an agent of the Bureau of Narcotics should come into their office to count their pills it meant they were under suspicion and cheating. In a way this belief permeates the medical profession.

There has been the question of this slowing down the use of methadone as a substitute for heroin. We have discussed this with many representative groups from the medical profession. I am sure that both Dr. Brown and Dr. Cohen have discussed this.

Dr. BROWN. I think you will be hearing from witnesses who will express this point of view quite cogently and articulately. All I can answer at this point is, yes, there is widespread concern in the scientific community as well as the medical practitioner community. They consider these somewhat oppressive controls over their practices.

Mr. CONABLE. What is the major sticking point in this respect? Is it simply that the intrusion of the Justice Department into the field in what they consider to be a dangerous degree? They seem to be asking for HEW to continue to maintain its control, feeling this would be more along the lines of how drugs should be handled?

Dr. BROWN. The heart of the matter seems to be the feeling of wanting to be bossed by one's own kind. If it were indeed Dr. Egeberg or the Chief of the Division or the Surgeon General or the Secretary of HEW who were calling the tune on these things, they would feel somewhat more comfortable than having the Attorney General or a law enforcement organization do so.

As to the actual impact or implications of these legislative and administrative behaviors, I think they are open to serious discussion as to what is best. The feeling is one of anxiety and concern.

Mr. CONABLE. It has been alleged in the press there have been tensions between Justice and HEW about this bill. Of course, we in the legislative branch don't have any way of knowing what kind of negotiations and discussions you had and I don't want to put you on the spot, Dr. Egeberg, but I wonder if you could summarize these tensions or describe whether they actually exist.

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Dr. EGEBERG. I would be glad to talk to this. I think we have had very friendly and cooperative meetings with Justice over a period of almost a year. While we have some points of what I would consider residual, slight differences, there is no doubt that the job of policing, the job of trying to cut down the amount of illicit traffic, the amount of people using the drug at the moment and perhaps for a long time is primarily in the sphere of influence of the Department of Justice.

Hopefully later on education will make it primarily a sphere of seeing that people get educated to the dangers of the drug.

The points where there have been differences and where you see the doctors worry is in the question of who is going to control the drugs used for research, and Justice has agreed that they will approve whatever the Department of Health, Education, and Welfare recommends on this score, unless they find that the person is a felon, has had a previous conviction of some kind for using drugs himself or has lied about something very obviously.

To my mind, this should satisfy those who are worried about restrictive influences on research.

May I say this is important. I am very glad to hear of that agreement because it is hard to get people started doing research on these very important issues. If we worry them about having somebody looking over their shoulder to see that they are counting every night, they might say they would rather go into something else.

But the fact remains that they have to be accountable for all of the things they are using, and I think this arrangement takes care of that.

This was arrived at yesterday really.

The other point is who should decide what drugs should be classified and how they should be classified.

At the present time, and according to this bill, this is to be decided by the Attorney General on the basis of recommendations received in writing from the Secretary of HEW as to what drugs should be classified and how they should be classified. This presupposes that they will speak to each other, understand each other, and probably cooperate. I feel that is a great likelihood.

Mr. CONABLE. Doctor, we understand about jurisdictional sensitivities here on the Ways and Means Committee. We even have some about this bill.

To summarize your position, it would be that you support this bill but feel it represents only part of the picture and that there must be something going hand in hand with it in the way of education and research that should be the jurisdiction of HEW and should contemplate the picture before we will have a rational drug control program; is that correct?

Dr. EGEBERG. Yes, I think this bill was written primarily with a view to formulating what the Department of Justice should do, to show their sphere of influence. There are others which have explained our responsibility through the Institute of Mental Health for prevention, education, treatment and so forth.

Mr. CONABLE. Looking ahead, what can we expect in the way of further legislation in this field, at least as recommendations from the administration?

Miss WOLFF. There is a good deal of legislation pending before the Congress now dealing with drug abuse education. HEW has presented testimony on some of these bills. Our position is that in this particular

area the Department's existing authority is adequate, and this is exemplified by numerous ongoing projects and activities which NIH, NIMH, and the Office of Education are conducting.

In the area of treatment and rehabilitation, the Congress recently has passed the Community Mental Health Centers Amendments of 1970. This act provides grant authority to increase support for construction, staffing, and training of specialized personnel for community-based treatment and rehabilitation centers which serve narcotic addicts and other drug dependent patients. I understand there is pending also some legislation which would add funds and expand the authority somewhat in this particular area.

In these two subject areas, drug abuse education and rehabilitation, I do not know of any specific additional legislative recommendations that the Department of HEW has made.

Mr. CONABLE. Thank you, Mr. Chairman. That is all.

The CHAIRMAN. Are there any further questions?

Mr. Bush.

Mr. BUSH. After these studies are going on, Dr. Egeberg, are you going to come out with one finding? Is there going to be a report on a certain date that everybody will have access to?

Dr. EGEBERG. On the marihuana?

Mr. BUSH. Yes, sir.

Dr. EGEBERG. According to the amendment that was added to the Hill-Burton bill, there would be a committee that would report and that would be appointed by the Secretary and it would give a preliminary report in 90 days on what the situation is. That is the current law, I am informed.

This report would then be given on the 31st of January, I believe, every year from then on.

H.R. 17463 provides that a committee appointed jointly by the Secretary and the Attorney General report in 2 years, with a one-time report, on the status of the research done to find out about marihuana.

So, in a sense there is some conflict, because, one report required under Hill-Burton is just the Secretary's responsibility, and H.R. 17463 says the Secretary and the Attorney General together will appoint a committee which will do this.

Mr. BUSH. Will the 2-year period give enough time to tell actual body effects? There are traces that memory is affected and traces of other things. Will 2 years give enough time?

The argument today is marihuana will not help you, it is perfectly OK, you drink, and so on. If these hints prove to be something more serious, can this be clearly established from a research point of view in 2 years?

Dr. EGEBERG. I would doubt it, but Dr. Cohen is right in that sphere.

Dr. COHEN. We believe that given 2 years of planned and funded research on marihuana—and we have a plan to explore this question and the very important question of the effects of the chronic use of marihuana—that in 2 years we can come up with a scientific answer to this question.

You may perhaps wonder how is it possible to know in 2 years what the chronic effects of marihuana are. What happens to the pothead after 20 years? Well, we can find this out in populations in other

countries that have been using the drug and study them in comparison with a group in that country that has not been using it. These studies are already contracted for and are beginning so that in 2 years we should be able to report to you some very significant evidence regarding a decision about the dangers of marihuana, if any, especially the long-term dangers, if any.

Mr. BUSH. What would you say to a 15-year-old kid today who asks why should I not use marihuana? How would you answer the question?

Dr. COHEN. First of all, I would point out the legal danger, the fact that it can put him into jail and second, I would point out that there are so many unknowns that he is indeed indulging in a fair amount of risk-taking if he is a consistent marihuana user.

Mr. BUSH. Thank you, Mr. Chairman.

The CHAIRMAN. Are there any further questions?

Mr. LANDRUM. I would like to know why he would place his reply in the order he answered Mr. Bush. Why wouldn't he reverse them?

Dr. EGEBERG. It is a good question.

Dr. COHEN. Jail is here and now, whereas the harmful effects of marihuana may be in the distance. We know of many drugs that have been brought into our culture which appeared harmless. Yet, after long study, we find that this is not quite so.

The same may be true of marihuana. There are hints in the older literature which are not quite scientific that there is impairment if strong marihuana is used over a long period of time.

Mr. LANDRUM. It would occur to me that it would be much better for the psychological values and also for the moral and spiritual values of the child if you reversed the order of your reply, for the mere reason you say jail, incarceration, restraint is purely temporary, but the lasting effects of something like this that needs to be impressed upon a child's mind, in my judgment.

Dr. EGEBERG. Dr. Cohen must have a special significance attached to jail.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. I understand you are going to use statistics on this, and you already are planning contracts on this now, and this will be more or less a statistical research endeavor as to what might be the dangers of the use of marihuana.

Dr. BROWN. Mr. Broyhill, we have a broad set of research, an effort of approximately $2 million a year, about $800,000 a year in contracts for a variety of subjects and $1.3 million out in grants. We are studying a wide range of scientific aspects of marihuana, its short term effects, its pharmacology, what happens in body fluids as well as doing this kind of ingenious thing that Dr. Cohen spoke to about checking with populations which have used it to see what or what has not happened. This is the sort of effort that will yield information.

My own guess is in 2 years we will know a lot more but not enough. It is like any other common substance interacting from human beings. We will be much further ahead, but we would still need to know more.

Mr. BROYHILL. What has been done with respect to cigarette smoking? We have passed legislation requiring labeling and with respect to advertising over TV and we have had a program of information, but we have provided no penalty for the use of cigarettes. The Govern-

ment has made a determination that use of cigarettes and tobacco is hazardous to your health, but there is no scientific proof of that, is there?

Dr. BROWN. The feeling with cigarette smoking is there is good scientific evidence that it does have harmful effects on your health, the kind of scientific evidence we accept in medicine and pathology, science generally speaking. This does highlight the issue that having the facts as to harmfulness does not necessarily change people's behaviors and philosophers can put that in quite a colorful way.

I think the fact that people are the ones who indulge in these activities is our part of the problem that we are trying to understand so that the controls are not only external, such as availability, but rather more as Congressman Landrum was speaking, internal, not wanting to do this sort of harmful thing to yourself or not giving adequate reasons.

My own guess is that in those instances where we have found that the drug has harmful effects or have good evidence toward harmful effects the actual use does decline. This was the experience with LSD which was going up rapidly from 1961 to 1967 among the college students. There was a lot of publicity about whether it hurt the genes and chromosomes. Now the use in college of LSD seems to have declined quite markedly.

On the other hand, the information which is somewhat more uncertain concerning marihuana as to whether it is harmful or not has correlated with rapidly increasing use of marihuana by Americans, as you know.

Mr. BROYHILL. I am concerned about the feeling of uncertainty as to the harmful effects of marihuana. Would you say now from the information that you now have that marihuana is certainly more dangerous and hazardous than the use of tobacco? You have been working on tobacco for a long time.

Dr. BROWN. At this point, without just trying to run away from the question, I would say we don't know about marihuana as clearly as we do about tobacco and the effects of using it for 20 or 30 years. The hardest evidence against tobacco is that chronic use over a 20-year period, anywhere from 10 to 40, does lead to heart disease, emphysema and lung cancer.

At this point, I could not say that about marihuana, but we are launching an effort to see if analogous or similar things are true about marihuana.

As to short term effects, we do know that marihuana has an impact on memory loss. It does bring on a hallucinogenic state in some. There have been a certain amount of people who have acute panic or psychotic or anxiety reactions. It is a small number thought. You don't get this from a few puffs of cigarettes. You don't very often, if ever, get an acute psychotic or crazy reaction from smoking cigarettes.

This has happened in a small number of cases with marihuana.

Mr. BROYHILL. You seem to minimize the tendency for the use of marihuana to lead into more dangerous drug usage.

Dr. EGEBERG. Could I answer your question a little bit there.

It seems to me that smoking is a man's own business. What it may do to him, it does to him. Marihuana use particularly because it starts at such an early age is apt to make many people go off into a pleasant euphoria or other means of evading the reality at a time, 15, 16, 17,

18 years when they should be getting ready for life when they should be setting their aims when they should be deciding or wondering where they are going.

This I would say, is the tragedy to all of society with respect to the use of marihuana. As we have said, it would apply particularly to the very young.

I don't think there has been any proof ever that the use of marihuana leads to the use of heroin. Rather, some people who seek marihuana early seek it because they are the kind of people who want physical satisfaction and demand it above mental satisfaction. These people will go on from any kind of physical satisfaction to whatever one suits them most and they could get there through alcohol to heroin, they could get there from sex to heroin.

There are a lot of different ways to heroin and naturally some of them might get there through marihuana or speed or any number of other things to heroin.

Mr. BURKE. What is your explanation for the problem that we have today? Drugs have been around for thousands of years. In my lifetime the people with whom I have been associated dreaded any participation in this type of activity.

Why do you think there is such a permissive use of drugs today and why do you think some people look so lightly upon the use of marihuana?

Dr. EGEBERG. I think we are in a very permissive era. What developed this era, I don't know. I am sitting between two people interested in psychiatry, so I hate to point the finger at them, but there has been a feeling that to raise children appropriately one should not inhibit them. I have a feeling that that is part of it.

Another thing is that the useful and realistic chores no longer exist. The things that would keep you busy feeling that you were doing something that you either had to do or could see the need for such as bringing in the wood, mowing the lawn, taking out the trash or any other number of things that occupied people when I grew up no longer have much validity.

I think both of these play a part.

Then comes this feeling that we don't understand the younger generation. I think perhaps part of it is that they have had a lot more time to think than we were allowed and maybe their conclusions are justifiable. But with this they have taken on a new culture. They look on us as belonging to an alcohol culture and they like to think of themselves as belonging to a marihuana culture.

So, it becomes a very significant thing, way beyond the use of that and probably way beyond the effect it has on the many people who just smoke it occasionally.

Mr. BURKE. Thousands of years ago their was a communications gap between the young people and the old people. I think if you read history down through the years you will always find there was a thrust on the part of the young people to enter into the unknown fields, to become pioneers.

What I cannot understand is why the young people cannot understand the dangers in the field they are entering into in the use of drugs. Do you think our educators, the parents or the churches have failed. How do you think this condition has been brought about?

Is it the permissive society we are living in? Is it the encouragement of pseudointellectuals who were educated beyond their commonsense in encouraging youngsters to get into this field? How do you think all of this has been brought about?

Dr. EGEBERG. For one thing, there is more misinformation about all of the narcotics than there is about almost any other thing. One of the things that the National Institute of Mental Health is trying very hard to do, which I think perhaps Dr. Brown should speak about, is educating the public as to what the facts are.

Dr. BROWN. I think the question you ask, Mr. Burke, is a fair one, but it is a tough one—what brings about a condition or set of values of this sort?

Certainly there is no simple answer as to whether it is school, church, pseudo-intellectuals, permissive educators, et cetera. As a psychiatrist I feel like the messenger that brought the bad news. We did not bring the permissive society about, but we try to treat the consequences thereof.

I could not begin to answer the consequences of it because of the complexity of it.

Mr. BURKE. You said the treatment of the conditions as they exist, but I think we ought to be looking into the causes. What good does it do to have all kinds of psychiatrists and doctors and tranquilizers around if the cause is continuing to exist? This is like trying to put out a grass fire with a broom, but it keeps spreading and spreading and you just put the fire out in a few places but it keeps spreading with the wind into other areas.

What I am trying to get from you people is what do you believe are the causes? What are the things that have brought this about? Why do young people today take the attitude that it is a good thing for them to use drugs?

When we were youngsters we knew enough to stay away from it. When people told us not to go into the whirlpools or where the currents were strong, we used to accept their advice. Once in a while some young kid would go out there and get drowned.

Why is it the young people today are not paying any attention to what over thousands of years people have known? In places like China and Africa where they have used all kinds of drugs over the years, we can see the results of that use of drugs in those areas. Why should a country like the United States with our advances in science and education and everything else, why should we suddenly find ourselves with such a problem?

I know in some of the communities in my district youngsters in grade schools and high schools are using marihuana, and it is common knowledge. I listened to a broadcast last night where one of the people speaking was complaining about the fact that nobody could seem to apprehend those who were distributing the drugs all over and making it available to younger children.

What I would like to find out from you is about the causes. What do you believe are the causes? I know that psychiatrists and mental institutions are doing their best to straighten out these people after they get to that point, but what do you believe are the causes?

Dr. EGEBERG. I will give him time to think a second.

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When I was little, often the man who had early sexual experience was looked up to by those who were slower as being quite a guy, and the fellow who smoked behind the barn was looked up to by the others. Both of these are not exactly things that one particularly admires. I think it is switched and I think there is a false looking up to the person who starts smoking marihuana at the age of 12 or 15. Instead of being considered to be what he really is, an emotional moron, he sort of becomes a hero.

That is part of a culture that has arisen. And how? I imagine there are many philosophers, psychologists, and others trying to find out.

Dr. BROWN. I just don't know. That is the reason I am hesitating with some genuine humility. I think there is at least one major dimension to the cause which has to do with the feeling of uncertainty towards the future and what the future will be like. Thus one turns inward to sort of experiencing things or having experimental experiences, if I can coin a phrase. In the "old days" one had a pattern or future in what one did. Much of our youth and some of the leadership, though, are so uncertain about the 1980's or 1990's or whether they will ever be there, they take a here-and-now experimental value.

I don't condone that, but this anxiety and concern for the future seems to be one of the root causes for the behavior. I would like to pass the buck to Dr. Cohen who has spent 20 or 30 years thinking about it on the fundamental level that you raised, Mr. Burke.

Dr. COHEN. You mentioned there has been a generation gap around since forever. Youth has always disagreed with their elders. Youth is also a time of risk-taking and I seem to recall going into speakeasies myself at a certain period.

In other words, I was doing deleterious things to myself some of which are being repeated now.

We have to consider that, but one important factor that Dr. Egeberg touched on is this matter of peer group—what is the gang doing, what is fashionable. Marihuana is definitely in these days. It is spreading down to the grammar school because the grammar school is mimicking what the college students are doing.

I would not be surprised but that when it gets down into the grammar school the college students will stop using it because it will be out and, although I have no good evidence to indicate that there is a leveling off of marihuana use, I think it will go through a cycle and someday we will see an end to it.

There are other reasons for this. The lack of purpose that was touched on, the lack of a future orientation, the affluence of our society are factors. All of these things and a lot more seem to combine to make this a drug-taking period of existence, and I hope it will go away.

Mr. BURKE. One of the answers given here is that the youth are concerned about the future. Of course, when you look back over the years, youth have always been concerned about the future. I think during the year 1929 when no one was working and youngsters did not have tuition to go to school, there were no jobs, there was unemployment everywhere. That was a bleak period in our history and yet the young people at that time did not turn to drugs or alcohol or other things—some of them did, but not in the proportion that they are today.

I was wondering whether we are not missing something here in failing to do something here that we could do. There is a responsibility on the part of the press. There is a responsibility on the part of radio and television. I was reading an article about Great Britain, how the great emphasis has been put on the Beatles and they have held up as great heroes.

Whether or not our schools and our homes have just encouraged the permissiveness and the laxity all the way down the line, and while we are writing legislation here, is legislation going to be effective if the other areas are not reached into? Are we trying to hold back the tide by passing legislation and giving the false illusion that we are really attacking this problem when actually we are only scratching the surface.

I am wondering whether or not people in this great society of ours—everybody expresses concern, but they go about their work everyday and youngsters are using marihuana everyplace.

How can it be possible in a small community of say 5,000 or 10,000? How can marihuana be distributed in that community and yet nobody seems to know where it is coming from? How can it take place all over the country? How can school teachers allow their children to be in their class and not observe that something is happening to a child in that class. What are the schools and local communities doing and what are the local churches doing and what are the news media and what are the rest of the people who all have a sphere of influence doing?

Of course, a great tendency is to blame it on Washington. Everybody says the Federal Government is to blame. That is why I am asking you for the causes. I am sorry you haven't got the answers. I haven't, but I do see a lot of areas where people in this country could do something about it and not expect Uncle Sam to cure a problem that is permitted by the permissiveness, the obscenity and vulgarity, and all of the other ills of our society which are so well exhibited around the Nation.

You can't have all of these things and keep a stable society.

I am going to support this legislation, but I hope we can have some reasonable answers from some people.

Dr. Egeberg. Dr. Cohen thinks he has part of one.

Dr. Cohen. I would like to respond to some of the thoughts you had, Mr. Burke, with two points.

One, a child brought up without limit-setting has been done a great disservice, because someone is going to set limits for him. If he does not learn them early, he is going to be in a bad shape later on. Then the police will set limits for him.

The other thought is that this society must develop new goals for this new world we are living in, appropriate goals, viable goals, goals which will attract the idealism of youth and this is the charge that you are referring to. This is what must be done in addition to passing this bill.

Mr. Burke. Of course, we should set goals. When I was a little boy they used to have the board of education in the schools. When I talk about the board of education I don't mean the elected board or the appointed board. The principal of the school had a board hanging on the wall down there that was shaped like a paddle and he used it once in a while. I don't recall anyone really being injured by it. I don't

like physical violence, but I think the use of a little paddle now and then might encourage a little bit of discipline in our society.

Dr. COHEN. That is what I call limit setting.

The CHAIRMAN. Mr. Pettis.

Mr. PETTIS. Doctor, I would like to pursue one other aspect of this. I conclude that there is an increase in the use of mood-elevating or mood-controlling drugs through legal channels. It would appear doctors are prescribing these more and more.

Is this a desirable thing in your mind as an expert in this field?

Dr. BROWN. A question like that gets us into the very fundamentals of what the values are in our society in meeting life's daily problems. I am not talking about illness, but the slight feelings of blueness or depression we have or slight feelings of being overactive and whether or not the medical profession or the industry through advertising promotes the use of drugs for the control of mood.

You are right and we have some studies to show that the use of mood-altering drugs is increasing rapidly. We have a set of studies and are monitoring the situation to measure the size of this use of drugs in cooperation with the industry and the FDA.

Whether or not it is the way to handle life's problems is a question for all of us and we in part would value your opinion.

Mr. LANDRUM. Mr. Pettis, would you yield a moment?

Mr. PETTIS. I yield.

Mr. LANDRUM. I would like him to include a comment to expand your question to include what he thinks about the articles we have read recently about the prescription of pep pills or drugs to students to increase their learning powers.

Mr. PETTIS. This was going to be my next question.

To what extent are we getting into a chemical society where we alter our life patterns by artificial means?

Dr. BROWN. Between the two questions, I think we have highlighted something that did not exist per se 20 or 30 years ago. Along with the many other technological and social changes that are taking place, the chemical revolution, the availability of new and more diverse and "better chemicals" to alter behavior and mood and feeling and thinking is part of the environment that our children are living in even more so than ours.

By the time you reach adulthood your propensity to use or not use drugs is pretty well established, whereas our adolescents are growing up in a culture where the drugs are part of what they feel in the very fabric.

I think, however, the role of the medical profession is but one role. The role of the industry, the role of advertising is another. I listen to my car radio and I am told what I should do if I feel a little nervous with over-the-counter prescriptions and this is part of the chemical revolution or control for the improvement or modification of behavior.

Specifically concerning the use of drugs for learning in children, there has been some publicity on that and some misinformation. There is good medical evidence that some young hyperactive children who have minimal brain damage or some neurological brain damage, paradoxically are helped by pep pills. This is a well-known medical fact, rather than pepping them up, it calms them down.

If this is done indiscriminately for the wrong children without adequate or medical attention, it is no good.

Mr. PETTIS. One last question. Is it your opinion that many of these tranquilizers which are being used for people who have mental disturbances, particularly those who have been institutionalized, has enabled us to get by with fewer medical personnel than we used to have in those situations and maybe in our total society where we are running short of medical personnel?

Dr. BROWN. In the psychiatric or mental hospital field, the drugs have substituted for the doctors who were never there in the first place and have had some dramatic effects in helping out. There is no doubt that any sophisticated knowledgeable layman or physician who visits a ward prior to the tranquilizer age currently will see a dramatic difference as well as significant numbers of people becoming well enough to adjust and do well in the community.

I think it would be an extension of our medical practice rather than a substitute for our medical practice.

The issue the two of you have brought up, which is so terribly significant, is when the drug use is above the medical practice, and how we live our lives and what we take and what is advertised and promoted. That is an issue bigger than the medical aspect of it.

Mr. PETTIS. No further questions.

Mr. ULLMAN. Dr. Egeberg, we have here, it seems to me, a series of problems that we try to treat as one problem. I am concerned about this legislation for that reason.

Certainly there is this problem of a chemical society, but as you have indicated, drugs can be a very useful tool. I certainly think there are times when drugs should be prescribed for a certain kind of child to accomplish a certain purpose. We are going to do that and I don't think there is any question about it.

But then we have the other problem of people just taking drugs for escape. This is not anything new. Since we have had wine and alcohol of any kind this has been part of the picture.

Right now the spotlight is on marihuana primarily because it is where the young people are and it is the "in" thing.

Do you think it is proper that we should lump marihuana into the same package with all other drugs under one set of rules in our law?

Dr. EGEBERG. We have separated both in the amendment to Hill-Burton and in this bill in saying it deserves particular, rapid and intensive study over the next few years so that we can clarify our thinking by having better knowledge about it.

If you are thinking of marihuana, it is in the same group with many other things like barbiturates. If you are talking about all four categories, barbiturates which do have a very useful thing, but which are also abused very, very much as are other substances which we know have a useful effect where as so far we are not aware definitely of any useful effect from marihuana.

I would say until we know more about it, it should be in one of the four categories of substances that we are thinking about or discussing.

Mr. ULLMAN. Of course, what we do around here when we don't have an answer to a problem we study it some more and that looks about like what we are proposing to do here.

Sometimes I am led to believe that marihuana is more a psychological thing than a real thing. When you take a certain amount of alcohol, you know it is going to go into your blood-stream and produce a certain result, varying in individuals, but for any individual it would be predictable.

Marihuana is, on the other hand, an indefinite thing. I have talked to people who have raised it during the war and smoked it and said it had no effect on them whatsoever. There is no standard marihuana. Some people raise it in their backyard. How much is psychology and how much is real?

I have talked to other people who say if you are in a group, you can begin to feel something because it is a psychological thing, but you can snap out of it right now which you can't do with alcohol.

To what extent is that a factor in the use of marihuana?

Dr. EGEBERG. I think I will refer to the psychiatrist for that.

Dr. BROWN. In hearing these stories, I think you have picked up a very interesting aspect of marihuana, and that is the experienced marihuana smoker often seems to need less rather than more. He does not build up tolerance. The reasons for this are subtle and interesting. It has to do with learning a reaction, feeling high or well, rather than the actual chemical or needing less chemical because he has learned how to go into this state.

I think the concern I have with the way you present it is to say that the psychology or feeling high or mania or different would be based just on psychology and not physiology. They sort of link together so closely it is hard to put your finger on one or the other.

It is well known with alcohol that you can take a drink or two and get pretty high, which has little to do with your alcoholic content. It has to do with the mood being set, being with friends and colleagues.

At other times, you will drink a minimal amount because your blood level would be higher. So, the interplay of psychology and physiology is a very intriguing and interesting one.

Marihuana does have this aspect that Dr. Cohen spoke to, that it is often smoked in peer groups and there is a lot of sensitivity to what you should feel. It may have more to do with that social or peer group pressure than actually the effect of the chemical in marihuana.

Mr. ULLMAN. Let's make a specific example—driving under the influence. We, of course, know driving under the influence of alcohol is a very real thing. You can test it. You can pretty well know whether a person has control of his facilities or has not. You never read about an automobile driver under the influence of marihuana. Why is that?

Dr. BROWN. I think because we have just not gotten around to it or tested it. We are doing a specific project in that area to see what the effect of marihuana is on the physiological function such as braking, alertness, et cetera. It has not just become part of our social patterns rather than it not being relevant.

I think also the marihuana smoking is done in a way that it is less common to take a ride in a car afterwards, although I am sure it happens. Also the officer would be less alert except that the person looks drunk, does not have any alcohol, and perhaps does not think of marihuana testing. This is why some of our pharmacological research is important. We are just beginning to have the first breakthrough and

being able to see traces of marihuana in the bloodstream which 3, 4, 5 years from now may be used in a similar way to testing driving under the influence.

I think we do know it has effects on behavior such as driving, and hope to be able to document it similar to alcohol.

Mr. ULLMAN. You have no evidence now.

Mr. BROWN. Let me ask Dr. Cohen who has been supervising specific projects in this area.

Mr. ULLMAN. If this can be smoked in cigarettes, why don't people who have hang ups take the marihuana cigarette and smoke it when they get in a car? What is it about this that you have to do it in a circle, in a dark room and you don't do it by yourself? What is the psychology involved?

Dr. COHEN. There are some people who use marihuana alone and while driving. The reason why you see very few reports of driving while potted is that we have no commercial test today like we do for alcohol for determining blood levels of marihuana. This, as Dr. Brown said, will come in a few years, but we don't have it today. So, we can't prove that a man is driving under the influence of marihuana today.

Mr. ULLMAN. What about in the case of crime. We have evidence that a lot of crimes are committed by people who are under the influence of something.

Is there something about marihuana that would give one the courage or the desire to commit a crime?

Dr. BROWN. This is an important question and I think that, as you hinted earlier, people don't take marihuana and get into a car and drive. Most of the marihuana smoking would be in social group settings rather than in the course of daily activities as it so often is with alcohol where a person has a cocktail at lunch, goes out in the evening and uses the car for transportation.

Marihuana is more often used in the company of others, but with considerably less of the sociability and gregariousness you see in alcohol. Alcohol is so widely used, but if you do look at the statistics for people who are caught and convicted in criminal behavior, I think you will find alcohol related very high, perhaps surprisingly high.

Mr. ULLMAN. Much higher than drugs?

Dr. BROWN. Much higher than drugs and I think low or minimal with marihuana. The marihuana taking leads more to a private, thoughtful, special experience in your head rather than an active getting out, doing something that you have not been able to do because you have not had the courage or the foolishness.

Mr. ULLMAN. Here again, we have real evidence that a lot of crime is caused by the hard drug users because it becomes costly and they have to get the money. It is just something they have to have. This is not true with marihuana; is it?

Dr. BROWN. You are correct; it is not true. It is true that in order to have $20 to $100 for heroin there is a very high order of criminal activity among the heroin addicts.

Mr. ULLMAN. Here again, we come to distinctions. I know Congressman Pepper and the committee decided that the use of marihuana did lead to hard drugs, but you said here this morning that there is no evidence, as far as you are concerned, that the use of marihuana does lead to hard drugs; is that right?

Dr. COHEN. Only in the case of the heavy marihuana user is there a tendency to go on to other more dangerous drugs. Some potheads are inclined, according to our surveys, to go on to amphetamines, barbiturates, LSD, and a few to heroin, but the pothead represents 5 to 10 percent of all marihuana users.

Mr. ULLMAN. Have existing laws inhibited research in this area?

Dr. COHEN. There is increasing marihuana research. We supply marihuana and THC to researchers and each year, for the past 5 years, there have been increasing numbers of studies so that, although marihuana research is difficult to do, there is quite a procedure. You need tax stamps, and you have to submit a protocol to a combined FDA–NIMH committee. Research in this field is increasing now.

Mr. ULLMAN. The laws have inhibited it?

Dr. COHEN. Yes; it has made it difficult.

Dr. EGEBERG. Also, there was a lack of interest on the part of the research community. I was on a Presidential commission looking into the whole drug question about 10 years ago, and it was difficult to get people interested without the difficulties of filling out papers.

Mr. ULLMAN. In order to really tackle this problem we have to answer the statements and the thinking of the young people. I just have not detected here real answers to the things that they are saying. I think that Mr. Burke and others in their questioning were trying to find out what makes them do it.

But what we need to do, I think, is get some people who use it here and get their arguments which I have heard many times. Many of them would sound really reasonable.

I remember just a few years back every kid smoked. He had to smoke cigarettes. It was not too long ago you sat around a table and if you didn't smoke you were an oddball.

Today the situation has changed. I wonder to what extent the kids in grade school, in place of having a cigarette and getting a cigarette habit, are doing this. In other words, to what extent are these things mutually exclusive?

Are they doing less cigarette smoking and less drinking if they go to marihuana? Or, in a permissive society, if they go to marihuana, are they likely to do the other things, too.

Do you have answers to that?

Dr. COHEN. According to our studies, there is no decrease in cigarette smoking among marihuana users. There may be some decrease in alcohol consumption among some marihuana users, although I know of others who use both at the same time.

Mr. ULLMAN. In other words, this is not a mutual exclusive thing as far as you are concerned?

Dr. COHEN. No; the statistics for tobacco and marihuana show that just as much tobacco is used by marihuana users and nonusers. There may be a slight decrease in alcohol consumption.

Mr. ULLMAN. Again, and we do not have the answers here today, but I would really like to see as a part of this record a series of statements by marihuana users and scientific answers to those statements because they can make a very convincing argument that the use of marihuana is not a hazard to society.

Dr. COHEN. Mr. Ullman, we have a publication called "Answers to The Most Frequently Asked Questions About Drugs," including a section on marihuana. We attempt to take these questions and deal

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with them as honestly and as scientifically as we can, and we will be glad to submit that for the record. (See p. 297.)

Mr. ULLMAN. I would say again, that one of the fallacies in this whole procedure is we are trying to deal with a whole series of different kinds of problems under one set of concepts. I think there has been too little distinguishing between the issues involved in different circumstances and with different drugs.

Until we really understand that, I do not think we can really tackle the problem.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Vanik.

Mr. VANIK. Dr. Egeberg, first of all, let me say your agency and the agency that is headed by Dr. Brown, I think particularly, have the gravest responsibility confronting any group in America today because you have this tremendous problem and you have the know-how and the skill to apply to it.

What attracts my attention in your statement is this sentence: "When people find out suitable goals and values, drugs can become meaningless and superfluous."

This seems to indicate, does it not, that drugs are sort of a medicine of despair. I appreciate the statements that distinguish one drug from another and so on, but what does the family do that has a problem with a child who may be disturbed or upset or unconventional or nonconforming or filled with some despair because of failure to measure up to family expectations? What doors are open? What books are there that say do this or do that?

Yes; see a psychiatrist, if you can, if he can be found. Where are the places where these young people can find solutions to their problems?

Dr. EGEBERG. In the first place, if the problem is evident, naturally, the first place to begin would be to have a talk within the family. By the time it is evident it is often much more helpful to get a neutral figure, possibly an authoritarian figure which could be from the church, it could, perhaps, most likely be the family physician. It could be someone in a YMCA or Scout group who can talk without all of the habits and relationships that the family has had in the past.

Part of the problem can be answered by just giving proper information if one speaks early enough. After that one may need the help one can find in the many clinics that the National Institute of Mental Health has helped to set up which will tackle this problem or others.

Mr. VANIK. What sort of place would there be where a young person on his own volition might walk in and say, "I feel the need for a medicine of despair and I am here." Where could that person go? What door is there here that is open?

Dr. COHEN. There are the Community Mental Health Centers that deal with the problems of dangerous drugs.

Mr. VANIK. What happens there? They are probably told to go see a psychiatrist, are they not?

Dr. COHEN. You are right. The facilities do not extend as far as the need.

Mr. VANIK. They get a book on drugs and if you have any further need for help, "Come and see us," but they don't really provide any services, do they?

Dr. COHEN. Yes, there is a service capability, but I would be the first to admit to you that it does not meet the need. The need has come upon us so quickly that we have not caught up with it.

Mr. VANIK. How do you feel about these groups of young people who gather together? Do they help each other?

Dr. COHEN. I think so.

Mr. VANIK. Isn't it time we recognize in these groups that they make of their own, they may be solving some of their own problems on their own. At least they have a sympathetic exchange if they are gathered together with people who share a despair and a shared despair is probably easier to handle than a privately held despair. Isn't there something to that?

Dr. COHEN. I think these rap sessions are very valuable because one young person will listen to another young person.

Mr. VANIK. Particularly when the other young person also has a problem.

Dr. COHEN. That is true. We know of groups where they have been extremely helpful.

I would like to mention one other resource that is springing up almost spontaneously, although we are trying to help; namely, the use of ex-drug users to help people who are attempting to turn off.

Mr. VANIK. Comparable to Alcoholics Anonymous.

Dr. COHEN. Yes, sir.

Mr. VANIK. Doesn't society discourage these people from gathering? Isn't there a tendency on the part of social groups and police authorities to discourage the gathering together of these young people rather than their meeting together? What about that?

Dr. BROWN. Mr. Vanik, you are putting your finger on a terribly critical point about where do you go as a young adolescent, anywhere from 13 to young adult, when you are despaired, discouraged, alienated. We know the medical or psychiatric setting does not quite meet the answer. The truth of the matter is that we have no good organized settings that you can go for that purpose. There are some churches where the minister or the leader has rather intuitively and on his own created a youth group where you can come to discuss.

Mr. VANIK. He gets in the paper sometimes.

Dr. BROWN. When a spontaneous physician does this who has been experienced with this problem, we run into the fact that there are these new peer groups which are formed and are on the constructive, creative side and they are looked upon with suspicion by the older group.

This can be a creative and new social form to meet a desperate need.

Mr. VANIK. Isn't it time we developed some technicians who are not psychiatrists, who do not have the capability of psychiatrists but who could, under direction, provide a great service to a great many people who have no access to psychiatrist reasons because of the scarcity of psychiatrists and the scarcity of services.

Should we not be building up a reservoir of technicians with some capability in this area so they could assist these people?

Dr. BROWN. Yes.

Mr. VANIK. My next question is this: Isn't it possible for the development of a publicly-funded place of refuge for disturbed young people, many of whom are going to drugs as a substitute for success

in life by conventional standards? Should we pick up some old facility that is surplus and turn it over or utilize it for the thousands of young people who have the need for a place to get strength?

Dr. EGEBERG. Could I answer this in terms of Los Angeles, sir?

In Los Angeles there was a great deal of marihuana used in East Los Angeles. There was a fair amount of heroin used. This is a community of primarily Mexican Americans. It has its counterpart in other parts of Los Angeles. But a group of young people there came to us—I worked for the Department of Charities and later I was the dean of a school that was in that area. They said, "We can take them off heroin. We have ex-addicts who can take them off marihuana, speed and so on. We can't get them off barbiturates because sometimes they die when we take them off of that and we need your help."

We managed to make available 10, 20, then 40 beds in one of the country hospitals, far enough away from here so there was a different atmosphere. These beds are constantly full. There is a feeling in the community that both the youth and the older people want to do something about it.

This was generated entirely in the community. They just came to us for help which we were very happy that we could give them.

I think if you can get something generated in the community, be sensitive to it and then help it, you have done the first five or six steps, as opposed to if you go to the community and try to start something.

Mr. VANIK. They need a place that is not a prison or a hospital, a place where lives can be readjusted.

Is your agency, under present law, authorized to provide such places demonstration grants to help? Have you made any effort to perhaps pick up some excess Federal property, and obsolete military establishment that can be utilized to provide a place or refuge and a place for readjustment?

Dr. COHEN. We have a capability to provide for innovative demonstration projects of the sort that you mention, although we have not taken over any battleships yet. There is one project that I can think of immediately in New Jersey that has occupied an old Army camp and is converted into a facility for the treatment of the hard drug user.

The marihuana user does not often appear there, but the speedfreak and the heroin addict is cared for in that facility.

Mr. VANIK. I am talking about the disenchanted young people. You have to reach them before they get into that category. I wonder what we do about this grave huge body of people who are filled with despair and disenchantment about our times and what we are doing.

Dr. BROWN. We can give you the bureaucratic answer which is we have the authority to do this. I have had occasion to offer informal consultation to youth councils across the country, trying to set up something like this, and they run smack into the difficulties of what kind of informal agreements can you make with the police.

This is the kind of a real problem they have. Who will be the sanctioning or authoritarian figure who will sponsor such a group? What other legal responsibilities are there since you run into runaways in situations like this.

I think it is a case where the people we are dealing with have such a variety of problems, legal, parental, social, as well as this drug aspect, which in perspective is but one dimension.

We do not have an organized approach to this very large need of our times.

Mr. CONABLE. Would the gentleman yield at this point?

Mr. VANIK. Yes, I would be happy to.

Mr. CONABLE. In New York State, we have done some work in this area. In my district there is a Job Corps camp built at great expense to the Government. It was closed within a year, also by the Federal Government. It was then turned over to the State of New York for a drug rehabilitation center. I must say we are having our problems with it, but there is progress being made. It is quite an isolated facility and apparently there are other facilities of this sort that are available that if there is an aggressive State government interested in it, it can work out the arrangement with the Federal Government for some interesting rehabilitative work.

Mr. VANIK. I am glad to hear that. I just want to say before I finish my questioning that I do hope among the documents and the publications that you develop that you develop one that gives advice, when your child is disturbed or you are concerned about your child, as to what can you do. I think everybody is aware of the minister, the priest, the doctor, the psychiatrist. It is beyond all that. It is what you do after you have exhausted all of the standard cliche remedies or suggestions.

I think most of the problems of most people go beyond that. They don't know what to do. There are very few places they can go. The psychiatric services that are available are very limited to persons in the lower economic status. There may be better services available to those who can afford to pay, but even among those who can afford to pay there are very few places and very few services that are available to help.

It seems to me that we are rejecting these people. We are forcing these people to solve their own problems—I hope they are.

It seems to me this is certainly a time for extensive demonstration, for extensive clinical research, and this other aspect of the drug problem which I think will do far more to solve the real problem than all of the laws we can write here today.

Thank you.

Mr. GILBERT. I have listened with great interest to your testimony about marihuana. It appears to me there is a great deal of confusion in the area, that the research is incomplete and I would suspect that this leads to a great deal of confusion in the minds of the public and in particular to the users or potential users of marihuana.

You were quite direct in response to a question with respect to the use of cigarettes and you ticked off very rapidly one, two, three, heart disease and lung disease and what the future would be for somebody that was a consistent user.

But yet in response to the question, I believe, of Congressman Bush, who asked about a 15-year-old inquiring about the use of marihuana, you said, "Well, it is a crime."

Well, I don't think that is a satisfactory answer because the 16-, 17-, and 18-year-olders know it is a crime. But what I think is the nut of the problem is what the medical result of the use of marihuana is. Or, what is the effect on the mental processes of the use of marihuana? I wish you gentlemen would address yourselves specifically to these two areas so the record might be complete.

Dr. EGEBERG. We have learned one thing and that is we had better be sure of the facts when we talk to the young. That is the reason for stressing the research aspects in the next 2 years.

At the present time, if a young fellow, a 15-year-old asks "What is the difference between what marihuana will do to me if I use it over a period of years and if I use alcohol?" I don't think we have the scientific evidence to say what the difference is.

So, we have to say there are very possible dangers. We have to say that it can make you forget or it can make you evade life now when it is so important for you to face it.

That, I think, we can say, but we can't say it is going to do certain things to your brain with any assurance, and if we say otherwise, they can sense that we are speaking off the top of our head. I think we do more harm. That is why I think it is extremely important that within the next few years and as quickly as possible we list what marihuana can do to people or is likely to do to people and have some statistical evidence as to how long you have to use it or how many people will be affected.

It took a long, long time to get that information on cigarettes. I think it took two decades. You can probably add to what I have said.

Dr. COHEN. I would like to underline the fact that especially the pothead, the person who makes a career of marihuana use is doing a great disservice to himself. He is interposing a chemical between the very things that make him grow and mature; namely, the frustrations of life. This I think is a real harm that any drug can do including marihuana and including alcohol, when used in that way.

Mr. GILBERT. Now you have interjected with the use of marihuana-alcohol, yet, we don't say that the use of alcohol is a crime. On the other hand, you say the use of marihuana is a crime.

How do you explain that?

Dr. COHEN. We are getting close to the core of the problem. Alcohol and tobacco are culturally accepted and have been for innumerable generations and we can't forget that fact. We tried to do something about our terrific alcohol problem and failed miserably because it was part of society.

Now the question becomes then should marihuana become part of society before we have the answers? Should we accept it and then find out later that it causes A, B, C, and D which we only have presumptions about now.

Mr. GILBERT. We say it is a crime to use marihuana, and there have been some very severe sentences to some of our young people for the use of marihuana. Yet, some of the best people of our society, the most intelligent such as yourself say you don't have the answers to the problem, and you say it may be potentially harmful to them both physically and mentally.

Then you say to them you have a choice now which you can make whether you are willing to take this risk or not. But why should society turn around and say to this individual who wants to take the risk, you are going to go to jail because you are using this product and yet you put it in the same category as smoking and the same category as drinking.

Dr. COHEN. Merely, and this is not logical, it is not part of our culture. Therefore, it is taboo. We are faced with this hard fact that for 30-odd years it has been a crime to do this thing.

Dr. EGEBERG. I think this became a cause celebre of the earlier Bureau of Narcotics. They suddenly decided that marihuana led to heroin and while they later could not prove that marihuana in and of itself was so bad, they clung to the fact that marihuana was the road to heroin and that they went together.

This has been built up and we have to unbuild it. To do that, we have to tear it down. To do that, we need a few more facts, many more facts than we have now. We want these. We think that the punishment has been completely unrelated to any crime. This was one of the things I personally felt violently about when I first came into this job that I hold and I think it helped open this subject.

We feel that this bill is a very good step in the right direction. Remember that this bill is more for the Department of Justice to help delineate their responsibilities and their relationship to us. We have through the Institute of Mental Health and through their mental health clinics and bills which support them, ways of approaching this problem both in prevention and in treatment.

But we still need a little more information on marihuana before we can go to our children and say categorically what we could say to them 5 or 6 years ago about smoking.

Mr. GILBERT. Is marihuana "marihuana" or are there different classes?

Dr. EGEBERG. It is the final chemical that does the trick to the smoking of leaves of marihuana raised in this country. Hashish and cannabinols are different aspects of marihuana. One is stems and everything ground up and compressed and another is a gum. They get the gum from the opium. Marihuana growing in different countries apparently has different potencies and now that they have been able to isolate the ingredient that causes the biological action, they can compare all of these with each other.

I would say that all of these come from marihuana. Their potency probably varies hundreds of fold.

Mr. GILBERT. Would you say, Doctor, that the smoking of marihuana, say, immediately at the time it is cut in Mexico to the time it reaches a college campus there is quite a difference in the potency of the marihuana?

Dr. EGEBERG. I don't know.

Dr. COHEN. Marihuana increases slightly in potency when it is dried, but after drying it starts losing potency and after a year or two has lost a considerable amount of its THC.

Mr. GILBERT. I heard or read some testimony to the effect that when the marihuana is first cut in Mexico, it is quite potent and devastating upon the individual. Then by the time it goes through its devious route and it finally reaches the ultimate user that there is quite a difference because of the fact that it is drying out, that the climatic conditions are not the same and for whatever myriad of reasons; there is a change in the potency of the marihuana.

What concerns me is that when we talk about marihuana and we don't know the effects of it, is it the ultimate user on the college campus, say, who smokes this marihuana at the stage where perhaps it is not as potent can turn around with great impunity and say, "Gentlemen, it really does not have any effect on me." Because it really does not have any effect on him and as the doctor said, it is a mental sort of condition and he is getting high kicks through some vicarious sort of thrill.

Do we have any statistics about that and how do we place it in the final perspective?

Dr. BROWN. The joints arriving on a campus have a 0.1 to 0.5 percent THC, depending on where it was grown, et cetera. This is why we had to start growing our own under our own auspices at NIMH so we could provide investigators with known quantities and known amounts. Without this kind of control you can't do any kind of sensible factfinding.

Indeed, it is true what you mention that quite often the home grown marihuana, pot, in our Midwest is so weak that people smoke it and decide there is no effect at all and they are correct. Often they will then run into a very powerful marihuana and have a psychotic reaction and be all surprised. So, this language of uniformity is quite accurate as you describe it.

Mr. GILBERT. Would that be more or less at taking booze which is 60 percent and they take a shot of booze that is 150 percent and and they see a difference?

Dr. BROWN. The difference is between diluted beer and Southern Comfort.

Dr. EGEBERG. You can tell the difference between 20 proof and 60 proof.

Mr. GILBERT. We are not speaking as experts, of course.

I thank you for your testimony here this morning, but I am as deeply concerned about the problem now as I was before and I am equally as confused. I think we have to supply these answers and very rapidly to our people so that they do realize that marihuana has an effect upon them, and having teenage children I am very, very concerned about it from the reports that I get from my own children and in speaking with their friends and just the general material that you would read in the newspapers.

I think the bill may be one thing, but I think the research is of vital importance, and I commend you gentlemen and I hope you can solve the problem a lot more rapidly.

The CHAIRMAN. Since there are no further questions, Dr. Egeberg, and those at the table with you, let me again thank you for your very fine testimony and for taking the time to come to the committee to deliver it.

(The appropriate parts of the publication entitled "Answers to the Most Frequently Asked Questions About Drug Abuse," follow:)

A Federal Source Book:

ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS ABOUT DRUG ABUSE

GENERAL QUESTIONS ABOUT DRUG ABUSE

WHAT IS A DRUG?

A drug is a substance that has an effect upon the body or mind. This publication deals only with those drugs that have a potential for abuse because of their mind-altering capability.

WHAT IS DRUG DEPENDENCE?

Drug dependence is a state of psychological or physical dependence, or both, which results from chronic, periodic, or continuous use. Many kinds of drug dependence exists: they all have specific problems associated with them.

Not everyone who uses a mind-altering chemical becomes dependent upon it. Alcohol is one common example of this point. The majority of persons who drink do not harm themselves or those around them. However, more than five million Americans are dependent upon alcohol.

WHAT IS HABITUATION?

Habituation is the *psychological* desire to repeat the use of a drug intermittently or continuously because of emotional reasons. Escape from tension, dulling of reality, euphoria (being "high") are some of the reasons why drugs come to be used habitually.

WHAT IS ADDICTION?

Addiction is *physical* dependence upon a drug. Its scientific definition includes the development of tolerance and withdrawal. As a person develops tolerance he requires larger and larger amounts of the drug to produce the same effect. When use of the addicting drug is stopped abruptly, the period of withdrawal is characterized by such distressing symptoms as vomiting and convulsions. A compulsion to repeat the use of the addicting drug is understandable because the drug temporarily solves one's problems and keeps the withdrawal symptoms away.

Drugs other than narcotics can become addicting. Some people have acquired an addiction to sedatives and certain tranquilizers. Stimulants in very large doses are addictive.

Whether the person is physically addicted or abuses drugs for psychological reasons, he is dependent upon drugs. Drug dependence of any kind is a serious problem for the individual and society.

ARE ALL DRUGS HARMFUL?

Every drug is harmful when taken in excess. Some drugs can also be harmful if taken in dangerous combinations or hypersensitive people in minute or ordinary amounts.

The fact that certain drugs can produce enormously beneficial results has produced the false notion that pills will solve all problems. Society must develop a new respect for all drugs. Drugs that affect the mind can have subtle or obvious side effects. These can be immediate or may become evident only after long continuous use.

WHY ARE DRUGS BEING ABUSED THESE DAYS?

Drug abuse is not a new phenomenon. Varying forms of drug abuse have been present for years in the United States and other countries. There are many reasons for the current epidemic of drug misuse. Very broadly, drug abuse can be described as an effort by individuals to feel different than they do. Many drugs temporarily allow their users to evade frustrations, to lessen depression and feelings of alienation, or to escape from themselves. Such misuse of drugs, of course, does not produce any improvement in the problems of the individual or society. Rather, it is a flight from problems.

Some of these factors in the great "turn on" of recent years are:

(1) The widespread belief that "medicines" can magically solve problems.

(2) The numbers of young people who are dissatisfied or disillusioned, or who have lost faith in the prevailing social system.

(3) The tendency of persons with psychological problems to seek easy solutions with chemicals.

(4) The easy access to drugs of various sorts.

(5) The development of an affluent society that can afford drugs.

(6) The statements of proselytizers who proclaim the "goodness" of drugs.

WHAT IS MEANT BY A DRUG CULTURE?

A drug culture or subculture is a group of people whose lives are committed to drugs. The members of any subculture may congregate in a particular geographic area, such as the Haight-Ashbury district in San Francisco.

Marihuana is almost invariably smoked in such communities, but hallucinogens, sedatives, stimulants and narcotics are also used. It has been demonstrated that these subcultures are transient in nature; only a minority of the members remain for more than a year.

WHERE ARE MOST DRUG USERS LOCATED?

The location of users varies with the drugs in question. Until recently, almost all heroin use was confined to males in urban ghettos. Now this pattern is changing. A few young people in suburban areas use heroin. Marihuana formerly was seen primarily in disadvantaged areas, in certain Mexican-American communities, and in some groups of jazz musicians and similar persons. Today, marihuana smokers and users of hallucinogens are found among middle and upper class young people and other groups. Barbiturates and amphetamines were once abused primarily by middle and upper class adults. Now, many youngsters of all classes are misusing them. The important thing to keep in mind is that drug use patterns are changing rapidly in the United States.

WHY DO DEPENDENCY PRODUCING DRUGS HAVE SUCH A WIDE RANGE OF EFFECTS UPON DIFFERENT USERS?

The effects of mind-altering substances are related to the expectations of the user, the setting in which the use takes place, and the potency of the drug. Mind-altering substances can have vastly different effects upon different people because such drugs release individual underlying personality traits that are ordinarily covered up. Internal controls are diminished or eliminated; one person may become angry, another amorous, a third happy, others disoriented, confused, or depressed, and so on.

Even the same person taking the same dose of a drug on a subsequent occasion may have an entirely different response. As self-control is lost, the person reacts to suggests from people around him and the setting in which the drug is taken. These factors can markedly alter the drug's effects.

DO DRUG ABUSERS TAKE MORE THAN ONE DRUG AT A TIME?

People who abuse one drug tend to take all sorts of drugs. Some of them say they are looking for a new "high." Some will take any drug to get outside themselves. Some play chemical roulette by taking everything, including unidentified pills.

WHAT ABOUT "PATENT MEDICINES"?

Certain over-the-counter medicines have been taken in excess and have been used to "turn on." Certain cough syrups and the stay-awake and go-to-sleep preparations are sold without prescription and may cause dependence. Paregoric (camphorated tincture of opium), which is available in some states without a prescription, is also being abused.

Another way in which patent medicines may contribute to the drug abuse problem is their manner of advertisement in the mass media. Children and adolescents hearing such commercials may become conditioned to believe that taking drugs for minor emotional difficulties is all right. To promote the belief that taking a drug will deal with the difficulties of everyday life is undesirable.

WHY DO AFFLUENT PEOPLE BECOME INVOLVED IN DRUG USAGE?

At one time we thought that if we could eliminate poverty, drug abuse would fade away. This notion was obviously erroneous. In a world where changes are rapid and yesterday's faiths and values may erode, affluence allows the time and finances to support drug excesses. Loss of goals and drive can be a by-product of affluence. When a person no longer needs to work in order to eat and clothe himself, he may develop problems of leisure. If he has no viable goals, no motivation or drive to create, to study or to help others, he may become bored or alienated, and vulnerable to the temptation of using chemical substitutes for productive living.

CAN THE EFFECTS OF DRUG ABUSE BE PASSED ON TO THE UNBORN?

Some babies born to heroin-addicted mothers have shown withdrawal symptoms. Not enough is known about the genetic effects of other drugs. Taking drugs without careful medical supervision during pregnancy is extremely risky.

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WHAT IS WRONG WITH TAKING ANY DRUG I WANT AS LONG AS I DO NOT HURT ANYONE ELSE BY DOING SO?

Society has duties to the individual, and the individual has certain responsibilities to the society in which he lives. A responsible social system provides its citizens with information about the dangers facing them, including the possible dangers of drugs. When a drug has both a harmful and a beneficial potential, regulations about the manner in which the drug is used should be formulated.

It is difficult for an individual to do something to himself that has consequences upon himself alone. Inevitably, the act will have an impact on those who are close to him and those who are dependent upon him. To "drop out" via drugs means that the person becomes dependent upon the social structure for a variety of services and supplies. Someone has to pay the bill.

WHERE DOES ONE GO IF HE IS BECOMING OR IS DEPENDENT UPON DRUGS?

If the user wants help, one's family, a friend, physician, or minister could be asked to help find the best resource in the community. The family doctor, mental health professionals, or school counselors should be among the first to be contacted. Some community self-help groups are effective. Many community mental health centers have special drug abuse units; all centers should be able to provide services or referral to an appropriate resource.

WHAT CAN A PARENT DO TO HELP A CHILD WHO IS ABUSING DANGEROUS DRUGS OR NARCOTICS?

Talk about it and try to understand why this behavior is taking place. Ideally, a relevant alternative to drug misuse can be figured out. Increased family interest and involvement in the child's daily activities will help. Professional advice may be desirable. Some communities have programs run by ex-users.

When the youngster is intent upon continuing his drug taking, the problem is much more difficult. Solutions must be individualized. In some instances, it may be desirable to point out that the family cannot be expected to support the drug-taking activity. Psychotherapy may be necessary, but it usually is not successful if the patient is resistant to change. Arbitrary restriction of the youngster may or may not work. If he runs away or is apprehended in some illegal act, he should know that the family will support and help him as soon as he decides to alter his destructive pattern of drug taking and antisocial behavior.

WHAT ARE THE BEST COUNSELING PROCEDURES TO USE FOR DRUG ABUSERS?

In general, the counselor whose approach is punitive is unlikely to succeed. Channels of communication must be opened, and the patient must acquire some measure of trust in the counselor. By listening to the drug abuser's story, the counselor should not give the impression that he is condoning the behavior because he is listening without judging. He must try to understand what the drug means to the patient, and then determine what non-drug alternatives are available.

Group therapy is often successful. Many treatment programs are very effectively using ex-abusers as part of their counseling staffs. Naturally, the skill of the therapist is an important element in achieving success, but the most important factor is the desire of the user to stop using.

IS IT POSSIBLE TO OBTAIN MEDICAL HELP WITHOUT INCURRING LEGAL PENALTIES?

A certified physician or psychologist can generally assure patients that discussion of drug abuse problems will be kept confidential. Practically all enforcement agencies cooperate with the person who wants help.

WHAT MORE CAN BE DONE TO CURB THE MISUSE OF LEGALLY OBTAINED DRUGS?

The family medicine chest may be a source of initial drug trials by children. It should not be used as a stockpile of drugs that are no longer needed. Physicians and pharmacists must carefully watch the renewal of prescriptions of drugs that can cause dependence. The patient should be warned about using such drugs exactly as prescribed.

All manufacture, transportation and distribution of large quantities of drugs in legal commerce should be controlled by adequate safeguards. Large amounts of stimulants and sedatives are being diverted into illegal channels by theft and fraudulent orders.

WHAT SORT OF PROGRAM COULD MAKE A REAL IMPACT ON OUR DRUG ABUSE PROBLEM?

1. Society should judge adults who misuse liquor or drugs by the same standards it judges young people. A double standard produces a credibility gap.
2. Children should not be continually exposed to the idea that the stresses of daily life require chemical relief.
3. Factual information about drugs should be stressed rather than attempts to frighten people.
4. Respect for all chemicals, especially mind-altering chemicals, should be instilled in people at an early age.
5. Efforts to detect all manufacturers and large scale traffickers of illicit drugs should increase.
6. Further research in prevention, education and treatment techniques should be carried out.

WHAT CAN ONE DO TO HELP PREVENT THE SPREAD OF DRUG MISUSE?

There are a number of things an individual can do:

1. He can set a good example by not abusing drugs himself. Since he can expect his children to model their drug-taking behavior after his, he can either refrain from drinking socially accepted alcoholic beverages, or drink in moderation.
2. He can learn as many facts as possible about drugs so that he will understand the problem and be equipped to discuss it in a reasonable manner.
3. If he learns that someone is peddling drugs, he should notify the authorities. It is the responsibility of both the individual and the community to keep the dealers out.
4. He should do what he can to assist anyone wanting help for a drug problem while awaiting additional aid from a trained person or a treatment facility.
5. Most important of all, he can strive to meet the ideals of parenthood, trying to rear his children so that they are neither deprived of affection nor spoiled. He should have a set of realistic expectations for them. He should give his children responsibilities according to their capabilities, and not overprotect them from the difficulties they will encounter. A parent should be able to talk frankly to his children, and they to him.

QUESTIONS ABOUT MARIHUANA

WHAT IS MARIHUANA?

Marihuana is Indian hemp (*Cannabis sativa*). The parts with the highest tetrahydrocannabinol (THC) content are the flowering tops of the plant. The leaves have a smaller amount. The stalks and seeds have little or none. THC is believed to be the active ingredient in marihuana. Many other compounds are present in marihuana, but they do not produce the mental effects of the drug.

DOES MARIHUANA VARY IN STRENGTH?

Yes. Some marihuana may produce no effect whatsoever. A small amount of strong marihuana may produce marked effects. The THC content of the plant determines its mid-altering activity, and this varies from none to more than 2 percent THC. Because THC is somewhat unstable, its content in marihuana decreases as time passes.

The plant that grows wild in the United States is low in THC content compared to cultivated marihuana, or the Mexican, Lebanese, or Indian varieties. Climate, soil conditions, the time of harvesting and other factors determine the potency.

WHAT IS HASHISH?

Hashish (hash) is the dark brown resin that is collected from the tops of potent *Cannabis sativa*. It is at least five times stronger than marihuana. Since it is stronger, the effect on the user is naturally more intense, and the possibility of side effects is greater.

IS MARIHUANA AN ADDICTING DRUG?

Marihuana does not lead to physical dependence. Therefore, it cannot be considered addicting. Chronic users become psychologically dependent upon the effects of marihuana. Thus, it is classified as habituating. The fact that a drug is not addicting has little relationship to its potential for harm, since dependence, whether psychological or physical, is a serious matter.

IS MARIHUANA A STIMULANT OR A DEPRESSANT?

Because it affects the individual's self control, the effects of marihuana vary so widely that it can be either a stimulant or a depressant. THC is a strong hallucinogen with some sedative properties. Occasionally, a person intoxicated with marihuana will become stimulated and overactive.

HOW IS MARIHUANA USED?

In this country, it is generally smoked in self-rolled cigarettes called "joints." It is also smoked in ordinary pipes or water pipes. Marihuana and hashish can also be added to foods or drinks.

WHAT ARE THE IMMEDIATE PHYSICAL EFFECTS OF SMOKING A MARIHUANA CIGARETTE?

Reddening of the whites of the eyes, an increased heart rate, and a cough due to the irritating effect of the smoke on the lungs are the most frequent and consistent physical effects. Hunger or sleepiness are reported by some individuals.

HOW LONG DO THE EFFECTS OF MARIHUANA LAST?

This depends upon the dose and the person. A few inhalations of strong marihuana can intoxicate a person for several hours. Weak marihuana will produce maximal effects for a short period of time. When a large amount is swallowed, the effects start later but persist longer than when the same quantity is smoked.

HOW DOES MARIHUANA WORK IN THE BRAIN?

This is not known. Studies attempting to clarify the question are underway.

DOES THE INDIVIDUAL'S TOLERANCE TO MARIHUANA VARY WITH REPEATED USE?

The development of tolerance to marihuana does not occur. Some people speak of "reverse tolerance." By that they mean that a person may require less marihuana in order to reach a specific "high." This is basically a matter of learning how to smoke the drug, and of learning what effects to look for.

DO HEAVY USERS SUFFER PHYSICAL WITHDRAWAL SYMPTOMS LIKE THE NARCOTIC ADDICT?

No. Sudden withdrawal may provoke restlessness and anxiety in a few persons who daily smoke large amounts of hashish, but true withdrawal symptoms as seen in the heroin addict do not develop.

WHAT ARE THE LONG-TERM PHYSICAL EFFECTS OF EXTENDED MARIHUANA USE?

These are not precisely known. Extensive scientific research is underway to answer this most important question.

WHAT ARE THE PSYCHOLOGICAL EFFECTS OF MARIHUANA?

The psychological effects of marihuana are variable. They include distortions of hearing, vision and sense of time. Thought becomes dream-like. The belief that one is thinking better is not unusual. Performance may be hampered or unchanged. Illusions (misinterpretation of sensations) are often reported, but hallucination (experiencing non-existent sensations) and delusions (false beliefs) are rare. Unfounded suspicion may occur, and this may be accompanied by anxiety. More often the feeling is one of a passive euphoria or "high." The individual tends to withdraw into himself. Occasionally, uncontrollable laughter or crying may occur.

WHAT KINDS OF EMOTIONAL PROBLEMS CAN THE MARIHUANA USER HAVE?

Anxiety reactions and panic states have been noted. Accidents have occurred due to impaired judgment and time-space distortions. The user, especially if he is inexperienced, may become excessively suspicious of people and take action that leads to injury. A toxic psychosis consisting of mental confusion, loss of contact with reality, and memory disturbances has been recorded.

The effects of prolonged use are not scientifically known. In those countries where *cannabis* use has been traditional, excessive amounts are claimed to induce loss of motivation, apathy, memory difficulties and loss of mental acuity. Reports of psychotic breakdowns from the extended use of marihuana are frequently found in the medical literature of the Near and Middle East, but these require further scientific investigation.

DOES THE HEAVY USE OF MARIHUANA AFFECT THE PERSONALITY DEVELOPMENT OF THE YOUNG PERSON?

It can. By making marihuana use a career, the young person avoids normal life stresses and the problems that are an intrinsic part of growing up. He therefore misses the opportunity to mature to his full physical and mental potential. In addition, the developing personality is known to be susceptible to the effects of all mind-altering substances.

DOES MARIHUANA LEAD TO INCREASED SEXUAL ACTIVITY?

Marihuana has no known aphrodisiac property. At various times in the past, both promiscuity and impotence have been attributed to the use of marihuana without scientific basis for either allegation.

WHY DO PEOPLE CONTINUE TO USE MARIHUANA?

The consistent user, the "pothead," is likely to be emotionally disturbed, according to many studies of this group. He is using the drug to treat his personality problems.

HOW MUCH MARIHUANA IS BEING USED IN THIS COUNTRY?

The use of marihuana is increasing. In a recent nationwide survey, 4 percent of those queried responded affirmatively to the question, "Have you ever used marihuana?" That would mean that more than 8 million people have tried the drug. Twelve percent of the young people indicated that they have tried it. Exact statistics are difficult to obtain because of the legal penalties.

In college surveys, two-thirds of those who said that they had tried the drug did so less than a dozen times. Another quarter are occasional users, and the rest—less than 10 percent—may be considered daily or heavy users.

WHY ARE SO MANY ADOLESCENTS EXPERIMENTING WITH MARIHUANA NOW?

In part this is because marihuana is "in." Peer group pressures have led many to try "pot." Some use it as an act of defiance. Some are curious. While most adolescents do not continue using the drug, 5 to 10 percent become heavy, daily users.

HOW ARE TEENAGERS INTRODUCED TO MARIHUANA?

In general, adolescence are introduced to marihuana by others in their group. There is little evidence to confirm the belief that "pushers" need to "turn on" a novice. His "friends" do it for him.

Heavy marihuana users may go on to more dangerous drugs as a result of group pressures or of their own volition. Occasionally, a "pusher" will persuade the buyer to try a more dangerous drug.

HOW DOES MARIHUANA GET ONTO THE BLACK MARKET?

Although truckload lots are sometimes detected, most marihuana smuggling and sales are small-time operations of a few pounds or less. Organized criminal syndicates have not been involved to date. About 80 percent of the marihuana comes in from Mexico. The rest is acquired locally. Hashish is made in the Near East and is smuggled into the U.S. Young people themselves account for most acquisition and sales, according to the Bureau of Narcotics and Dangerous Drugs.

WHAT IS THE RELATIONSHIP BETWEEN MARIHUANA AND CRIMINAL OR VIOLENT BEHAVIOR?

Any drug that loosens self-control may contribute to criminal behavior. Persons under the influence of marihuana tend to be passive, although some crimes have been committed by persons while they were "high." The personality of the user is as important as the type of drug in determining whether chemical substances lead to criminal or violent behavior.

CAN ONE SMOKE A LITTLE MARIHUANA, EQUIVALENT TO A DRINK OF ALCOHOL, AND NOT BECOME INTOXICATED?

Some people familiar with the drug are able to control its effects to permit only a feeling of relaxation. However, the usual intent of the user is to become "stoned." As a rule, either no effect or an intoxicating effect is obtained from the use of marihuana.

IS MARIHUANA LESS HARMFUL THAN ALCOHOL?

The results of intoxication by both drugs can be harmful.

We know that alcohol is a dangerous drug physically, psychologically or socially for millions of people. There is no firm evidence that marihuana would be less harmful if used consistently. In countries where alcohol is forbidden by religious taboo, skid rows based on marihuana exist. The "rumhead" and the "pothead" are both unenviable creatures.

IF ALCOHOL IS LEGAL, WHY NOT MARIHUANA?

It would seem more logical to deal with our millions of alcoholics than to add another mind-altering chemical to our existing problem. Whether another intoxicant should be accepted into the culture is the question.

Only during the past 3 years has the sophisticated, scientific study of marihuana been underway. It would seem prudent to await the results of ongoing and planned studies before treating marihuana as we do alcohol.

DOES MARIHUANA HAVE ANY MEDICAL USES?

Marihuana has no approved medical use in the U.S. Some researchers are attempting to determine whether THC may have appetite-enhancing, anticonvulsant, or antidepressant capabilities.

WHAT RESEARCH IS BEING DONE ON MARIHUANA?

A considerable amount of research with marihuana and THC is underway or planned. These investigations will help provide answers to many questions about the drug.

With the recent availability of synthetic THC and the ability to determine the amount of THC in marihuana, it is now feasible to know the exact quality of the substance being studied. This permits precise analysis that was not possible before in such ways as the following:

1. An examination of the changes that occur in the body when marihuana is smoked, as well as the observation of the metabolic changes that take place in THC.
2. The labelling of THC with radioactive material in order to learn the distribution and excretion of the drug.
3. The effect of marihuana on the chemical components of the brain and other tissues.
4. A testing of the acute and chronic toxicity of marihuana.
5. Research to discover the physiological and psychological changes in man caused by varying doses of marihuana. This ranges from studying brain-wave patterns to testing a subject's ability to perform complex tasks.
6. An examination of the effects of THC and other marihuana components upon chromosomes.

To determine the effects of the long-term use of marihuana more accurately, negotiations are now underway with qualified scientists in countries where the use of the drug has been customary for years. Groups of long-term, daily users will be compared with matched groups of nonusers. The results of physical and psychological examinations will be studied for the two groups.

IS THERE ANYTHING IN MARIHUANA THAT LEADS TO THE USE OF OTHER DRUGS?

There is nothing in marihuana itself that produces a need to use other drugs. Most marihuana smokers do not progress to stronger substances. Some do. Surveys supported by the National Institute of Mental Health show that the "pothead" does tend to experiment with other drugs. Hashish is frequently tried, and large numbers of "potheads" later use strong hallucinogens, amphetamines, and, occasionally, barbiturates. Some try opium and heroin.

In one college survey, 1 percent of the "potheads" became addicted to opium heroin. In surveys of heroin addicts, 85 percent had previously tried marihuana, but a still larger percentage had used alcohol before heroin.

It appears that the person who becomes seriously overinvolved with any drug is likely to have the emotional need to seek other kinds of drugs and to try them repetitively.

Questions About Hallucinogens

WHAT ARE HALLUCINOGENS?

Hallucinogens (also called psychedelics) are drugs capable of provoking changes of sensation, thinking, self-awareness and emotion. Alterations of time and space perception, illusions, hallucinations and delusions may be either minimal or overwhelming depending on the dose. The results are very variable; a "high" or a "bad trip" ("freakout" or "bummer") may occur in the same person on different occasions.

LSD is the most potent and best-studied hallucinogen. Besides LSD, a large number of synthetic and natural hallucinogens are known. Mescaline from the peyote cactus, psilocybin from the Mexican mushroom, morning glory seeds, DMT, STP, MDA and dozens of others are known and abused. Along with its active component THC, marihuana is medically classified as an hallucinogen.

IS IT TRUE THAT ANY DRUG WILL MAKE YOU HALLUCINATE IF TAKEN IN SUFFICIENT AMOUNTS?

Many drugs will cause a delirium, accompanied by hallucinations and delusions, when taken by people who are hypersensitive to them. Extraordinarily large amounts of certain drugs may also produce hallucinations. However, the mind-altering drugs are much more likely to induce hallucinations because of their direct action on the brain-cells.

WHAT IS LSD?

Lysergic acid comes from ergot, the fungus that spoils rye grain. It was first converted in 1938 to lysergic acid diethylamide (LSD) by the Swiss chemist, Albert Hoffman, who accidentally discovered its mind-altering properties in 1943.

WHAT ARE THE IMMEDIATE PHYSICAL EFFECTS OF LSD?

A person who has consumed LSD will have dilated pupils, a flushed face, perhaps a rise in temperature and heartbeat, a slight increase in blood pressure, and a feeling of being chilly. A rare convulsion has been noted. These effects disappear as the action of the drug subsides.

WHAT IS THE LSD STATE LIKE?

The LSD state varies greatly according to the dosage, the personality of the user and the conditions under which the drug is taken. Basically it causes changes in sensation. Vision is most markedly altered. Changes in depth perception and the meaning of the perceived object are most frequently described. Illusions and hallucinations can occur. Thinking may become pictorial and reverie states are common. Delusions are expressed. The sense of time and of self are strangely altered. Strong emotions may range from bliss to horror, sometimes within a single experience. Sensations may "crossover," that is, music may be seen or color heard. The individual is suggestible and, especially under high doses, loses his ability to discriminate and evaluate his experience.

WHAT IS A "GOOD TRIP"? A "BAD TRIP"?

In the parlance of the LSD user, the "good trip" consists of pleasant imagery and emotional feelings. The "bad trip" or "bummer" is the opposite. Perceived images are terrifying and the emotional state is one of dread and horror.

WHAT ARE SOME OF THE MORE HARMFUL EFFECTS OF LSD?

During the LSD state, the loss of control can cause panic reactions or feelings of grandeur. Both have led to injury or death when the panic or the paranoia was acted upon.

The prolonged reactions consist of anxiety and depressive states, or psychotic breaks with reality which may last from a few days to years.

WHAT IS A "FLASHBACK"?

A "flashback" is a recurrence of some of the features of the LSD state days or months after the last dose. It can be invoked by physical or psychological stress, or by medications such as antihistamines, or by marihuana.

Those individuals who have used LSD infrequently rarely report flashbacks; intensive use seems to produce them more frequently. Often a flashback occurring without apparent cause can induce anxiety and concren that one is going mad. This can result in considerable fear and depression and has been known to culminate in suicide.

CAN LSD DAMAGE CHROMOSOMES?

A number of reputable scientists have reported chromosomal fragmentation in connection with LSD exposure in the test tube, in animals, and in man. A similar number of equally capable scientists have been unable to confirm these findings. The question whether LSD itself can induce congenital abnormalities remains unresolved. Further work is continuing and will clarify this question.

IS THERE ANY EVIDENCE THAT HEAVY LSD USE CAUSES BRAIN CELL CHANGES?

In experiments designed to answer this question, some changes in mental functions have been detected in heavy users, but they are not present in all cases.

Heavy users of LSD sometimes develop impaired memory and attention span, mental confusion, and difficulty with abstract thinking. These signs of organic brain changes may be subtle or pronounced. It is not known whether these alterations persist or whether they are reversbile if the use of LSD is discontinued.

ARE PEOPLE MORE CREATIVE UNDER OR AFTER LSD?

People who have taken LSD feel more creative. Whether they actually are or not is difficult to determine. In studies done to compare individuals' creative capabilities before and after LSD experiences, it was found that no significant changes had occurred. Creativity might conceivably be enhanced in a few instances, but it is diminished in others because LSD may reduce the motivation to work and execute creative ideas.

IS THE LSD STATE LIKE THE MYSTICAL STATE?

The transcendental or mystical state includes feelings of wonder or ecstasy, a sense of perceiving beauty, the absence of rational thought, a sense of discovering great meaning. Many of these phenomena can be mimicked by the LSD state, which is why it has been called a "religious" drug. The LSD-induced mystical state differs as significantly from the natural one as an artificial pearl from the real thing.

DO YOU REALLY GET TO KNOW YOURSELF AFTER LSD?

The *illusion* that one obtains insights about one's personality and behavior while under LSD may occur. From an analysis of these "insights" and of subsequent behavior, it is doubtful that true insights happen with any regularity.

WHY WOULD ANYBODY TRY A DRUG LIKE LSD?

People give many reasons for trying LSD, ranging from curiosity to a desire to "know oneself." The overwhelming majority of people take the drug for the "high"—to feel better. This may be because they are unable to deal with life's frustrations, or feel alienated. If the LSD state were not accompanied by a "high," it would never have become popular.

WHAT PERCENTAGE OF STUDENTS HAVE TRIED LSD?

Most surveys indicate that about 4 percent of college students have tried LSD at least once. This figure has remained relatively stable for the past three years. However, numbers of high school and junior high school students are known to have tried this drug recently.

IS THE USE OF LSD INCREASING?

The use of LSD has levelled off and may be decreasing. Although some very young people are turning to LSD, a number of the older users are discontinuing its use. This shift is probably due to the growing knowledge of the side effects, the "flashbacks," the possibility of chromosomal changes, or imply because the users finally have come to recognize the illusory nature of the LSD experience.

WHAT HAVE WE LEARNED FROM LSD?

LSD is the most potent of all hallucinogenic substances used by man. A minute amount reaching the brain produces striking effects on mental functioning.

From research with LSD we have gained much basic information about the nature of brain cell transmission, and how distortion of the chemical mediators of transmission can result in disruptive mental functioning. Experiments that have sought to find a use for this unusual chemical have been inconclusive. It has been tried for the severe alcoholic, in certain character disorders, in childhood autism and as an aid to psychotherapy. At present no medical usefulness has been found.

IS MUCH RESEARCH GOING ON USING LSD?

More than 300 investigators have been given supplies of this drug through the National Institute of Mental Health to carry out research in the past three years. Considerable important work is continuing.

WHAT IS THE SOURCE OF ILLICIT LSD?

Almost invariably, illicit LSD comes from clandestine laboratories or is smuggled in from abroad. The precursors, lysergic acid and lysergic acid amide, can be converted into lysergic acid diethylamide (LSD) by a proficient chemist who has a reasonably well-equipped laboratory.

When obtained from illicit sources, the quality of LSD varies. Some LSD is fairly pure; other samples contain impurities and adulterants. The amount contained in each capsule or tablet usually differs greatly from the amount claimed by the "pusher." The user has no way of knowing the quality or the quantity of his LSD.

QUESTIONS ABOUT STIMULANTS

WHAT IS A STIMULANT?

Stimulants are drugs, usually amphetamines, which increase alertness, reduce hunger and provide a feeling of well being. Their medical uses include the suppression of appetite and the reduction of fatigue or mild depression.

Many stimulants are know, including: cocaine, amphetamine (Benzedrine "bennies"), dextroamphetamine (Dexedrine "dexies") and methamphetamine (Methedrine). The latter drug is commonly called "speed" or "crystal." Stimulants are also known as "uppers" or "pep pills."

HOW DO AMPHETAMINES WORK?

According to current research findings, amphetamines increase the availability of noradrenaline at the nerve cell connections. This is particularly true in areas of the brain associated with vigilance, heart action, and mood. Excessive stimulation of these brain cells is normal under emergency life conditions, but when it is prolonged by amphetamines, undesirable secondary changes develop.

HOW ARE STIMULANTS TAKEN?

Usually stimulants are taken by mouth in the form of capsules or tablets. Crystal methamphetamine and cocaine can be inhaled or "snorted" through the nose.

They can also be injected into veins, in which case the effects are immediate and more intense.

HOW MANY PEOPLE ARE ABUSING AMEPHETAMINES?

The exact number of amphetamine abusers is unknown, but the abuse of very large quantities of amphetamines is increasing. The drug-using subcultures, such as Haight-Ashbury in San Francisco, are now essentially "speed" subcultures. The abuse of amphetamines in weight-reducing pills is also on the rise. Approximately 10 billion amphetamine pills are legitimately manufactured every year, and a large amount of these will be diverted into illegal channels. Many illicit laboratories that manufacture stimulants have been discovered and seized.

WHAT ARE THE VARIOUS TYPES OF STIMULANT ABUSE?

There is the occasional user who takes the drug to exert himself beyond his physiological limits. He may want to stay awake to drive, excel in an athletic contest, or cram for an examination. This type of abuse rarely leads to difficulties, but it may. Instances of death during athletic contests have been traced to amphetamine use.

A second type of abuse is taking 75–100 mg. per day (the average dose is 15–30 mg.) for long periods of time. These individuals are drug-dependent.

A relatively new type of abuse involves the injection of massive doses intravenously once or a dozen times a day. This produces practically the same effects as cocaine. These users are referred to as "speed freaks."

WHAT EFFECTS DO AMPHETAMINES HAVE?

In ordinary amounts the amphetamines provide a transient sense of alertness and well being. Hunger is diminished, and short-term performance may be enhanced in the fatigued person.

When amphetamines are taken intravenously in large amounts, an ecstatic "high" occurs which decreases over a few hours. Re-injection is then necessary to reproduce the stimulation. This cycle can go on for days until the person is physically exhausted. Shakiness, itching, muscle pains, and tension states are common. Collapse and death have occurred.

Upon withdrawal the "speed freak" feels terribly depressed and lethargic. Re-injection of amphetamines relieves these symptoms. Since tolerance to high doses develops and withdrawal symptoms occur, large amounts of amphetamines are considered physically addicting. Small amounts are psychologically habituating.

WHAT ARE THE PHYSICAL COMPLICATIONS OF AMPHETAMINE ABUSE?

In addition to those diseases which accompany the unsterile injection of material into the body, the excessive amounts of amphetamines can cause certain medical problems. Liver damage may result from the enormous quantities being taken. Brain damage from such quantities has been demonstrated in animals. Abnormal rhythms of the heart have occurred, and a marked increase in blood pressure is well known.

Neglect of personal hygiene can lead to skin infections or dental decay. Drastic weight loss, and malnutrition and vitamin deficiencies are part of the list of adverse physical complications.

WHAT ARE THE PSYCHIATRIC COMPLICATIONS OF AMPHETAMINE ABUSE?

While under the influence of large amounts of amphetamines, the individual may become overactive, irritable, talkative, suspicious and sometimes violent. He reacts impulsively. This combination can lead to belligerent or homicidal behavior.

There is a deterioration of all social, familial and moral values. Like the heroin addict, the "speed freak" will do anything to obtain his supplies.

The paranoid psychotic state can last long beyond the period of drug activity and resembles paranoid schizophrenia.

WHAT CAN BE DONE ABOUT THE "SPEED" PROBLEM?

The elimination of the large-scale illicit supplies and better controls over legitimate production are part of the answer. In addition, the consequences and

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complications must be made known as widely as possible. The user needs skilled treatment. It is likely that only the very disturbed person will become involved in the "speed" scene if the known effects of taking the drug are properly disseminated.

ARE THERE ANY SPECIAL DIFFICULTIES IN THE TREATMENT OF STIMULANT ABUSERS?

The "speed freak" is a difficult patient to rehabilitate. Although he may want to stop using the drug, his "high" is so intense that he is attracted to the enormous euphoria that he obtains from the chemical. Persons who seem to have broken the speed habit often relapse.

Treatment may require the close support of the user's friends and family, plus medical and psychological help. In some cases, closed-ward hospitalization may be necessary. One of the more successful forms of treatment is group therapy in which ex-users interact with "speed freaks." Those who have come through the "speed" scene are trusted, and their counsel is likely to be accepted by the person who wants to stop his destructive use of the drug.

WHY HAS SWEDEN VIRTUALLY ABOLISHED THE MEDICAL USE OF AMPHETAMINES?

Sweden has a major problem with the amphetamine-like substance, phenmetrazine (Preludin). It was introduced as a "safe" weight reducing pill, but for the past 10 years its illicit use has been increasing. It is estimated that about 10,000 people (Sweden has a population of 8 million) use large amounts of this drug, most of it by intravenous injection.

At present only those few cases which are approved by a special commission can be legally treated with amphetamines. Despite this cutoff of legitimate supplies, the problem continues. Illegal laboratories still provide the material, and much is brought in from other countries where it is readily available.

QUESTIONS ABOUT SEDATIVES

WHAT ARE SEDATIVES AND TRANQUILIZERS?

Sedatives induce sleep. When taken in small doses they reduce daytime tension and anxiety. The barbiturates constitute the largest group of sedatives. When used without close supervision, the possibility of taking increased amounts and becoming dependent are present. In street parlance, the sedatives are also called "goof balls," "sleepers," and "downers."

The tranquilizers are drugs that calm, relax and diminish anxiety. Like sedatives, they may cause drowsiness. Tranquilizers that are used to treat serious mental disorders are not dependency producing. It is tranquilizers like meprobamate (Miltown, Equinil) to which dependence can be developed.

ARE SEDATIVES PHYSICALLY ADDICTING?

Yes. Tolerance to the effects of barbiturates develops and withdrawal effects occur when the drug is stopped. A strong desire to continue taking the drug is present after a few weeks on large amounts. Addiction to 50 or more sleeping pills a day has been reported.

ARE BARBITURATES THE ONLY GROUP OF SEDATIVES WITH DANGER OF ADDICTION?

No. Other addicting sedatives include glutethimide (Doriden), chloral hydrate and many others. Everything that is said about the barbiturates can be applied to the non-barbiturate sedatives.

WHO ARE THE ABUSERS OF BARBITURATES?

People who have difficulty dealing with anxiety, or who have troubles with insomnia may become overinvolved with sedatives or tranquilizers and come to depend on them.

Barbiturates are taken by some heroin users either to supplement the heroin or substitute for it.

People under excessive stress, or those who cannot tolerate ordinary stress, are vulnerable. A few years ago sedatives were drugs of abuse for adults. Now they are being consumed more and more frequently by teenagers and preteenagers.

Persons who take amphetamines and become jittery might also take barbiturates to ease their tension.

WHAT ARE THE MEDICAL USES FOR SEDATIVES?

In addition to inducing sleep and relaxing tensions, barbiturates are used for psychosomatic conditions such as high blood pressure and peptic ulcers. One barbiturate, phenobarbital, is useful as an anticonvulsant.

WHAT HAPPENS IF A BARBITURATE ABUSER SUDDENLY STOPS TAKING THE DRUG?

If the barbiturate dependence is severe, sudden discontinuance of the drug can be dangerous. A severe withdrawal state resembles delirium tremens. The patient is sweaty, fearful, sleepless and tremulous. He is restless, agitated, and may suffer convulsions. In addition, he may see things that aren't there and have delusional, confused thoughts. The amount of barbiturates must be slowly decreased; the patient requires considerable medical and nursing support.

Sudden barbiturate withdrawal is an acute medical emergency requiring hospitalization and intensive care.

ARE SEDATIVES TAKEN IN LARGE QUANTITIES DANGEROUS?

Yes. The most common mode of suicide with drugs is with sleeping pills. Accidental deaths due to taking a larger number than intended are not uncommon. In the latter instance, the person takes one or two pills at bedtime, falls asleep and then awakens. Not remembering that he has taken his sleeping medicine, he takes some more. If this is repeated a few times during the night a poisonous overdose may be consumed.

DO PEOPLE FALL ASLEEP WHEN THEY TAKE LARGE AMOUNTS OF SEDATIVES CONTINUALLY?

Ordinarily they go into a coma. If they are tolerant to large amounts, they may remain awake and appear intoxicated. Speech and movements may be uncoordinated. Skilled tasks are performed sluggishly and without precision. Judgment and perception are impaired. Confusion, slurred speech, irritability, and an unsteady gait are often seen in chronic users.

HOW CAN ONE BREAK A LARGE SEDATIVE "HABIT"?

This should be done with the help of a physician. Sometimes hospitalization is necessary. Gradual reduction is safer than abrupt discontinuance.

IS IT TRUE THAT SOME PEOPLE ABUSE SEDATIVES AND STIMULANTS SIMULTANEOUSLY?

Yes. Although the two types of drugs have opposite actions, some individuals become dependent upon the combinations. It might be imagined that an "upper" would completely neutralize a "downer," but this is not so. A desirable feeling is obtained, and large numbers of such combinations may be swallowed habitually.

IS IT TRUE THAT THE COMBINATION OF SLEEPING PILLS AND ALCOHOL IS DANGEROUS?

Yes. Taken together, less than lethal doses of alcohol and sleeping pills may be fatal. The person who is drunk may take a few barbiturate capsules and not survive. Barbiturates when taken with narcotics, anesthetics, and tranquilizers may also be fatal.

QUESTIONS ABOUT NARCOTICS

WHAT IS A NARCOTIC

A narcotic is a drug that relieves pain and induces sleep. The narcotics, or opiates, include opium and its active components, such as morphine. They also include heroin, which is morphine chemically altered to make it about six times stronger. Narcotics also include a series of synthetic chemicals that have a morphine-like action.

WHICH NARCOTICS ARE SIGNIFCANTLY ABUSED?

Heroin accounts for 90 percent of the narcotic addiction problem. It is not used in medicine, and all heroin in the U.S. is smuggled into the country. Morphine, methadone, and meperidine are used medically and are infrequently seen on the black market. Paregoric and cough syrups containing codeine are also abused.

IS NARCOTICS ADDICTION INCREASING?

As of December 31, 1968, the Bureau of Narcotics and Dangerous Drugs reported 64,011 narcotic addicts in the United States. This is an increase of 2,000 (3 percent) over the previous year. These figures include only those addicts who have been reported to the Bureau. The reporting system is voluntary on the part of the reporting agency and, as such, is not all inclusive. The New York State Narcotic Control Commission reports about 60,000 narcotic addicts in New York alone. The heroin abuse problem has been increasing since World War II and it continue to increase. Perhaps the most realistic estimate of the number of opiate addicts in the country is between 100,00 and 200,000.

WHY DO PEOPLE TAKE OPIATES?

People in physical or psychological pain may turn to heroin for relief, especially if their ability to endure distress is low. Many are introduced to the drug by "friends." Some youngsters mimic the behavior of grownups who are addicted. Certain addicts derive gratification from turning others on.

Many believe, "It can't happen to me." They think they can use heroin occasionally and not get hooked. These are often weekend "joy poppers." A good number of these individuals end up addicted.

Young males from minority groups who live in central city areas are most likely to become addicts. There is evidence that some middle-class youngsters in the drug-using communities have begun to abuse heroin. A small number of doctors and nurses who have the drugs available have become addicted.

WHAT DOES THE HEROIN ADDICT LOOK LIKE?

He may appear normal. Some of the acute symptoms associated with heroin are sniffling, flushing, drowsiness and constipation. Very contracted pupils are typical of opiate use. Some addicts may have an unhealthy appearance because of poor food intake and personal neglect, Venereal disease among female addicts is not uncommon.

Heroin addicts appear at hospitals with blood infections, hepatitis, symptoms of overdose and, more rarely, lockjaw.

Fresh needle marks and "tracks" (discoloration along the course of veins in the arms and legs) are detectable during an examination.

A sample of the addict's urine will reveal heroin or quinine. Barbiturate and amphetamine abuse can also be detected by urine testing.

CAN A PERSON FUNCTION WHILE ON NARCOTICS?

If the person is tolerant to an opiate he can usually function satisfactorily. This assumes that he is on a constant dosage level, and that his body's reaction to the drug is minimal. It merely keeps him comfortable.

This ability to perform, stay awake and alert after being kept on a maintenance level has been demonstrated with the methadone maintenance treatment. An occasional person will be drowsy.

WHAT IS IT LIKE TO TAKE A SHOT OF HEROIN?

Generally, there is a feeling of relaxation and of being "high." This is accompanied by an "awayness" or pleasant, dreamlike state.

As tolerance develops, the "high" is generally lost. The addict then requires heroin to avoid the withdrawal sickness. In other words, at this point he is using heroin to feel normal.

WHAT ARE THE PHYSICAL DANGERS OF ADDICTION?

The physical complications are many and some are life endangering. An overdose, resulting in death, occurs when someone has lost or never developed toler-

ance because he was using very diluted heroin. If, by chance, he obtains pure heroin, he may die moments after injection.

Infections from unsterile solutions, syringes, and needles cause many bacterial diseases. Viral hepatitis can be epidemic among addicts. Skin abscesses, inflammation of the veins and congestion of the lungs are further complications. Venereal diseases, tuberculosis and pneumonia are not uncommon.

The life expectancy of the addict is much lower than that of the non-addict. Addicts of both sexes are less fertile, and infants born of addict mothers may suffer withdrawal symptoms.

WHAT ARE WITHDRAWAL SYMPTOMS LIKE?

When addiction exists, stopping the drug provokes withdrawal sickness some 12 to 16 hours after the last injection. The addict yawns, shakes, sweats, his nose and eyes run, and he vomits. Muscle aches and jerks ("kicking the habit") occur along with abdominal pain and diarrhea. Chills and backache are frequent.

Hallucinations and delusions can develop, and these are usually terrifying. An injection of an opiate brings about immediate relief.

WHAT ARE THE PSYCHIATRIC COMPLICATIONS OF NARCOTIC ADDICTION?

The life of the narcotic addict is deplorable. His waking existence is centered around obtaining money to buy heroin ("hustling"), making a connection with a pusher ("copping"), and trying to avoid withdrawal.

The activities that an addict will resort to in order to obtain heroin are harmful to himself and those around him. He may steal from his loved ones, double-cross his best friend, or pander his wife. It is obvious that a career of heroin addiction must lead to personality decay and seriously impair emotional maturation.

IS THERE AN ADDICTIVE PERSONALITY?

It has been demonstrated that anyone can become addicted if he takes opiates regularly for a few weeks. Even animals can become addicted. However, certain kinds of people are more likely to become involved with heroin than others under similar life situations. These individuals have a low frustration tolerance and great dependency neeeds. Impulsive, immature, inadequate individuals are likely candidates. Many are "now" oriented, seeking the immediate "high" without regard to future consequences. Some have a character disorder that permit deviant behavior without guilt feelings.

Should a reasonably mature, stable person become addicted, the prospects of his rehabilitation are much better than those of the immature, unstable addict.

WHAT TREATMENT PROCEDURES ARE AVAILABLE TO THE HEROIN ADDICT?

"Once an addict, always an addict" is simply untrue. Many treatment procedures are possible for the heroin user. Ex-addict self-help groups have been useful for some. Others have benefitted from methadone maintenance. This consists of the substitution of methadone, a narcotic, under close supervision. If the patient on methadone takes heroin he will notice no effect from it because of cross tolerance. Another approach uses cyclazocine, a narcotic antagonist, not a narcotic. If heroin is taken after cyclazocine, no effect is noted.

Taking the addict off heroin is not too difficult, but keeping him off is. He usually needs counselling, job training and other rehabilitative efforts. The Federal Government and some States have civil commitment and voluntary rehabilitation programs. Many more narcotic addict rehabilitation centers are coming into existence at the community level. At these centers the addict seeking help can be given all the rehabilitation assistance he needs.

IS THERE A RELATIONSHIP BETWEEN HEROIN AND CRIME?

Many addicts had criminal records before they became addicted. Nevertheless, a direct relationship between the addicted person and criminal activity does exist because of the need for large sums of money in order to support his "habit." Shoplifting, pimping, prostitution, peddling heroin, and car theft are some of the crimes to which the addict resorts. When he is feeling symptoms of withdrawal, he may commit more violent crimes in order to obtain his drug.

Addicts who are sufficiently affluent to buy heroin will not commit criminal acts. The opiate state is one of passivity rather than aggression.

WHAT ARE THE ORGANIZED CRIME ELEMENTS THAT DEAL IN NARCOTICS AND DANGEROUS DRUGS?

Trafficking in heroin is usually undertaken by the organized criminal elements based in major metropolitan areas throughout the country. These organizations have the manpower, financial ability, and international connections with which to procure and successfully smuggle large quantities of heroin into the United States from France and other countries. To a lesser extent, numerous individuals and independent groups smuggle illicitly produced Mexican heroin in small quantities across the Mexican border.

WHAT IS THE QUALITY OF HEROIN BOUGHT ON THE STREET?

Heroin is invariably diluted with milk sugar, quinine, or other materials. Capsules or cellophane "bags" which may vary from 0 to 10 percent heroin are sold to users for $2 to $10. The material is unsterile. Some of the heroin has been "cut" so much that the addict has a "needle habit," not a heroin "habit." A "needle habit" is one in which the user obtains gratification from hustling for narcotics and injecting himself with the material even thought it contains little or no heroin.

WHAT ABOUT THE "BRITISH SYSTEM" OF DEALING WITH HEROIN ADDICTION?

Until recently, English heroin addicts were able to obtain heroin by prescription after registering with a physician. During the past decade, however, the number of known heroin addicts rose from a few hundred to several thousand. The number of known addicts under 20 years of age increased from one in 1960 to 1,016 in 1969. (These figures are regarded as underestimates, since many addicts do not come to official attention.)

As a result of this increase, the "system" was changed in 1968. British physicians can no longer prescribe heroin. Instead, rehabilitation centers have been established for the treatment of drug addicts. In cases where total abstinence is not possible for an addict, some heroin or methadone may be prescribed. The British system is considered a failure and has been modified to meet the increasing problem of addiction. However, it has largely prevented the involvement of organized criminal elements in heroin traffic. At present, the illicit traffic consists of addicts selling their supplies to others.

QUESTIONS ABOUT OTHER SUBSTANCES OF ABUSE

MODEL AIRPLANE GLUE, GASOLINE, PAINT THINNER AND OTHER VOLATILE SOLVENTS HAVE BEEN REPORTED AS ABUSABLE SUBSTANCES. WHAT ARE THEIR EFFECTS

These substances, which were obviously never meant to be taken by man, contain a variety of chemicals, some quite dangerous. Others are toxic only when used over long periods. They provide a clouded mental state that can develop into a coma. Temporary blindness has been reported. Death is known to occur when the solvent is inhaled without sufficient oxygen as, for example, when the individual loses consciousness and his mouth and nose fall into the plastic bag containing the solvents. Damage to bone marrow, kidneys and lungs has been described in autopsy reports.

CAN NUTMEG BE ABUSED?

If large amounts of nutmeg or mace are taken, they can induce a drunken, confused state. This requires a substantial quantity, which can irritate the kidneys. Abuse has been reported in immature adolescents, and in prisoners who have access to these spices while working in prison kitchens.

WHAT IS KNOWN ABOUT BELLADONNA AND JIMSON WEED ABUSE?

A large number of wild plants can cause delirium or death, depending upon the amount ingested. They include belladonna and Jimson weed (stramonium) which grow in many parts of the country. They have long been used as intoxicants; they were the constituents of the witches' brews of earlier days. The notion that witches flew on broomsticks was the result of the hallucinations of those under the influence of these powerful plants.

Dryness of the mouth and skin, a high fever and dilated pupils are characteristic of these weeds.

Asthmador is a drug that contains a combination of belladonna and stramonium and is prescribed as an asthma remedy. It, too, has been occasionally misused.

DRUG GLOSSARY

Acid: LSD, LSD-25 (lysergic acid diethylamide).
Acidhead: Frequent user of LSD.
Bag: Packet of drugs.
Ball: Absorption of stimulants and cocaine via genitalia.
Bang: Injection of drugs.
Barbs: Barbiturates.
Bennies: Benzedrine, an amphetamine.
Bindle: Packet of narcotics.
Blank: Extremely low-grade narcotics.
Blast: Strong effect from a drug.
Blue angels: Amytal, a barbiturate.
Blue velvet: Paregoric (camphorated tincture of opium) and Pyribenzamine (an antihistamine) mixed and injected.
Bombita: Amphetamine injection, sometimes taken with heroin.
Bread: Money.
Bum trip: Bad experience with psychedelics.
Bummer: Bad experience with psychedelics.
Busted: Arrested.
Buttons: The sections of the peyote cactus.
Cap: Capsule.
Chipping: Taking narcotics occasionally.
Coasting: Under the influence of drugs.
Cokie: Cocaine addict.
Cold turkey: Sudden withdrawal of narcotics (from the gooseflesh, which resembles the skin of a cold plucked turkey).
Coming down: Recovering from a trip.
Connection: Drug supplier.
Cop: To obtain heroin.
Cop out: Quit, take off, confess, defect, inform.
Crash: The effects of stopping the use of amphetamines.
Crash pad: Place where the user withdraws from amphetamines.
Crystal: Methedrine, an amphetamine.
Cubehead: Frequent user of LSD.
Cut: Dilute drugs by adding milk sugar or another inert substance.
Dealer: Drug supplier.
Deck: Packet of narcotics.
Dexies: Dexedrine, an amphetamine.
Dime bag: $10 package of narcotics.
Dirty: Possessing drugs, liable to arrest if searched.
Dollies: Dolophine (also known as methadone), a synthetic narcotic.
Doper: Person who uses drugs regularly.
Downers: Sedatives, alcohol, tranquilizers, and narcotics.
Drop: Swallow a drug.
Dummy: Purchase which did not contain narcotics.
Dynamite: High-grade heroin.
Fix: Injection of narcotics.
Flash: The initial feeling after injecting.
Flip: Become psychotic.
Floating: Under the influence of drugs.
Freakout: Bad experience with psychedelics; also a chemical high.
Fuzz: The police.
Gage: Marihuana.
Good trip: Happy experience with psychedelics.
Goofballs: Sleeping pills.
Grass: Marihuana.
H: Heroin.
Hard narcotics: Opiates, such as heroin and morphine.
Hard stuff: Heroin.
Hash: Hashish, the resin of Cannabis.

Hay: Marihuana.
Head: Person dependent on drugs.
Hearts: Dexedrine tablets (from the shape).
Heat: The police.
High: Under the influence of drugs.
Holding: Having drugs in one's possession.
Hooked: Addicted.
Hophead: Narcotics addict.
Horse: Heroin.
Hustle: Activities involved in obtaining money to buy heroin.
Hustler: Prostitute.
Hype: Narcotics addict.
Joint: Marihuana cigarette.
Jolly beans: Pep pills.
Joy-pop: Inject narcotics irregularly.
Junkie: Narcotics addict.
Kick the habit: Stop using narcotics (from the withdrawal leg muscle twitches).
Layout: Equipment for injecting drug.
Lemonade: Poor heroin.
M: Morphine.
Mainline: Inject drugs into a vein.
Maintaining: Keeping at a certain level of drug effect.
(The) Man: The police.
Manicure: Remove the dirt, seeds, and stems from marihuana.
Mesc: Mescaline, the alkaloid in peyote.
Meth: Methamphetamine (also known as Methedrine, Desoxyn).
Methhead: Habitual user of methamphetamine.
Mikes: Micrograms (millionths of a gram).
Narco: Narcotics detective.
Nickle bag: $5 packet of drugs.
O. D.: Overdose of narcotics.
On the nod: Sleepy from narcotics.
Panic: Shortage of narcotics on the market.
Pillhead: Heavy user of pills, barbiturates or amphetamines or both.
Pop: Inject drugs.
Pot: Marihuana.
Pothead: Heavy marihuana user.
Purple hearts: Dexamyl, a combination of Dexedrine and Amytal (from the shape and color).
Pusher: Drug peddler.
Quill: A matchbook cover for sniffing Methedrine, cocaine, or heroin.
Rainbows: Tuinal (Amytal and Seconal), a barbiturate combination in a blue and red capsule.
Red devils: Seconal, a barbiturate.
Reefer: Marihuana cigarette.
Reentry: Return from a trip.
Roach: Marihuana butt.
Roach holder: Device for holding the butt of a marihuana cigarette.
Run: An amphetamine binge.
Satch cotton: Cotton used to strain drugs before injection; may be used again if supplies are gone.
Scag: Heroin.
Score: Make a purchase of drugs.
Shooting gallery: Place where addicts inject.
Skin popping: Injecting drugs under the skin.
Smack: Heroin.
Smoke: Wood alcohol.
Snorting: Inhaling drugs.
Snow: Cocaine.
Speed: Methedrine, an amphetamine.
Speedball: An injection of a stimulant and a depressant, originally heroin and cocaine.
Speedfreak: Habitual user of speed.
Stash: Supply of drugs in a secure place.
Stick: Marihuana cigarette.
Stoolie: Informer.
Strung out: Addicted.

Tracks: Scars along veins after many injections.
Tripping out: High on psychedelics.
Turned on: Under the influence of drugs.
Turps: Elixir of Terpin Hydrate with Codeine. a cough syrup.
25: LSD (from its orginal designation, LSD-25).
Uppers: Stimulants, cocaine, and psychedelics.
Weed: Marihuana.
Works: Equipment for injecting drugs.
Yellow jacket: Nembutal, a barbiturate.
Yen sleep: A drowsy, restless state during the withdrawal period.

[Produced jointly by: Department of Defense; Department of Health, Education, and Welfare; Department of Justice; Department of Labor; Office of Economic Opportunity: Distributed by: NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION]

The CHAIRMAN. Without objection, the committee will recess until 2 o'clock this afternoon.

(Whereupon, at 12:10 p.m., the committee recessed to reconvene at 2 p.m., the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Martha Griffiths presiding.)

Mrs. GRIFFITHS. This committee will come to order.

We are very happy to have you here, Congressman Pepper. You may proceed as you wish.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PEPPER. Thank you very much, Madam Chairman and members of the committee.

I thank you particularly for the opportunity and privilege to appear before your distinguished committee this afternoon.

On behalf of the Select Committee on Crime, I wish to say that we generally support the purposes and aims of H.R. 17463, introduced by your distinguished chairman, Mr. Mills, and the ranking Republican member of this committee, Mr. Byrnes.

As you perhaps know, in addition to holding hearings here on the Hill on a number of subjects, our committee has held a number of hearings in cities around the country. We have held hearings in Boston, Omaha, and Lincoln, Nebr., San Francisco, Columbia, S.C., Miami, Baltimore, New York City, and just last week for 2 days in Philadelphia, Pa.

Two weeks ago, several of my colleagues and I visited correctional institutions in five different States. In every city and correctional facility that we visited, it was conclusively shown with two exceptions, that the drug problem has grown in epidemic proportions within the last 2 to 3 years. Those two exceptions are San Francisco and New York City. San Francisco has been combating the dangerous drug problem for over 5 years. New York City, unfortunately, enjoys the distinction of being the heroin consumption and distribution capital of the world and has been for some time.

It is my understanding that dangerous drugs and most of the hallucinogens are not in principal consideration before the committee at this time. On March 2 of this year, I appeared before the Subcommittee on Public Health and Welfare of the Committee on Interstate

and Foreign Commerce and testified with respect to amphetamines, barbiturates, tranquilizers, and hallucinogens.

A majority of my colleagues on the Crime Committee had joined with me in the introduction of H.R. 16123, which dealt with the control of those substances.

For your information, I shall leave with you copies of the statements submitted by our members on those subjects. My present remarks, therefore, will be limited to narcotics, their derivatives, and marihuana.

Of all the narcotics and dangerous drugs available today, the most deadly and devastating is heroin. Traditionally, this addiction has been a ghetto phenomenon. However, our investigations and hearings reveal that this menace is no longer confined to the ghetto areas and has spread by geometric progression into the suburbs of every metropolitan area in our country.

Madam Chairman and members of the committee, I say with great personal regret that the son of one of the outstanding businessmen of Miami at the tender age of 18 was the victim of overuse of heroin. Within a week of that same date, a wealthy young man who had established a place of business in Miami Beach, Fla., having moved from Chicago where his family was prominent, was also found dead with a needle in the arm.

So, it is no longer a ghetto phenomenon.

As you know, heroin is a highly refined morphine byproduct. Morphine, in turn is derived from the opium poppy. Heroin was originally developed to combat morphine addiction; however, it soon became readily apparent that greater addiction resulted from the use of heroin than morphine.

The intravenous taking of heroin is believed to have begun in Cairo, Egypt, in the 1920's. This method of taking the substance is preferred over skin popping and snorting since less of the substance is lost in taking it and there are more areas of the body which can be utilized in the injection of this deadly drug. The intravenous injection method was copied by seamen who soon transmitted this knowledge to every large port in the world.

On June 25, 26, 27, 29, and 30, our committee held hearings in New York City to examine in detail heroin trafficking and its tragic ramifications. Our hearings dramatically portrayed the details of heroin trafficking from its beginning in the poppyfields of Turkey to its end, in the arm of an addict.

One of the most informative witnesses that appeared before our committee was Dr. Milton Helpern, chief medical examiner for the city of New York. Dr. Helpern advised us that although there was a substantial number of addicts during the 1930's in that city, there were few deaths.

During the period of World War II, heroin was virtually unobtainable in the United States. However, after the end of the war, in 1945, a very lucrative, organized illegal traffic in heroin started, smuggling the drug in ever-increasing quantities into the United States. With this renewed supply, the larger urban centers like New York began to experience the birth of the epidemic with which we are confronted today.

Unfortunately, there are no precise figures on the number of narcotic addicts in the Untied States. One indicator of the extent of this

problem is provided by official investigation of fatalities directly caused by or related to addiction.

Dr. Helpern stated that there has been a steady increase in such fatalities in the last 20 years; especially in acute deaths directly caused by narcotism (these are the so-called overdoses).

The total number of deaths from narcotics in New York City from 1950 through 1959 was 1,070. During the next 9-year period, from 1960 to 1969, this figure was 3,354. In 1969, there were almost 1,000 additional deaths, making the total for the last decade 4,254, or about four times more than the previous decade.

Casualty figures for the entire State of New York from January 1, 1961, through March of this year show that there were 3,565 deaths as a result of our involvement in Vietnam. So, you can see that more people are being killed on account of heroin addiction in New York City than there are casualties on the battlefield in Vietnam from New York State.

The situation continues to worsen. For the first 6 months (through June 26) of 1970, there have been 389 deaths from narcotic (heroin) addiction. Of these 89 occurred in adolescents (14–19 years), and 300 between the ages of 20 and 40.

In fact, at the present time in New York City, narcotics addiction is the greatest single cause of death of adolescents and young adults from 15 to 35, and exceeds any other single cause such as accidents, homicide, and natural diseases.

At this point, I would like to interject an additional bit of information furnished our committee by Dr. Helpern that we had not known.

Dr. Helpern stated that the word "overdose" is in a sense, a misnomer. He further stated that an addict of many years standing could shoot heroin of the same quantity and quality on the same day of his death that he had done on the day before and yet suffer an acute reaction and die with the needle sticking in his arm.

In other words, you can build up a tolerance for the substance but, because of other variables such as metabolism, other illnesses, amount of sleep, et cetera, what one day could be a tolerable dosage, could on the very next day kill you.

Mr. Chairman, the most moving and poignant part of our hearings in New York City occurred on Saturday afternoon. The committee was invited to meet with a few citizens in the basement of a church in the South Bronx. We were invited by a nun, Sister Phillippa. The sister is a lady who, for many years, had helped to serve the needs of the South Bronx. About 13 years ago, she was transferred to Hawaii, and recently returned to visit some of her old friends in the old neighborhood. What she saw broke her heart and compelled her to remain in the South Bronx rather than to return to Hawaii.

We rode to the church in a bus and had an opportunity to see a large portion of the Southeast Bronx. It was like a war-torn city, gutted-out buildings, boarded up windows, debris littering the streets and sidewalks, and a feeling of deprivation and decay permeating the air. Four or five of the local residents, both men and women, attempted to describe for the committee the constant fear with which they had to live every day because of the curse of heroin addiction and trafficking.

Addicts mugging, robbing and stealing to support their habit—carrying furnishings, TV sets, furnaces, and other things of value out

of apartments in broad daylight, defying anyone to stop them with the threat of physical reprisal against anyone stupid enough to report them or their pushers to the police. Mothers and young children slipping and sliding on the blood in the hallways where addicts had come to "shoot up." These citizens have no alternative but to witness this sad and tragic spectacle each day of their lives.

Can you imagine how difficult it must be for them to explain this shameful neglect to their school-age children.

The people who testified did so voluntarily and at great risk to their personal safety. Although these men and women were obviously poorly educated and inarticulate, their depth of concern and honesty was evident and movingly manifested in their message.

Fortunately, they were accompanied by a man by the name of Bernard Butler, who is director of community planning of the Office of the Borough President of the Bronx. Mr. Butler is a black man and a graduate civil engineer. He practiced that profession successfully for 20 years. Last year he felt an obligation to try and do something and for that reason gave up an extremely lucrative position to go to work for the municipal government.

At this point, with the committee's indulgence, I would like to read from the transcript of our hearings a portion of Mr. Butler's statement:

Mr. Butler: I better identify myself. My name is Bernard Butler and I am Director of Community Planning of the Office of the Borough President of the Bronx. I am involved in this primarily through Sister Philippa's efforts. I am here primarily to reinforce.

I recognize that perhaps a story that we are telling you seems to be somewhat unbelievable. I can personally guarantee from our exposure at the Bronx level, seeing the totality of the operation in the Bronx, that what we are dealing with here is a social, political and economic system the likes of which I would dare-say exists nowhere in the world. We here in the South Bronx are very close to total disaster. If in real effort we can't turn this trend around very quickly my suggestion would be to chop the South Bronx off and sink it out at sea.

We brought in what we thought or felt was a representative group of people living right here in the community because they live in it every day. I don't. But I guarantee certain things that have been presented here to you as being true without reasonable doubt. Maybe we can coalesce the story into a series of things.

There is a 100 percent total breakdown in the social system in the South Bronx at all levels, whether we talk about the government, police protection, sanitation, housing, education, total breakdown, total collapse. It ties in distinctly to this total narcotics problem. Now, maybe I can typify this.

We talk about payoffs. We cannot reasonably expect people who have to live in a community every day to fight this kind of a problem because the impact turns around and they become the villains. There isn't an operation that we can do in these areas with the legal government authorities that they don't get paid off whether it be demolishing an old building, putting up a new building, a crossing guard at a corner and we don't even have to get involved with the more complicated system of picking up known narcotics agents, known narcotics addicts, raiding a location that we know is a place where they not only sell it but package it.

We have factories here where they bring it in wholesale, cut it and package it and it is well known, it is reported and nothing is done about it.

We are losing more housing the South Bronx than we could build if you could pump $100 million into the South Bronx. Last winter between November and February our office, the Borough President's office received on an average of 1,000 calls a week, 1,000 calls a week from the South Bronx where they just don't steal plumbing fixtures, they steal the boilers, oil burners, strip it. They can strip buildings better than you can with a demolition crew.

I guarantee you within three blocks of where you are sitting right here today, now, that you can buy anything you want, narcotics, television sets, guns, automobiles. This is how the habit is supported.

You ask about the men in the neighborhood. Three-quarters—because of the economics of it, three-quarters of the men that we have living here, the family structure that we have living in this area in the South Bronx, we have something like 800,000 people in the South Bronx, 75 percent of those are families that don't have husbands at all. Why are they living here? It is the only place they can afford. They move into another neighborhood and the family structure is different because the economics are different.

In the South Bronx we have families that are raised, run, operated by women. The few men that are here I can't reasonably except a—and I exaggerate not. The men who are here are not working two jobs but three jobs trying to support a family. Their whole social, economic, educational background is such that I can't send them down to work in Wall Street or in a large organization or in a corporation. They don't have the background, the education and they don't have a field.

We have dropped in our whole social level to the extent of where even you get a person who really wants to do something, he has seen the futility of dealing with government structures, with politics, with the educational system. He has seen the futility of it and if I ask him, if I implore him, if I beg him to come out and help and assist he won't do it. He recognizes that he has wasted his life.

I daresay you gentlemen here who are perhaps in an ideal situation to relate some of these things, if I am in the situation—this is war, this is total war. Every time I stick my head up somebody shoots at it. I soon learn to keep my head down. I soon learn.

These people put their very lives, and I am not exaggerating, they put their very lives on the line coming in here to testify before you today. When we walked from the convent around the corner to the school here, at that stage of the game the community knows that they are sticking their necks out to come in here and I would not be a bit surprised if before the night is over actually repercussions will be taken against some of the people sitting here testifying.

This is the kind of community that we are involved with today. It doesn't look like a normal community, it doesn't act like a normal community because in real effect it is not a normal community.

Now the obvious question is what can and should the Federal Government do to combat this menace of epidemic proportion that threatens to destroy our society? It is my considered judgment that it will take a massive infusion of money, talent, and commitment. The approach should be threefold:

1. Controlling and limiting the source of supply of heroin and the continuing prosecuting of heroin traffickers;
2. A national educational campaign in order to prevent and dissuade potential addicts and young adults from experimenting with this dangerous drug; and
3. Treatment and rehabilitation of addicts.

Since the principal thrust of the bills before this committee are directed to the regulation and control of narcotics, I will restrict my remarks to that subject. Although all of my remarks have been directed to heroin and later on in my testimony I will address myself to the marihuana problem, one other drug that is rapidly becoming a major problem is cocaine.

Although we have received substantial testimony, especially in our Miami hearings on that drug, because of time considerations, I will limit my statement to heroin and marihuana.

I would, of course, be happy to furnish at a later time any specific information that you would like to have with respect to cocaine.

Michael Costello, special agent, Bureau of Narcotics and Dangerous Drugs, stationed in New York City, furnished us with two very revealing charts—one, which, as you can see, shows the routes that are

used by the smugglers to bring heroin into this country. The other chart shows the typical organized crime structure which uses these routes.

The one on my left shows the origin of the poppies from which first opium and then the morphine base is made in the fields of Turkey and then is brought out by various ways through southern France and largely into Marseilles and then by various and devious routes it is brought into New York and into the United States.

A newly developed route is one being through South America. When our hearings were held in Miami it was disclosed half of the cocaine supply of the United States is coming into Miami from South America. They are now using that as one of the main supply routes of getting heroin into the United States.

The far chart shows generally the organization by which they bring heroin into the United States and the authorities, many of whom testified in New York City, said that most of the heroin is brought into the United States by 12 to 15 people in the organized crime category. They are the big ones that put up the money. They are the skilled and knowledgeable people who direct and control the operation.

Regrettably, from the viewpoint of law enforcement, they are so high in the structure and so isolated or insulated from the actual transaction by layers of other people that it is very difficult to get to them. If we stop the morphine from coming out of Turkey and keep heroin from coming out of France it is one of the best ways of keeping it from being distributed in the United States.

Based on the testimony taken at our hearings in New York City, it is abundantly clear that it is virtually impossible to have a substantial impact on the quantity of heroin being distributed in this country if we want to seize the substance at the distributor level.

There is everything from the little pusher, the addict himself who sells it to someone else who sells it to sustain his own addiction all the way to the overseas gangster and the pyramid at the top.

We had a witness who was prosecuting attorney of New York County who said 48 percent of the cases in that court involved possession or traffic in heroin and another 25 percent of the cases in that court involved crimes committed by those who were the addicts of heroin to sustain the addiction.

So, you can see, this prosecuting attorney said, without our having to take these emergency pleas from the hoard of defendants brought in we would not be able to carry on our court. It is bogged down now, but it would be just paralyzed if we were not able to ease our dockets by plea bargaining.

So the numerous cases are directly attributable to the heroin traffic.

For that reason, the most efficient use of money and manpower to control the supply would be, in my opinion, in Turkey where the poppy is being grown and harvested and in Marseilles, France, where morphine base is refined into heroin, and at the importer level before heroin is cut for distribution.

At this point, you gentlemen have a difficult choice to make. Traditionally, we have controlled narcotics through the use of the taxing power. If we are to continue this concept, then the principal law enforcement agency of the Treasury Department, namely, the Customs Bureau, must be given sufficient authority to do the job. At the present time, in my opinion, they do not have it.

I read with interest the prepared statement of Secretary Kennedy which was delivered to you gentlemen yesterday afternoon. In that statement, the Secretary reiterated the fact that the President had directed him "to initiate a major new effort to guard the Nation's borders and protect against the growing volume of narcotics from abroad. There is a recognized need for more men and facilities in the Bureau of Customs to carry out this directive."

As you know, Congress cooperated fully with the executive branch of the Government by passing in December of last year an appropriation of $8.75 million which provided for 915 additional men and improved equipment to the Bureau of Customs. The House Appropriations Committee, in recommending to the full House that these extra moneys be granted stated:

> The committee strongly supports the Department's objective of reducing to a minimum the smuggling of this contraband into the United States. The committee specifically allows the 915 additional positions requested and urges the Department to move ahead on this project as rapidly as practicable.

Later on in his prepared text, Secretary Kennedy assured this committee that—

> Neither that bill (S. 3246 as passed by the Senate) nor the present bill changes the Treasury Department's existing enforcement and investigative responsibilities—as exercised through the Bureau of Customs—to deal with offenses under customs and related laws, whether or not some or all of the merchandise involved may consist of narcotics and dangerous drugs.

However, what the Secretary neglected to point out to your committee was the fact that through the device of a Presidential directive jurisdiction of the Bureau of Customs was severely limited. Such limitation, in effect, made the additional money, men and equipment meaningless. I have a copy of that directive here in my hand.

Customs inspections of both passengers and cargo are an absolute necessity in controlling the smuggling of narcotics into the ports of entry into our country. Most of the significant seizures are accomplished by tips from informers and reports from undercover agents.

Yet, under the new guidelines issued by the current administration, the only agency accredited to represent the U.S. Government in dealing with foreign law enforcement officials on narcotics questions is the FBNDD within the Department of Justice.

More importantly, customs jurisdiction is limited to smuggling through customs lines and does not include preparatory acts prior to bringing the articles within U.S. borders. Also, in order to check on channels of distribution, it is sometimes better to allow shipments to pass through customs untouched and then follow them to their final destination.

Yet, under the new guidelines of the current administration, customs is forbidden to do this without the specific approval of FBNDD. Thus, as a practical matter, customs is forced to turn over all such surveillance activities to FBNDD even though that agency had nothing to do with the details of commencement of such investigation. Naturally, guidelines of this nature inevitably must cause uncertainty, rivalry and consequent inefficiency between the two agencies. Something must be done to iron out these difficulties. Because of the seriousness of the problem, we simply cannot afford petty jurisdictional bickering among bureaucrats.

Madam Chairman and members of the committee, just let me refer to two or three portions of this Presidential directive of May 1970.

Bureau of Narcotics and Dangerous Drugs should be designated the agency to control the narcotics area. Customs should support FBNDD's efforts to reduce and eliminate the flow of narcotics into the United States and its intelligence network should be used to assist in the overall effort.

Another part:

The Bureau of Narcotics and Dangerous Drugs controls all investigations involving violations of the laws of the United States relating to narcotics, marihuana and dangerous drugs both within the United States and beyond its borders except as set forth in the first sentence of 2(a) below. BNDD has primary jurisdiction over all investigations originated by officers of that Bureau either within or outside the United States including smuggling of narcotics, marihuana and dangerous drugs into the United States. In the foreign area BNDD is the accredited United States agency for contact with foreign law enforcement officers on narcotics, marihuana and dangerous drug matters. Customs personnel shall communicate on narcotics with foreign law enforcement officials only after prior approval (in writing if possible) of the Director of BNDD or his designee.

If BNDD does not give approval, BNDD will communicate with foreign officials with respect to the particular matters requested by Customs and will expeditiously advise Customs of the result of the communications.

BNDD has jurisdiction and authority to investigate and coordinate with foreign personnel in all narcotics, marihuana and dangerous drug matters in those foreign countries where both BNDD and Bureau of Customs have assigned personnel.

Incidentally, customs has far more offices. Customs had 65 offices in different countries of the world and BNDD has less than 12 offices in the various parts of the world. So, you can see it would seem to me to deny customs the right to carry on its own contacts with foreign officials is a very severe limitation.

Then it adds:

BNDD may establish offices in border cities.

I thought that was one of the normal activities of customs to have its offices on the borders of the country.

Another one: "For this purpose smuggling is understood to mean the actual passing"—this is the jurisdiction of customs—the Bureau of Customs responsibilities. The Bureau of Customs because of its responsibility to suppress smuggling in the United States has primary jurisdiction at ports and borders for all smuggling investigations including those involving narcotics marihuana and dangerous drugs except those initiated by BNDD. For this purpose smuggling is meant to mean the actual passage of heroin, marihuana and dangerous drugs. It does not include preparatory acts prior to bringing the article within the boundaries of the United States. Smuggling violations not terminated at ports or borders come within the jurisdiction of BNDD unless such jurisdiction is waived in writing if possible by the Director of BNDD or its designee.

We had testimony in New York that there were some $23 million worth of heroin on a table in our hearing room, representing captures by customs agents I believe since 1968. It was fantastic the job that they had done.

For example, in one case, a group of gangsters had acquired a little cannery down in southern Spain and had bought from an institution in northern Spain large quantities of canned fish somewhat like tuna, which was the custom to be imported into the United States.

But when they got the shipment down to southern Spain 8 cases of it were empty cans with the regular labels on all of them, but they put into those empty cans with the regular labels heroin, 68 cases of it.

But in order to equalize the weight of the heroin with the canned fish they had to put two little pieces of lead in the can. Well, customs through its intelligence service in Spain found out about that. They got tips on it.

So, they knew that a large quantity of canned fish, many cases of canned fish were coming through customs bound for a certain consignee in New York, but they did not know which of the cans had heroin in them and which had fish. They got access and used an X-ray machine. When they found out the ones with heroin had the little pieces of lead in them, that was the way to identify them.

So, the origin of that shipment was in Spain. That is where the informers were. That is where they got the first intelligence of what it was, how it was done, when it was coming out and in what form and so on. It came on through the ship and they let it go through in New York because they wanted to catch the consignees. They let it go through and their agents had to undergo 3 days of ordeal and they followed that shipment through to a house in a part of Greater New York.

For 2 or 3 more days they waited and watched around to see if there would be any exodus or anything from that house.

On the third day two men came out with suitcases and looking around, seeing nobody got into a taxi and drove away. Customs agents had all of the exits under surveillance because they thought there might be some more people coming out of there with some more heroin.

They followed those people until they got in touch with somebody else and then they arrested the whole group.

Now that case is a good illustration of the fact that if customs is going to do a good job at the ports, they need to have authority to follow their own tips and develop their own intelligence and their own sources of information, to establish confidential relationships with their own informers and then the ability to follow it through when the heroin gets into the United States and in the hands of the consignee.

One other illustration, if I may, Madam Chairman: A major in the Army coming from France somehow or another was approached by some of these heroin importers and he agreed to let them put heroin into the lining of his Frigidaire which was to be shipped to the United States as a part of his furniture. He was moving back to the United States with his family. They got a tip. They had informers over there.

They let it come on through and when finally that man got to Fort Benning, Ga., they established contact there with some people who came to look at the Frigidaire and so on and took this lining out. Then they arrested those people.

There again the knowledge originated in France and they followed through, the same agency, into Fort Benning, Ga.

Also, there was a TWA plane that left from Germany with a number of large packages of heroin tied up in black socks about a foot long. They had it knotted at the end and a string on the end of it and

a button on the other end. In some way or another, they made arrangements with some in custody of that plane in Germany and they went into the lavatory and you know where you throw the towels in, back behind that flap, they put some things to hold these slips. They had about a dozen of these packages of heroin in these black socks hung on nails or something back behind that lavatory flap where you throw the spare towels.

The customs people again had informers and contacts and they knew about it when it was put on. The man who put it on got off of the plane, left the heroin back behind the flap in the lavatory. The plane was destined to go to some other city, but the plane was diverted to Washington. There was nobody on the plane at all that bothered about the heroin. It was up there in the lavatory, but since they had knowledge of it, an agent got on the plane at Washington.

Nobody for a while seemed interested in the heroin. It was up in the lavatory. Then a gentleman got up casually between Washington and Chicago and went into the lavatory with his briefcase.

In a little while he came out of the lavatory with his briefcase and came back and got a seat. The agent was watching and spotted him. The fellow did not get off the plane in Chicago. The agent stayed on the plane. Between Chicago and St. Louis the agent indicated to somebody he was going to get off. He got off the plane in St. Louis. The agent got off the plane with him. The fellow with the heroin took a plane to New York, and he followed him until he made some contact with some other people and then they arrested him.

There again, we all know the difficulty of having the same nuances, the same disclosure of all of the necessary information when one person passes it to another, particularly when one agency passes it to another.

Those are just three, I thought, very interesting experiences as to why it was desirable to let customs do this work. I think customs is one of the oldest agencies of the U.S. Government and has its origin from the earliest days of our Republic.

Yet, for all practical purposes, the efficiency and the effectiveness of the Bureau of Customs and markedly the morale of those customs agents are very severely limited and affected by this directive.

I have not had a chance to see yet what showing was made to the Appropriations Committee last December, I believe it was, when the Appropriations Committee authorized over $8 million additional money to customs, authorizing the employment of 915 additional customs agents.

I am sure it was because they emphasized the need for more agents primarily to deal with this matter of narcotics coming in such dangerous quantities into our country. Congress surely felt customs was going to have a major part on combating this menace of bringing heroin into this country.

As I said, Mr. Kennedy did not make any reference to this directive. On the contrary, as I said here a while ago when he testified before this honorable committee he distinctly said that there was to be no impairment of the former and recognized jurisdiction of the Department of the Treasury and the Bureau of Customs in dealing with the narcotics question.

I am not here to decry the essential work to be done by the Bureau of Narcotics and Dangerous Drugs. They were very gracious and very cooperative with our committee. But we were told by the highest officials of customs and the Bureau of Dangerous Drugs and Narcotics in our New York hearing that we are able to interrupt only about 20 percent of the heroin that comes into this country.

So, I am merely saying, Madam Chairman and members of the committee, there is enough work for both of them and more, too.

I don't think an old established and recognized and effective agency should be so hamstrung. All it is to do is examine the bags and persons as they come through the ports. That is about what they have been limited to do.

Now, I think their past deserves an opportunity to do better than that.

Mrs. GRIFFITHS. This is being done now by Presidential directive?

Mr. PEPPER. Yes. This Presidential directive, not by statute, but by Presidential directive who interestingly enough left it up to the Attorney General, the head of the Department of Justice, where BNDD is located to be the arbitrator between Treasury and the Department of Justice. I had generally assumed that it was an established principle that a man is not to be the judge of his own case.

With all due respect to the Attorney General, if he is going to be an arbiter between two departments of Government, it should not be the head of one of the departments.

All we want and I am sure all this committee wants is for the best possible job to be done. I am convinced from having heard a lot of witnesses that we have to do vastly more. I understand we are giving Turkey a loan of $3.5 million to try to reduce the quantity of heroin.

My, my, think of how much it costs us in this country to deal with it when it gets here. If we gave them $100 million, if we could reduce substantially the amount of it, not to speak of lives, the saving would be enormous.

So, I think we need a stepped up, much more adequately financed, much more effective program. I will say one thing more Madam Chairman, and members of the committee, if I may. If over in southern France there were a group of sinister men who shot missiles into New York City and thus far this year up to June 26 had killed 389 citizens of New York City, I think we could find something to do about it.

I think maybe diplomatic niceties might be stepped up to the point where we could say:

> Listen, this is coming out of your laboratories. Relatively little is being done by your police to effectuate restrictions upon the import of heroin from those areas, and in some way or another if you want to be our friend—you are killing our people—and if you want to be our friend as we want to be yours, and traditionally have been, somehow you must let us help you more if you can't do it yourself to save our people from this terrible thing.

It just shows that the heroin is almost a death sentence. We have found out in these hearings it is almost a death sentence when anybody gets to be an addict of heroin. We have two Federal institutions, one in Texas and one in Kentucky, and they only claim a 5-percent cure and I am not so sure those figures are correct.

The distinguished chairman will recall a doctor testifying in her city of Detroit of many boys and girls coming to his center who are

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drug users. This has become one of the most grevious national menaces of which I am aware.

I am reminded by my chief counsel that in 35 years, only one major laboratory and the people operating it have been the subject of arrest and seizure in France.

Madam Chairman, since I know that there are a number of other witnesses scheduled this afternoon, I will attempt to keep my remarks on specific legislation pending before you brief. Unfortunately, our New York City hearings were not concluded until 3 weeks ago today. Since that time, we have also had hearings in Philadelphia and investigated prison conditions in five States.

Consequently, the members and staff of our committee have not had sufficient time to refine some of our conclusions into specific legislative proposals. Therefore, I will direct my testimony to H.R. 17463 which is substantially similar to S. 3246 which has already passed the other body, and made a few suggestions for improvements.

HEW OR AN APPROPRIATE COMMISSION RATHER THAN THE DEPARTMENT OF JUSTICE SHOULD DESIGNATE THE SUBSTANCES TO BE CONTROLLED

As the committee knows, title II of H.R. 17463 gives the authority, after consultation with the Secretary of HEW and the Scientific Advisory Committee to dsignate which substances will be controlled and on what schedule they should appear.

Earlier this year, several of my colleagues and I introduced H.R. 16123, which dealt with amphetamines, barbiturates and some of the hallucinogens. Under that bill, the authority to schedule substances would be vested in the Secretary of HEW.

As you know, our Nation's drug industry has developed and marketed a number of synthetic narcotics. I am sure that they will continue to do so. We are also advised that there are a number of substances that are extremely difficult to classify and there is a real question as to whether some of them are addictive or nonaddictive.

When the House Select Committee on Crime considered this matter at an executive session, a majority of our members came to the conclusion that the classification function more logically would lie with the Department of Health, Education, and Welfare. The decision to be made is essentially a scientific and medical one with incidental law enforcement aspects. I firmly believe that the decision we are talking about involves the public health of this country, and major participation is required by that department of government which is charged with that overall responsibility.

Perhaps an excellent compromise between law enforcement and the medical communities could be achieved through the adoption of an approach currently being considered by the Public Health and Welfare Subcommittee in its markup of its portion of the Dangerous Substances Act.

That proposal would create a commission on drug classification with five commissioners appointed by the President—one from HEW, one from Department of Justice, and three knowledgeable people from the general public. Such a commission has the obvious benefit of bringing to bear the specific interests of science, medicine, law enforcement, and the overall interest of the general public.

These interests should and must be heard on the classification of each individual potentially dangerous substance that is made available to the American public.

PENALTIES

Heroin

Title V of the proposed act is the penalty section. Although I am sure that Chairman Celler's Committee on the Judiciary will also wish to look into this matter in detail, based on evidence received to date, I have come to the reluctant conclusion that we should seriously consider making the arrest of a person with a substantial amount of narcotics in his possession a nonbailable offense.

I mean more than just a cigarette in the pocket or a little bit of quantity of even heroin to be used. Anything that indicates that that individual is engaged in traffic, in profiting financially over the misery and perhaps the death of his fellow citizens.

Traditionally, bail is not offered for the crime of murder. Major traffickers in narcotics are worse than murderers in that they condemn their victims to a living death for a number of years before they are put out of their misery by an overdose or some other cause.

Although one can never condone the deliberate taking of a human life, crimes of passion can often be explained in terms of human frailties. However, when individuals motivated solely by their own greed and lust for power prey on fellow human beings for massive profit, there can be no mitigating circumstances justifying such heinous conduct. Major narcotic trafficking is a totally premeditated act.

We are advised that major traffickers, upon their arrest and release on bail, usually do one of two things—they either jump bail and leave the country or stay in the business to make hay while the sun shines until they are eventually incarcerated. With court congestion being what it is, some of these men can effectively stay out of jail for 3 or 4 years because of the delay in our trial courts and a number of appeals. To allow these merchants of death to continue to operate for such a length of time after apprehension is unconscionable.

The task of dealing with the problems of possession and of sale was further complicated by the District of Columbia Circuit Court of Appeals last week in the case of *Watson* v. *U.S.* The effect of that case seems to me to be that the next time the possession issue is before that court, they will hold that those provisions of the Federal narcotics laws involved—

> * * * do not apply to a narcotics addict, not trafficking in narcotics, who has purchased or otherwise received narcotics not in the original stamped package, who has imported narcotics contrary to law, or who has received, concealed, purchased, or facilitated the transportation or concealment of narcotics imported contrary to law, so long as the narcotics involved are for the addict's own use. Likewise, that decision would appear to compel the conclusion that, when these acts are engaged in even by an addict who trafficks in narcotics, *Robinson* v. *California* makes unavailing any attempt to apply these statutes to him.

No doubt the Committee on the Judiciary will at some future time hold extensive hearings on this precise question. Unfortunately, we do not have the time to debate esoteric points of law in the war against narcotics traffickers.

Therefore, it seems to me as an interim step that a law could be written that would create a statutory presumption of intent to sell

whenever a person was found with 1 kilogram or more of heroin of a certain quality in his possession.

It would be impossible for the most extreme addict to shoot up more than 30 nickel bags in a day. There are roughly 100,000 nickel bags of 10 percent heroin in a kilogram. By using the figure 50 bags a day, one can calculate that this amount would far exceed that needed by an addict with an extreme addiction for over 5 years.

May I add we had case after case brought to our attention by prosecuting officials and by Customs and Narcotics agents, after they worked sometimes years to break up a ring bringing cocaine or heroin into the United States and had gotten some prominent participants in that ring, they would come up and put up a cash bond of $100,000 or $50,000 bond, some of them being from out of our country, some of them being from Latin America, and they would skip bail and never be heard of again.

That is very discouraging to law enforcement agencies to see the courts allow their prey which they have been so long and so assiduously attempting to catch slip out of their hands by such devices. They told us in New York these big operators could lose billions of dollars in a shipment and go along and do the same thing next week.

If they can come in and put up a $100,000 or $50,000 bond, that is duck soup to them to enable them to get out of the country.

So, they raised questions about whether we shouldn't make a man when he gives the bail agree if he skipped bail he can be tried in absentia. There should be something to convict him and maybe we could get an agreement or an authoritative provision of law of taking a deposition in a foreign country if the defendant does skip his own bail.

These are very serious matters which I bring to your honorable attention.

Paraphernalia and diluents

Madam Chairman, on the basis of our committee's detailed investigation into drug trafficking in the New York City area, we uncovered many aspects of drug merchandising which had never been publicly focused upon, but which nonetheless aid and abet the successful merchandising and packaging of heroin.

In the argot of narcotics trafficking, the necessary accoutrements to merchandising and packaging of heroin are referred to as "paraphernalia." When the street wholesaler and trafficker purchase heroin in kilo or multikilo lots, it is necessary for the trafficker to cut or dilute the heroin prior to distribution to the street addict.

This process of cutting and diluting is facilitated by the easy access which traffickers have to the procurement of the necessary diluents and packaging materials. Heroin is usually cut through the use of quinine, mannite, dextrose, or lactose. Once, cut, it is packaged into "bags" or glassine envelopes, normally in sizes 1½ by 1½.

I hold here the size of these envelopes we found they were using. This would be a $5 package of heroin that would be sold in this little glassine envelope.

Madam Chairman, you may wonder where a narcotics trafficker purchases the necessary cutting and packaging materials. Surprisingly, these materials are readily available to the trafficker at his local drug store or stationery shop in Harlem and in the Southeast Bronx in New York City.

Our investigation revealed that one particular stationery store sold 52 million glassine bags of the heroin package size in the year 1969 alone. These sales accounted for nearly 20 percent of this store's gross revenue.

In testimony which was adduced at our hearings it was established quite clearly that glassine bags, sizes 1½ by 1½ are not used by stamp collectors, as has been claimed by the manufacturer of such bags in the past. Nor are these bags used by jewelers or watch repairmen as has been maintained by several manufacturers to justify their profiteering. Our investigation revealed that these bags have really no other use but to package the deadly substance heroin, which was the subject matter of our New York hearings.

Similarly, our investigation revealed that several drugstores operating in Harlem and in southeast Bronx sold massive amounts of quinine, mannite, lactose, and dextrose during the past year. One drug store, for example, sold over 40,000 ounces of quinine worth $60,000. That same small drugstore sold over 4 tons of mannite during the same period.

Estimated revenues from sales of diluents in New York City alone run in excess of $5 million a year. Our investigation revealed that sales for legitimate purposes of quinine, mannite, lactose, and other heroin additives should only total a few hundred thousand dollars a year for New York City.

Our committee is currently in the process of studying the results of our investigation and evaluating the testimony which was received from over 55 witnesses, several of whom testified reluctantly under our committee subpenas. We are seriously considering legislation which would limit the quantity of heroin diluents which could be distributed through the channels of interstate commerce. We are also considering legislation which would require registration for all companies which manufacture and distribute known heroin diluents and paraphernalia.

Madam Chairman, we respectfully suggest that your committee consider adding a section in the current legislation which would encompass this aspect of heroin trafficking, thereby rendering the merchandising of this deadly drug a much more difficult and hazardous venture.

I bring these points out to recommend to your honorable committee that you consider the expansion of your prohibition to the manufacture or sale obviously for purposes in connection with the transfer and ownership of heroin of using these devices to cut or package heroin.

REDUCED MARIHUANA PENALTIES

An analysis of State laws reveals a recent trend to adopt laws dealing with marihuana less severely for so-called "simple possession" offenses, and where appropriate, parole, deferral and suspension of sentences for first offenses. Alabama and Colorado are the only States which do not permit suspended sentences, probation, or parole for drug abuse convictions. Fifteen States allow probation for first offenses only. As a condition of probation or suspension, some States require a program of care and treatment at a State institution whereas others merely impose a periodic examination to assure nonuse.

While no State appears to have eliminated all statutory control

over the possession and/or sale of marihuana, 23 States now provide misdemeanor-type penalties, with suspension and probation possible, for mere so-called possession for personal use-type marihuana offenses.

Thus it seems clear that the trend of State amendments to their drug abuse laws is toward a program of care and treatment for the drug addict, more judicial discretion in the sentencing of first offenders, and a reduction of penalties for possession-type marihuana violations.

The above trend is indeed a considerable one and it would be the hope of our committee that the U.S. Government will follow the same trend. Certainly under existing law, the penalty imposed under Federal law is disproportionate to the "crime against society" of experimenting with marihuana.

As a result of our hearings we found that, generally speaking, judges are extremely reluctant to impose a sentence in such cases. Courts are not about to sentence a president of a high school student council or anyone else who has not had a criminal record, to serve time in jail or a penitentiary; instead they are given probation. This is not to say that occasionally a first-time offender is not apprehended and given a felony conviction with which he or she shall have to live.

Criminal conduct cannot be condoned. However, the penalty attached to the prohibited act should bear a rational relationship to the harm or potential harm to others. In the case of simple possession of marihuana (the person who has a small quantity for personal use), it would appear that the penalty proscribed in both Federal and many State statutes is too severe.

In the opinion of the committee, uneven enforcement of justice is unfair justice. Laws must be, as much as possible, uniformly enforced. Currently, scientific and medical data indicate that marihuana should remain illegal: it is a dangerous substance for the reasons cited in portions of our committee's report on the subject, and, as such, is a serious public health concern.

It would appear that ongoing studies should provide definitive answers as to marihuana's long-term effects by the end of 1971. It is our recommendation that until the definitive answer is found, the Congress should adopt misdemeanor treatment of the first-time offender.

One of the more enlightened laws that we have found in our hearings was discovered during those conducted in Omaha, Nebraska, on October 8 and 9, 1969. Briefly, the Nebraska statute provides:

(1) Maximum of 7 days;

(2) Segregation of users from all other prisoners; and

(3) Requirement to take a drug abuse education course. The committee feels that such a law could be fairly and impartially administered; thus enhancing public respect for the law and the criminal justice system. Should subsequent scientific studies further expand our knowledge as to the long-term effects of marihuana, then the law should be amended accordingly.

We had testimony from the Superior Court Justice of Massachusetts that he never heard of a boy or girl being sent to a penitentiary for 2 or 5 years as the Massachusetts Law provides for the possession of marihuana.

The court just finds some way of getting around the law. We are advocating that your honorable committee approve substantially what is in this bill, that large discretion shall be vested in the trial court

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even for the second offense for the possession of a small quantity of marihuana which appears to be in the possession of one having it for his own use rather than for traffic and trade in it.

We found one interesting statute in Nebraska where the Nebraska statute provided in the case of the first possession of marihuana, first unlawful possession of marihuana the maximum penalty for the one found in possession to be 7 days in jail—7 days during which time, half of the time must be employed in trying to teach the one there the dangers of the use of drugs.

Then they segregate these users from other prisoners so they will not be contaminated by them.

Madam Chairman, I will give you one other illustration. We had a young man in New York who at 17 years of age was found guilty of the sale of heroin in a small quantity and was put in the Federal institution at Chillicothe, Ohio. There this 17-year-old boy met some of the big shots in New York in the heroin trade. He established an agreeable relationship with them and became friendly. He did some favors for one of them.

So, when he got out, he looked up his old friends that he made in prison. By that time they were back again dealing in large quantities, relatively large quantities of heroin. They liked this boy. So they began to consign—give him a consignment, a quantity of heroin without having to pay for it.

In a little bit he was making $6,000 a week taking some of that heroin from an old prison friend that he did not have to pay anything for, making a couple of trips out to Chicago, delivering it, bringing his money back, paying them the purchase price of it and profiting his profit of $6,000 a week. That is the reason I say it is so important that we keep this first offender so that they come out better than when they went in.

So the committee respectfully suggests that there should be lighter penalties and greater discretion in the trial courts in respect to marihuana.

The last thing—just a little bit more—the study on marihuana.

STUDY ON MARIHUANA

Under section 801 of title VIII of H.R. 17463, it is proposed to establish a committee on marihuana. Last year we conducted a number of hearings investigating marihuana usage in this country. Our activities were culminated by the introduction of House Resolution 739, which would require appropriate agencies in the executive branch of Government to conduct an authoritative study on the subject and report back to Congress.

The young people of this country have not accepted any final word as to the character of marihuana. They are still arguing it is no worse than liquor which we old people enjoy and nobody knows actually what the effects upon the body are from the sustained use of marihuana.

So, a study is highly desirable. The Medical Facilities and Construction and Modernization Amendments of 1970 have provided that the Secretary of HEW after consulting with the Surgeon General shall have an authoritative and thorough report prepared and filed

with the Congress or we will have factual data upon what is the real character of marihuana.

I understand somebody made the comment here or asked the question before this honorable committee that I said that marihuana led to the use of heroin. I did not say that. What I said was that in our study, in our investigation, we have actually found only one or two cases where a heroin addict had not at the beginning of his use of drugs begun to use marihuana.

Marihuana is not a narcotic and it is not addictive in the sense that heroin is, but most of the heroin addicts unmistakably started off using marihuana.

We also compiled our own report on the subject and filed it with the House. Today, I have extra copies of that document and will leave them with your clerk so that you can examine it at your leisure.

It would appear that section 801 and our House Resolution 739 are now moot. As you know, the Medical Facilities Construction and Modernization Amendments of 1970 became law on June 30th. Under title V of that act the Secretary of HEW after consideration with the Surgeon General and other appropriate individuals, is required to transmit a report to the Congress by January 31, 1971 and annually thereafter containing current information on the health consequences of using marihuana, and such recommendations for legislative and administrative action that he may deem appropriate.

Also, under that act, the Secretary is required to transmit a preliminary report to us by September 30th of this year.

CONCLUSION

In summary, it would be my hope that your committee would make the following modifications in H.R. 17463:

(1) Decide whether or not the Customs Bureau should stop narcotics smuggling; if not, then the additional 915 agents should be given to the Federal Bureau of Narcotics and Dangerous Drugs;

(2) Recognize that the scientific community should have a major influence in classifying dangerous substances;

(3) Make major trafficking in narcotics a nonbailable offenses;

(4) Lessen marihuana simple possession penalties to a misdemeanor pending the results of an authoritative study;

(5) Consider the problem of limiting and registering the production and distribution and sale of narcotics diluents and paraphernalia.

Madam Chairman and members of the committee, I urge your most earnest and expeditious handling of the bills now before you. We have an epidemic in our midst. If the Federal Government does not move quickly and effectively our entire Nation will suffer the same "total breakdown in the social system . . . at all levels, whether we talk about the Government, police protection, sanitation, housing, education; total breakdown, total collapse that we saw in the South Bronx.

Thank you for your time and attention.

Mrs. GRIFFITHS. Thank you for a very fine statement and for bringing us the benefit of the advice of the Select Committee on Crime.

Mr. VANIK. When the Attorney General was here, I suggested the possibility, with respect to hard drugs, since Turkey is the principal source of supply, of giving the President the authority to impose economic sanctions against a country which does not take proper actions

or steps to curb the production and the trafficking in opium and heroin. This could be done in our trade bill perhaps, or perhaps in separate legislation.

It would seem to me that simply giving him that power might alert an offending nation that it is not living up to its obligations as a friendly nation and that it might then be compelled to more vigorously seek to control the production and the trafficking in this serious drug. Would such power be something that would help solve the problem?

Mr. PEPPER. I will tell the able gentleman from Ohio that I would heartily approve the Congress itself looking directly into this matter, finding out what is being done by the executive branch of the Government, and then deciding for ourselves whether we think that is enough or not.

At the present time, negotiations which are considered secret are going on between our Government and at least one, if not both of the countries I mentioned—Turkey and France. They did not want us to have the State Department witness who was familiar with that subject in open sessions in our hearings in New York. So we agreed we would hear him here in the city of Washington.

I realize our Government has to maintain relations with nations and we have many interests and that sort of thing. But there are few interests of our Government that are superior to the lives and health of our citizens.

For example, the information I have is, as I said a while ago, that our Government is lending $3.5 million to Turkey where this subject is politically sensitive, I understand, to enable them to reduce the number of provinces where opium poppies are grown.

Some of the farmers who find this an ordinary crop in their terrain where this crop is grown, they don't want to give it up, no doubt. But I would not limit, if $10 million would do more good, or $25 million, I would not hesitate to deal with so vital a subject as that with just giving $3.5 million, if another amount would be a more realistic one that would get better results.

Every dollar spent in keeping it from getting out of Turkey and getting into France or getting out of France, I can assure you, will save no telling how many dollars in actual expenditures in trying to stop it in this country, not to speak of the tragedy in lives and human affairs that it causes.

I would be glad to support legislation that would give the power to impose sanctions or to reduce or withhold foreign aid or to do whatever else. As I said, if those were missiles being shot over here, I dare say, we would find something to do about it. It is so difficult for us to control it once it gets here, I think we are just going to have to put the principal emphasis on keeping it out of this country.

There are 20,000 miles of coastline around the United States with 200 some-odd ports in the United States. Once it gets on the high seas or in the air, there are so many places it can come in that it is a great problem to stop it at our shores.

So I think we in Congress have a right to be informed of what is going on in these negotiations and how effective they might be.

Mr. VANIK. I would say the distinguished chairman has done a remarkable job in bringing about the action we are about to take to put

some legislative curbs on this practice, and I certainly hope we can do something strong, something that approaches the embargo sanction or approach to it. There ought to be a way of getting to the source of supply and just closing it up.

Then we have to be concerned about substitutes and alternatives. I suppose if we were able to control all of the drug traffic, the young people and others who are disenchanted might learn that they got some jolly effects out of turpentine or castor oil or something else will come along.

Mr. PEPPER. There are 30,000 places they say on each ship where you can secrete heroin.

Mr. CHAMBERLAIN. I would like to join my colleagues in commending Mr. Pepper for the effort he has made. I think your committee has made a great contribution.

Mr. PEPPER. Thank you very much.

Mr. CHAMBERLAIN. I do have a couple of questions.

You have suggested that Congress itself should look into this. I am wondering if the gentleman can tell us what he has in mind in the way of the Congress taking a further look beyond what the gentleman's committee has done and beyond what we are doing.

Mr. PEPPER. I will say to my friend, the first thing we should do is find out what we are doing and then evaluate that effort and see if it is adequate or not.

Mr. CHAMBERLAIN. Isn't that what the gentleman's committee is doing? Are you suggesting we start over?

Mr. PEPPER. We are just getting into that aspect of it and within the next few days we expect to hear from the State Department. They wanted to be in executive session. We will hear what the state of the negotiations are and just what our Government through the executive branch is doing with respect to Turkey and France.

Once we get the facts, then we will be in a position to evaluate them a little bit better.

The second thing is we very strongly feel that both the Bureau of Narcotics and Dangerous Drugs and the Customs Bureau should be strengthened perhaps a great deal more than they are now. Customs had 331 in 1968 and they have 1,003 employees now. These are agents. They have a great many more inspectors and other personnel.

The Bureau of Narcotics and Dangerous Drugs, I believe they have a total of 1,600 employees, whereas Customs has about 10,358 total number of people working for them.

Congress appropriated $8,700,000, I believe, to authorize 915 more agents to work with the Bureau of Customs and they are now getting those agents on the job and they are beginning to take some effect. But we don't have near enough even now, I will say to the distinguished gentleman.

One of the things we could do and it would be an economy to the country, would be to add on a great many more agents to the Bureau of Narcotics and Dangerous Drugs and Customs.

Mr. CHAMBERLAIN. I agree with the gentleman that we need to hire enough people to do the job, but the Secretary of the Treasury told us yesterday, sitting in the same chair, they didn't need any more and they had all they could use.

Mr. PEPPER. I just cannot believe that the Secretary of the Treasury was fully informed or was not acting under the influence of the Bureau of the Budget.

Mr. CHAMBERLAIN. I asked him the same question. I am just as disturbed about this as the gentleman from Florida. I asked him how many they had requested of the Bureau of the Budget in addition to the 915 they had. He said 200, but when they got around to checking into it, the 915 was the maximum they could recruit and train in the time they had, and that the 915 was adequate.

Did your committee determine whether or not the BNDD was adequately staffed insofar as their personnel was concerned?

Mr. PEPPER. No, neither one of them. I think the most effective reply to my friend is to say that it was agreed by both BNDD and Customs at our New York hearing that we were catching only about 20 percent of the heroin that came into the country.

Now, if you say we have all of the personnel we need, why are we only getting 20 percent, and 80 percent coming in undetected?

Mr. CHAMBERLAIN. The gentleman's estimate is a little high. Someone told us 10 percent.

Mr. PEPPER. The figures we got from some of the officials in New York was 20 percent.

Mr. CHAMBERLAIN. If more are needed, then we have to provide them.

Mr. PEPPER. You are exactly right. When we are fighting a war you never hear you can't get enough men and you can't get them trained and you can't waive the operations you feel you have to waive. The FBI seems to be able to get agents and they have high standards of personnel. I have no doubt but what if they were authorized by Congress and instructed by Congress to obtain another 1,000 agents apiece that within less than 6 months they would have them on the job and they would be holding up and stopping some more heroin from coming into this country.

I must say to my friend that our efforts, like in so many other cases, they are too little and too late to deal with the massive danger that is confronting our country.

If the people of this country really realized what a growing menace heroin is, I think it is the largest single domestic menace that we have, because it is growing every day.

We were holding a hearing in Boston. The New England representative of our Government, the head of the Narcotics Bureau, said 2 years ago marihuana was the main drug being used, today it is heroin. All over the country you will get almost the same thing—increasing quantities coming in of heroin. We have hardly found anything to do about stopping the addiction. They are trying methadone on a limited basis.

We are not beginning to scratch the surface on the amount of money we should spend on research on how to cure an addict. In New York they say they think they have 100,000 addicts. No wonder the gangsters ply their trade to satisfy that market, because there are so many of them.

We are hoping that before we can finish this subject that we can perhaps bring some awareness of the seriousness to the attention of the Congress and the country and we will do more. We have done a lot, of course, but I am just respectfully saying I think we should do more.

Mr. CHAMBERLAIN. I thank my distinguished colleague from Florida.

Mr. GILBERT. I would like to commend my colleague from Florida and commend him for the work he has done in this field.

This morning we had testimony from Dr. Egeberg and his staff of HEW and the Director of the National Institute of Mental Health with respect to the effects of marihuana. From the thrust of their testimony, it appeared that their conclusions were inconclusive with respect to the effect of marihuana upon an individual, both from the physical point of view and from the mental health point of view. I am just wondering, sir, if in the course of your hearings whether you have had testimony from the medical profession in the areas of research and mental health addressing themselves particularly to the effects of marihuana upon the individual?

Mr. PEPPER. I will say to my friend we have had a number of witnesses in different parts of the country. We have had top people from the agencies here, the Bureau of Mental Health, HEW, and a number of outstanding professors, authors and writers and drug addicts in the country.

We had, for example, at our Boston hearing, a professor from Harvard Medical School. In his first questioning, that professor stated that marihuana did not adversely affect the use or the responses of one's nerves or nervous system and his muscles. Then he said, therefore, marihuana did not adversely affect the manipulation of a machine, the operation of some sort of a mechanical device.

Well, immediately I saw that the headlines would say, "Harvard medical professors says you can drive an automobile without any impairment of your capacity after having smoked marihuana."

I asked this professor: "Professor, would you like your children to ride in an automobile driven by a man who had been smoking marihuana?" He said, "No." I said, "You said a while ago you indicated you felt the danger would not be increased."

He said, "I didn't mean that. I didn't mean that the judgment of the driver would not be affected. I did not mean that his ability to judge distance would not be affected or his ability to perceive signals and approaching vehicles and the like."

Mr. GILBERT. What about his reaction?

Mr. PEPPER. We were having a hearing in Lincoln, Nebr., and a State highway patrolman was testifying and he said just a few days before the hearing he arrested a young student at the University of Nebraska for having a serious automobile accident.

Immediately the young man explained to him, "I have been smoking a marihuana cigarette. I did not realize how near the light was. I thought that automobile was farther away than it was when I was approaching it." It was his judgment.

Now there is a professor at the University of California who has written several books on marihuana and drugs. He says that he can tell by their behavior, the students in their class who are smoking marihuana. They giggle a little, their memories are less retentive, and there are some people who have more violent reactions from the use of it.

On the other hand, there are some people who seem to be able to smoke it for a considerable period of time within moderation who

don't seem to show any effects and it may be that it depends somewhat on the individual, the constitution of the individual.

But one very dramatic thing was said by Judge Tauro, chief justice of the Superior Court of Massachusetts in response to what is so often said by the young people. "You old people have your liquor but you don't want us to have our marihuana." Judge Tauro replied with two arguments that I think have a lot of weight.

One of them he said, "Yes, suppose marihuana is no worse than liquor. Did you know that 70 percent of the people in the prisons of the country were there because of an association with the excess use of whisky?" He said that the liquor culture is a part of our lives and we are not going to change it. We tried that and we didn't like it, so it was useless. Now he said, "Can this country allow another culture even of comparable character to be fastened upon it and have two permissive cultures—the liquor culture and the marihuana culture?"

Then he added the second point, "especially in view of the availability of marihuana as related to the availability of liquor."

Now, I have seen in my life a lot of people who use liquor but I have seen very few people carry liquor around in their pocket. Maybe at a game they might have a flask when they go off for a special occasion, but you don't see people reach down to their side pocket and pull out a flask full of liquor and drink it right down.

The judge pointed out with marihuana all you have to do is drop a marihuana cigarette in your pocket and pull it out any time you want it, maybe when you are driving a car. I don't suppose most of the ladies carry a little bottle of liquor around in their handbags, but it would be just as easy to drop a marihuana cigarette into ladies' handbags and take it out whenever you want to.

Ordinarily with liquor, it is associated with some social activity such as going to a bar or a party or a person's home.

That is why I commend this study to the Congress, the way we got the facts on cigarette smoking. We advocated that last year.

The availability of it alone in excess of the ordinary availability of liquor is a telling point against encouraging the permissive use of it although I do advocate a lesser penalty.

Mr. GILBERT. Congressman, one of the questions asked this morning of Dr. Egeberg was if a 15-year-old came to you and asked "Why shouldn't I smoke marihuana, what would your answer be?" He said, "No. 1, it is against the law and it violates the law."

Mr. PEPPER. You say what would one's answer be?

Mr. GILBERT. This was the response of Dr. Egeberg from a question of one of the members of the committee. He said, "No. 1, it violates the law and No. 2, it may have some hallucinogenic effect upon the youngster."

Prior to this question, someone asked the question, what effect does smoking a cigarette have upon the individual. He went ahead and ticked off some of the most horrible reasons for not smoking cigarettes—it would affect your heart, your lungs and you would have all sorts of complicating problems if you smoked cigarettes over a 20-year period.

Sitting and listening to the response to the questions, I came to the conclusion that it did not seem that we knew too much about the effect of marihuana because his answer evidently was not as potent and

would not have that effect upon the 15-year-old or anybody who raises that question.

So, I asked then why should this be against the law if we are not certain of the effect of marihuana. I am not advocating that we eliminate the law, but I raised these questions because I think they are important in the deliberations of this committee and your committee and the people who are doing research on the problem and the Members of Congress.

Mr. PEPPER. I will say to our distinguished friend from New York that whoever says that in my opinion is not in consonance with the best medical opinion in the country. In the first place, people have been smoking cigarettes a long time, so we have pretty well established data about the injury of cigarettes. We don't have that kind of data with respect to marihuana and nobody can say with certainty what will be the effects of the smoking of marihuana over a relatively long period of time by any individual.

The second thing is that while liquor leads in many cases to bad results and smoking cigarettes in many cases leads to bad results, I don't know of any results from smoking cigarettes or drinking liquor comparable in this respect—I don't know of worse things that you want when you start smoking a cigarette or drinking liquor that is comparable to most people who start smoking marihuana.

I will say, many people who start smoking marihuana are not satisfied with that intoxication and they move right on up the ladder to different amphetamines and methoamphetamines and heroin. You just ask the addicts and see how few of them will tell you they didn't start off taking marihuana. It is not addictive in the sense that heroin is, but it seems to be the first step along the road that seems to lead onto these worse things.

Mr. GILBERT. In other words, it is your conclusion that marihuana probably is one of the first steps that the hard drug addict would take along the road.

Mr. PEPPER. It creates a euphoria, and we have had many, many of these addicts who testified and they like the effect of it, but after a while they become accustomed to that, and drugs were so plentiful, a man in your great city, Mr. Gilbert, testified a little bit ago and said you can get heroin as easily as you can buy the New York Times on the street and it is so available and so many relatively weak characters want to experiment with it and they get the exhilaration that comes from it, and the first thing they know they are caught, as they say.

Mr. GILBERT. One of the problems we discussed this morning and you alluded to it a little while ago was the fact that the individual smoking marihuana, the effects of marihuana could be involved in an automobile accident or some traffic violation and yet there is no way of detecting that this individual is under the influence of marihuana, whereas a person could have one or two drinks of alcohol and there is an immediate way of determining the alcoholic content in the person's bloodstream.

Mr. PEPPER. That makes it all the more dangerous. You can detect the fellow who has been drinking too much, but you can't do that with marihuana.

Mr. GILBERT. That is correct, and I don't believe there would be any statistics available except the person who would volunteer, as you

gave the example a few moments ago, of the person whose judgment was impaired and wound up in a lake while he or she was under the influence of marihuana.

Again, I wish to commend you, sir.

One other thing in your discussion with Mr. Vanik, in hearings that I have had through my district and public discussions with respect to drugs and narcotics, really so many people make reference to the fact that the law enforcement or the lack of law enforcement in the areas of detection of the sale of marihuana, et cetera, but one thing that they always refer to back to when they say, why is it that we can't stop the drugs from coming in from Turkey and through France and Marseille and then ultimately into the United States.

I am glad that you did raise the discussion here this afternoon, but I am just wondering if you have any specific recommendations in this area other than increasing the number of customs agents? Are there any other specific ways that we can dry up this area?

Mr. PEPPER. The first should be the maximum insistence upon it staying in Turkey or preventing its getting out of France in the refined form as heroin.

Next it was intimated to us by one of the witnesses who appeared at the New York hearing, the development of devices that will enable the investigating officers to detect the existence or the presence of heroin. In some instances, you can detect things. We are developing these electronic devices so you can tell to a degree whether anybody has a weapon on him when he goes through that electronic device.

With some money carefully spent on research, we could help the law enforcement officers a great deal by perfecting some instruments that would detect the presence or proximity of heroin. I spoke earlier about what I called the fish case. Had they not had an informer, he would not have known they contained heroin. Those cans were the same size and weight as the others.

If there were some way an officer could run a rod over a suitcase and tell whether there was any heroin in there, that would be a big help to the law enforcement officer. Perhaps more money to BNDD and customs to enable them to pay more informers, would come under personnel, would help.

Then another thing, unless they have information that makes them suspicious about somebody or sometimes if they have a tip they will search everybody on a plane. They don't ordinarily search on an average of one out of six who come through customs. There are over 200 million people a year who come into the United States, people coming back and outsiders coming in—200-some million people a year who come in through airports and shipping ports and other areas of access and on transit, so that is an enormous problem.

I think it would probably be desirable to investigate more people. I heard on the radio the other day twice, a statement from Mr. Ambros of customs explaining to the American people that they hoped they would understand if they were delayed a few minutes at a port coming in, it was because our Government was trying to protect our people against things being brought into this country that was dangerous to our citizens and he hoped our citizens would take it with kindness and light.

Another thing which is very important, I think, is to speed up the trial of cases in courts. In addition to that bail question I mentioned a while ago, if you are going to allow them out on bail for a month, they may make enough in a month to pay their lawyers and the cost of the court, and maybe pay any fine they have to pay.

There are many facets to it and it is going to take a massive really heroic attack upon the problem.

By the way, one other thing, and that is to diminish the market by a great deal more research in the treatment of addicts. We had a witness who happened to be a personal friend of mine, a doctor in New York. He did not practice that kind of medicine, but he has treated a fellow on a Friday, and Monday morning that fellow went to work. I don't know whether he has found the solution or not, but I do know somewhere we should have big research going on to try to find a method by which we can treat the addicts and then we ought to have treatment centers in practically every populated community in America, so there would be facilities to give them the training, because that is where the market is and that is where the tragedies are.

Mr. GILBERT. This bail question intrigues me. At what point do you feel that the individual should be denied bail?

Mr. PEPPER. I would go so far as to say that if he is dealing with a rather large quantity, it looks like he is engaged in the traffic, I would be prepared to take the strong position and I have suggested in my statement one kilo or more, a little over 2 pounds, that anybody who had that much in possession would be presumed to have it in his possession for sale and should be denied bond and given a speedy trial. That would help at least.

These law enforcement officers tell sad stories——

Mr. GILBERT. Like the revolving door.

Mr. PEPPER. That is right. They bring up the cases. A fellow will be put on a $100,000 bond and he will go back to South America and they will never be able to find him again.

Mr. Celler appeared before the Rules Committee a few days ago in support of a bill to grant immunity to witnesses who testify before congressional committees and before courts. I am rather in favor of that bill because we had two alleged gangsters, Mr. Gilbert, who appeared before us in New York, at least we had information that they had been engaged in large-scale traffic in heroin. They both came in and took the fifth amendment. They admitted their names and from then on everything was "I refuse to testify on the grounds that it might tend to incriminate and degrade me."

They had their lawyers there with them. I took the liberty of holding up some photographs that the Chief Medical Examiner of New York had shown us of victims who had died with a needle in their veins. I held these up. I said, "You see these pictures are of your fellow citizens and yet you are not willing to give this committee the benefit of any knowledge you possess about this heroin traffic in the hope we might reduce the number of your fellow citizens that die these horrible deaths from it."

All he would say is "I take the fifth amendment." If we could get a few of these top fellows who do know what is going on and have information about the traffic, it would be helpful. We could either put them in jail for contempt or disclose. I guess they would not disclose,

they would go to jail, it sure would help to be able to get a little more information on the subject.

Mr. PETTIS. Thank you, Mr. Chairman. I would like to ask if in your investigations you have had any indication from the medical profession that they are near a breakthrough on a cure for the drug addiction. I understand it is a pretty hopeless situation.

Mr. PEPPER. We have not found anything yet like a cure. We had a gentleman on the stand who with his wife developed methadone. It seems to be one of the best things in a certain way that has been developed so far. Yet he and the head of the institution where the methadone program is carried out, on the largest scale of any place in the country—Dr. Dole of New York with his wife who developed methadone, he said methadone was not the answer to the problem.

At best it was only for the hard addicts. There are a lot of people who raised questions which they thing are serious about methadone while you don't ordinarily go out and rob to sustain the addiction because methadone does not talk very much, but they said it is moving from one addiction to another which is not a desirable thing for the individual. So that is the reason I say I don't know of any great sum of money that is being spent anywhere under the influence of the Government.

We have a bill up over there today where we are appropriating money for a big research program. I don't know of any item in that bill for research in trying to find the cause of taking heroin. Maybe there is something but if there is, I am sure it is something relatively minor.

If we would go at it on a massive scale the way they are trying to find the causes of cancer and heart disease and some of these other things, we could do better. To answer your question, no, the answer has not been found.

Mr. PETTIS. I commend my colleague for the work he has done.

Mr. CORMAN. I join my colleague, Mr. Pepper, and thank you very much for some real insights into this problem. Let me preface my question by saying I am very much opposed to legalizing marihuana. I think that is no answer at all. As a matter of fact, if we had no alcoholics and tobacco addicts I would not be proposing we legalize either of those two things. We are saddled with them now.

The thing that disturbs me is looking at it from the point of view of the very young person, the high school or college student. We say it is against the law to buy or smoke cigarettes before 18 and we pay no attention to the law. Any youngster 12 years of age can go buy cigarettes out of a machine. Then we tell him it is against the law to smoke marihuana and at least under the present law, there are very harsh penalties just for the possession and smoking. Then we tell him it is against the law to use heroin or other very hard drugs.

It seems to me we tend by our practices and what we say is against the law, to make it very difficult for the young person to have respect for the law in the first place. What are we telling him when we tell him something is against the law when in one instance we pay no attention to it and we make fortunes by pushing one product, tobacco, and then send him to prison for the other, marihuana.

I am wondering if it is possible to make a distinction between marihuana and these other much more destructive drugs. I don't know how we do it, but it does seem to present a problem.

Mr. PEPPER. My able friend from California has put his finger on what has been a great error on the part of public authority, Federal and State, but still in many areas there is no distinction made between marihuana and hard drugs or even heroin. They are not in the same category. Much as I am distressed by the use of marihuana by anyone, as much as I would be opposed as my friend is to its being permissive, it is not the same as taking heroin or some of the other hard drugs.

The young people felt we were not discriminating, not selective in our penalties. The law has been, it was the Federal law, and I believe it is still the Federal law and President Nixon prior to his last recommendation, previously recommended in the other antidrug law, that the penalty still be from 2 to 10 years.

After we held hearings and the Government no doubt learned more about it, when the President came back he softened his recommendation to substantially what it is here, but we would have developed more respect for a mild prohibition in respect to marihuana if we had distinguished them.

But the thing just grew up historically. When we legislated we just painted a big brush stroke over the whole thing and it was a mistake.

Mr. CORMAN. I thank my colleague for that answer. I note that in this proposed legislation we are treating heroin and marihuana under the same schedule because there is no known medical use for either one. Perhaps we should explore the possibility of distinguishing those two.

The other question I had is whether you have any information about the efficacy of enforcement procedures such as Operation Intercept at the border in California some months ago and the more recent indications that there may be a very careful search of each tourist's personal belongings when he comes into this country.

I just wonder about the efficacy of using our manpower in that way as a means of cutting off the drugs. I really do not know. I was a little incensed at Operation Intercept because the only person they found was one of my constituents with diet pills and they treated her atrociously. I had a feeling that they wasted their time. She was ultimately acquitted in court but she suffered severe persecution as well as prosecution during the process.

Is that not perhaps a waste of effort so far as narcotics are concerned?

Mr. PEPPER. I say to my friend that the permanent value of those things is probably not very great because the objection, the protest toward a tight Intercept Operation like that, the cost of it, the search and evidentally the dissatisfaction of the Mexican Government there was so great that we finally had to diminish it. We did put some more people down in Mexico to cooperate with them and the like. But those things emphasize the great difficulty of keeping it out of this country, and there are numerous problems involved.

That is why I say it is so important to keep it way from the shores of our country because it is so difficult at the border. Really, I have talked to the Canadian authorities and have been in Canada and talked to their top people about the problem. They are very much aware that many drugs come across the Canadian border into this country. I suppose we could step up our program by putting more people on and all that, both of us could, but it is very difficult with so many areas of ac-

cess between, say, Canada and the United States or Mexico, and the United States. It is a very difficult problem at best.

There are so many facets to it, but I think we have to do all of these things, I will say to my friend. Just doing one thing is not enough. We have to try to keep it out. We have to try to stop the addiction and we have to try to stop the addiction in it. We just have to make a massive approach but it ought to be a coordinated approach. We ought to start out just like we do in a way.

We are going to achieve this objective. I have been thinking about how we could get a task force of some sort that would command every facet of our Government's forces and try to mobilize it all against this menace. I am sure if Congress were presented the proper program, it would pass it.

Mr. VANIK. Mr. Pepper, did you want these exhibits put into our record? Can they be reduced in size?

Mr. PEPPER. We will make them available to the committee and they would not have to be put in, but they can be made available for anyone's use.

Mr. VANIK. Thank you very much, sir, we very much appreciate your testimony before this committee.

Our next witness is Mr. Mario Biaggi from the State of New York. The committee will be pleased to hear you at this time.

STATEMENT OF HON. MARIO BIAGGI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. BIAGGI. Thank you, Mr. Chairman and members of the committee.

I beg the indulgence of the committee. I ask permission to supply my statement to the committee tomorrow.

Mr. VANIK. Without objection, you may introduce your statement in that way.

Mr. BIAGGI. I have been listening to the distinguished chairman of the select committee, Mr. Claude Pepper, and I can say I am gratified that he is not traveling down the same beaten path. As a police officer for some 23 years, I have made numerous observations that have left me somewhat cold insofar as Government effort is concerned in dealing with the drug problem.

Finally at this stage of the game, there is a recognition by some segments of the community and the Government as to the gravity and magnitude of the problem.

Many years ago there were a few voices in the wilderness trying to attract attention to the menace. Now the point has been very clearly driven home. This problem touches or can potentially touch every living human being in the United States irrespective of social, ethnic or educational strata.

We have a great deal to do in informing and alerting the Nation as to the danger. That comes under the heading of education.

In that area we have been a little lax. There has been a major thrust toward law enforcement locally, on a national basis and, yes, even on an international basis. Chairman Pepper talked about dealing with the drug problem at its origin in Turkey and France. Last month I introduced a bill to cut off economic aid to any country that produces or assists therein illegal drugs that find their way to this country.

He stated further that some $3.5 million is being provided to buy up some of the poppy seed crop. I say it is a futile gesture; $3.5 million would be coming along legal channels. The moneys that are being derived currently and historically from the illegal growth come along illegal channels. And are far in excess of this sum and find their way directly into the pockets of people of all levels in these nations.

In my judgment, the illegal traffic could not possibly continue unless there are corruption in both governments.

I spoke on the House floor in connection with this issue, specifically as it relates to Turkey. The decision would have to be made, of course, by the foreign government whether it wants aid from the United States or whether it prefers to continue lining its pockets with illegal sources of money.

I believe frankly that it will be a very difficult decision for some governments to make. We have had corruption in the law enforcement agencies of our country. We have, today, in law enforcement agencies, members who are themselves drug users. We have some here in the District of Columbia police department, and we expect them to enforce the law.

It has been said and rightly said, unless we have a massive total commitment to solve this problem, it will be an exercise in futility. I share that opinion.

Yet I am also optimistic in that I see some of the production and some of the attention being given to this problem and I know that this committee will weigh the statements and the need for advocating this as a top priority problem for that is what it is. I have seen it in my time reduce human beings, normal human beings to animal status—just that—groveling creatures reduced to that condition by hard drugs.

We don't know as yet what effects marihuana may have medically. But I will tell you this: if it does nothing else than to introduce a use into the family of narcotics, it should be kept illegal. I don't take the hard-nose approach insofar as punishment and penalities relating to marihuana are concerned, given the mores of the community. But legalizing it is absolutely out of the question.

I think the gentleman from California, Mr. Pettis, made an inquiry as to whether chemistry or research had developed anything that would be antagonistic to the various drugs. The National Institute of Mental Health is investigating one possible antagonist called Naloxone—they have not checked all of the controls yet, but it is something a little better than methadone in that it is not addictive, has no withdrawal problems and it is vastly superior in many other respects. It has not been introduced and it has not passed all of the tests yet however. Insofar as a choice between methadone and heroine, there is no question but that methadone is a substantial step forward. Dr. Dole and Dr. Sweinger conducted a survey in New York involving 2,800 addicts and found that only 200 of those interviewed did not stay with the methadone program. However, 2,600 did and they became functional human beings—functional human beings! They didn't steal. They didn't lie. They worked. They raised families. And the drug is cheap—about 17 cents a dose.

Millions of dollars are being sought for programs—millions of dollars have been spent, but most of that, unfortunately has been spent on creating administrative hierarchies. We don't say that meth-

adone is the complete answer because it is not. Therapy, too, has its place. We need a multifaceted approach. What is good for one is not necessarily good for the other.

In my judgment, science and research will ultimately provide the answer because you are talking about the potential addicts, you are talking about those that we have, in the incipient stages and the hard core addicts. Methadone is a step forward in that area.

I listened to the testimony concerning the largest suppliers and attempts to deal with organized crime. There is no question that organized crime has a large part to play in this. Historically, organized crime has had a monopoly, but a careful review of this entire picture will reveal a transition. Organized crime does not have the monopoly, any longer—a large segment, yes, but there are more independent entrepreneueurs than ever before. And these independent operators have more customers.

Every school represents a potential sales area. They deal with numbers. I don't know how many numbers we have and I have been around for some 25 years in this area. Frankly, I don't think there was a soul in existence who can with authority state a figure. It is a numbers game. They will use the credentials of one individual who may have speculated as to a number as justification for another number. Before you know it, you are round and round again.

But what we do know is that the problem is becoming almost universal. It is increasing in leaps and bounds.

What I have done on a very small scale in the district that I represent, the 24th District in New York, is to establish my own little task force. I have addicts who maintain themselves on methadone. They serve as counselors. Ours is a multifaceted program. We have a place where users can go and speak to somebody who understands their problem. And the problems are pathetic.

The families plead, they cry, they are heartbroken, and we understand it. There is always one stage of the game where an addict seeks help and we are happy to provide some little help in that area. They come and they are counseled daily, and we refer them to agencies.

I am in a particularly advantageous position because many of the people on the task force staff are employed in the various referral agencies in earning their livelihood. So I have particular access, but the lack of referral agencies are a problem.

The other area, which is, frankly, most important, and which relates to a question raised earlier. I think Congressman Pepper stated there was a device that would detect heroin. I am aware of it. Its effectiveness still remains to be determined despite the fact that the city of New York has purchased a number of them. The greatest single device in detecting heroin is man's willingness to cooperate and give information.

We have in the Bronx, like every place else in the world, I guess, a reluctance to be a tattletale, to be a stool pigeon, to give information. My section no more or less than any other. Mine is not an abysmally poor area. They are hard workers; they are homeowners. We do have some high rises. But in the south Bronx which represents pockets of poverty, they, too, are subjected to the same culture, the same mores—don't get involved with the police. Don't inform, and that is the way it was. I say "was" advisedly, because it has changed. People know what is happening.

Right now citizens provide most of the information to the police in New York City, and to the narcotics squad—an absolute contradiction of all historical tradition—but they do it.

About 90 percent of the arrests made in the Bronx are in the south Bronx—not because we don't have narcotics in North Bronx, but the people there will refuse to accept the fact that it exists and would rather not get involved in providing information.

But the day of awakening will come to them when it strikes one of their own children.

What we have done in this particular instance with this particular task force, to provide some insulation from the police, we ask my constituents to provide us with the information and we will forward it to the police without identifying the citizen. As a result, the information is starting to trickle through and some arrests have been made.

I am gratified with our effort in providing this information even though it is on a small scale.

Insofar as the Federal agencies are concerned, I have nothing but the highest regard for the customs agents. They have traditionally done a great job and I strongly advocate a supplement to their personnel.

As far as the Bureau of Narcotics is concerned, I have not had the same high regard for them. Perhaps this administration will change that.

Another area to which we could address ourselves on a local basis, but perhaps it can emanate from Washington, is an item which I am now pursuing. That is the gambling in the Nation. It relates directly to the drug problem in the sense that police officials and administrators in cities and other political subdivisions would rather devote more personnel toward enforcing oftentimes unpopular gambling laws than enforcing the narcotics laws.

New York is well on its way toward legalizing gambling in every respect. They have lotteries. They have passed legislation which has legalized off-track betting. It is underway. Already discussion is underway in connection with legalizing "policy." I can see a change coming very shortly in these laws that have been unpopular and have really made a farce of the courts in their treatment. In any event, they are the laws people just did not want to obey on the theory that if it is legal to gamble on the inside of a track it is alright to do so outside.

I can foresee where we will have legal gambling in the State of New York in every aspect. Once that happens, it will release thousands of police officers who could then be directed to deal with narcotics.

In addition, right now we have an expanded narcotics bureau which is still insufficient. There should be a thrust on the part of the administration to have all of the uniformed officers make arrests, providing incentives, so we can utilize the more than 30,000 people that represent the New York City Police Department—police departments all over the country really—to deal with the problem.

A thought that occurred to me while I was listening, is the system. There are a number of layers and eventually you make the top man inaccessible. That is almost pleading defeat, and I don't buy that.

In this country, we have been able to break many secrets on an international basis which were even more confidential, even more carefully guarded. If there is a real thrust in this area, it can be done. You

have many people in prison today who were prime movers in narcotics yesterday. They are in there probably for the rest of their lives.

It might be well for the agencies involved to make inquiry; try to talk to them now. Perhaps they may be more receptive than they were originally, if they spent 5, 10, 20 years in there with no hope for the future.

It could be a great source of information. But unless we deal with it on a multifaceted basis, with a massive and total commitment starting right from the source—I mean hard, fast and meaningful—I think we will see a petition of all of the yesterday's and all of the rhetoric in this area.

Thank you very much.

Mr. VANIK. Thank you very much Mr. Biaggi.

(Congressman Biaggi's prepared statement follows:)

PREPARED STATEMENT OF HON. MARIO BIAGGI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Madame Chairman, gentlemen of the committee, heroin addiction in the United States costs non-users about two billion dollars in stolen property last year. Moreover, in just one city—New York—800 addicts died last year as a result of heroin overdoses. Of these, 200 were in their teens or younger. Drug addiction today is also the leading cause of death among New York City residents between the ages of 15 and 35.

It is no understatement, then, to say that heroin addiction is the most costly habit in terms of loss of life and property. Yet despite the high costs to every member of our society, the drugs continue to flow into the hands of the addict and the prospective addict. Citizens continue to ignore the problem until it touches them personally. Governments continue to lock up the addict-user in ever increasing numbers, while the big suppliers and manufacturers live in palacial estates in the best parts of town.

The problem of drug abuse pervades every corner of our society, touches every member either directly or indirectly. Daily, cries are heard for more laws to fight the problem, more money to treat the addict. What we need, however, is a well-coordinated approach to the entire problem at all levels.

Lawrence Pierce, director of the New York Narcotics Addiction Control Commission lists four basic solutions to the problem of drug abuse, none of which can be effective without the other three. They are:

1. Strict laws with adequate enforcement;
2. Research into the cause and consequences;
3. Rehabilitation; and
4. Education.

I would add two more: elimination of foreign supply and broad-based availability of comprehensive psychological and psychiatric counseling similar to medicare programs.

The bills being considered today are addressed to the first solution I listed. I believe my bill, H.R. 16901, entitled "The Controlled Dangerous Substances Act" meets the needs for strict, but fair, laws that can be properly enforced. As compared to the Senate-passed bill on the subject, S. 3246, and the companion House measure. H.R. 17463, my bill differs in several substantative ways.

The first of two major alterations I have made gives the Secretary of Health, Education, and Welfare the responsiblity to classify all drugs according to the criteria listed in the bill. The Senate bill would require classification by the Attorney General.

The reason for this change is that HEW has the extensive research and professional capability to properly analyze and determine what drugs should be classified and where. To provide the measure of cooperation and coordination necessary between the two departments on this matter, the classification would be handled in consultation with the Attorney General. However, the enforcement responsibility would still remain with the Attorney General.

The second major change I have made is in the classification of certain listed drugs. The criteria for classification into one of four schedules is the same in my bill as in the others mentioned.

Schedule I would contain drugs with a high potential for abuse that have no currently accepted medical use and which will lead to severe psychic and physical dependence. Drugs such as LSD, heroin, and mescaline would be included in this category.

Schedule II would contain drugs with a high potential for abuse, that have, however, currently accepted medical use. Here again the possibility for severe psychic and physical dependence, but possibly high psychological dependence. Various stimulants and depressants would be listed in this section.

Schedule IV would include drugs with a low potential for abuse that have currently accepted medical use and might result in only limited physical and/or psychological dependence. Low per dosage amounts of codeine and morphine would be included here.

Now in the Senate-passed bill, amphetamines are listed in Schedule III and marihuana is listed in Schedule I.

In my bill, I have amphetamines classified in Schedule I; however, after further research and consultation I believe Schedule II or III may be the better category.

My original feeling was that the drugs were being more abused than properly used and it would be best to outlaw them completely. However, after reflecting on the other portions of the bill, it becomes apparent that the abuse results chiefly from insufficient regulation of the manufacture and distribution of these drugs. The bill, of course, would correct this deficiency in existing law.

In my bill, marihuana is included in Schedule IV which, I believe, reflects current medical opinion on the physical and psychological effects of this hallucinogen. Although I do not believe it should be ranked with heroin and LSD, marihuana nevertheless served as the introduction into these more serious drugs for many of the present addicts. Once a young person comes into contact with the criminal element that markets the marihuana, he becomes an easy mark for sale of more serious drugs.

I would like to add a few thoughts on other sections of the bill which are basically the same. There are special provisions for those guilty of selling drugs to minors or those engaged in a criminal conspiracy involving drugs. The stiffer penalties in both cases reflect the seriousness of these crimes and the high degree of threat they pose to the community.

Another provision would permit special judicial consideration of first offenders under 18 years of age. Too often youngsters are taken up into the drug scene by unscrupulous adults out of their own financial gain or by the pressures from companions to be "part of the crowd" or by a natural youthful curiosity. It would be unequitable to treat these offenders with the same severity as a hardened criminal.

Therefore, the bill provides for a probation period and complete expunging of the record after that time. This would mean if a young boy of 16 were arrested for possession, realized his actions were wrong and resolved to stop his activities, he would suffer no stigma for the offense later in life. I believe this puts the element of compassion in the law that is so often missing, yet so necessary in our complex society.

Yet, Madam Chairman, this bill only answers one of our needs in the fight against drug abuse. It provides the strict, but fair, law on which our enforcement agencies can act with confidence and effectiveness.

However, this Congress must also act to appropriate increased funds for research into the causes and prevention of drug abuse and research into better methods for rehabilitation.

I have been recently encouraged by reports that our research grants in this particular area may soon pay off.

The National Institute of Mental Health is sponsoring studies of a narcotic antagonist called Naloxone. This drug, unlike Methodone, is not a narcotic. The patient will not develop a tolerance to the drug, nor will he experience withdrawal symptoms if he should suddenly stop taking the drug.

Methadone, on the other hand, while it has great possibilities as a rehabilitative tool, is addictive and subject to abuse. Nevertheless, at present it is an excellent drug to help put the addict back into the productive mainstream of society and then hopefully help him off dependency on any drug. Treatment programs using methadone have been highly successful and should be expanded.

Scientists are presently working to develop a synthetic formula for Naloxone that would be of long duration and effectively administered orally. All commentary on the drug points to a medical breakthrough in the foreseeable future. This is the type of research we cannot afford to cut back. Rather it should be encouraged and hastened along.

Likewise, there is an increased need for preventive educational programs on a wider scale and drug addict recognition and treatment programs for teachers, doctors, social workers and other citizens.

My bill, H.R. 14376, entitled "The Drug Abuse Prevention and Rehabilitation Act" and others like it would provide these additional programs. This measure would also establish a National Council on Drug Abuse to coordinate all efforts at the Federal, state and local level—an urgently needed supra-structure for our anti-drug abuse campaign.

These pieces of legislation direct themselves to the four pronged effort I mentioned earlier—better laws and law enforcement, and more research, rehabilitation and education.

My fifth prong would eliminate the supply of drugs such as heroin at the source. H.R. 17914, which I have sponsored, and H.R. 18397, which Mr. Rodino and others including myself have sponsored, would cut off economic and military assistance to countries failing to take positive action to eliminate the flow of illegal drugs into this country. It is clear to me that these drugs could not be grown or processed in the foreign countries unless corruption in the various levels of government permitted such a free rein for the illegal operators. Certainly, some foreign bureaucrat is getting a share of the profits from illegal drugs.

My sixth prong, which is still in the developmental stage, would seek to make generally available psychiatric treatment and psychological counseling for all citizens—but especially our young—in the hopes of solving the root psychological or mental problems that cause an individual to start a drug habit.

Madame Chairman, all this legislation is urgently needed. The bills before us today dealing with the control of dangerous substances are a step in the right direction.

Yesterday we celebrated the first anniversary of man's landing on the moon. Colonel Armstrong said of his efforts at that time, "One small step for man, one giant leap for mankind." So that drug abuse doesn't force this nation to take a step backward, I urge favorable action by this committee on my bill, H.R. 16901, or similar legislation.

Thank you.

Mr. GILBERT. I would like to extend a personal welcome to my colleague from the Bronx whose district adjoins mine. I know the work Congressman Biaggi has done in the area, but I think of particular interest is the subject he mentioned a few moments ago, and that is the establishement of the task force in his own congressional district.

This morning, Mr. Biaggi, I think many of our colleagues on the committee were greatly concerned about the care and the treatment of the addicts. It appears that from the discussion and the answers that there really isn't one massive type of a program which would be of benefit to the narcotic user. I think in particular Congressman Vanik asked where does this young person go or turn to, who wants to get off the drug? He has all sorts of psychological hangups. Whom does he go to see? Obviously he is not going to discuss it with his parents. Perhaps for one reason, whatever it may be, he has turned away from the regular channels such as, say, the religious institutions. I think he would perhaps be more comfortable in the confines of people who are closer to his age bracket, somebody who can sit down and discuss this problem with great confidence.

I raise this with you because I know this is what you have been doing.

Mr. BIAGGI. That is right.

Mr. GILBERT. You have established what you call the Hotline, and you have made this phone number available to your constituents so that at almost any hour of the day or night you could receive or someone in your office would receive a call and perhaps send one person on the way to recovery or driving him away from the use of hard drugs or even to start marihuana.

I think that your statement this afternoon with respect to your observations and your experience is of great help to the committee.

I know you have spent many years in the law enforcement field, particularly in the police department and that a great deal of your time and energies were devoted in this particular area.

Again, I want to thank you for your statement this afternoon. I am sure it will be of great help to the committee in its deliberations.

Mr. BIAGGI. Thank you very much. Since I innovated the task force, several other Congressmen have visited and observed the operation which I have put into effect. In addition to that, we coordinate all of the efforts in the community. By virtue of our position, we have a district office and we have the necessary prestige that motivates the people. They need one huge umbrella to function. Otherwise there will be store fronts all over the place without coordination. So far it has worked out satisfactorily.

We have educated various groups and we encourage them to start their own groups all on a volunteer basis. Sometimes it occurs to me it would be nice to have a paid staff. But the minute you think of that, the question of money becomes involved and I think it causes trouble, and reduces dedication.

Mr. VANIK. The gentleman from California.

Mr. PETTIS. Thank you, Mr. Chairman. I would like to take this opportunity to also command our colleague, Mr. Biaggi, from New York. It occurs to me, and I don't know whether you have thought of this or not, that it might be well if we had all of the Members of Congress who have your background, and there are some others who have somewhat similar backgrounds, were to give us your observations on how effective the legislation that this committee is studying will be and if you have suggestions that might improve it from the standpoint of the goals that we have in mind.

Have you thought about this? I have been very much interested in what you had to say about the general problem.

Mr. BIAGGI. As a matter of fact, I have some of the comments in my formal statement which I will submit.

I cannot emphasize too emphatically the approach on the international basis. That is going to take some doing. Congressman Pepper said it very nicely, step up the diplomatic activity. Based on my own practical experience with these things there is absolute corruption and people are becoming millionaires in both France and Turkey. It will take a great deal of persuasion, a great deal. I know it can be done. The question is just how much persuasion will be applied.

Mr. PETTIS. If the gentleman would yield just for this further question, maybe I drew the wrong inference, but I gathered that a few moments ago you were suggesting that maybe we ought to look very carefully at some of the people or at least the organizations that are enforcing our present laws and that there might be some collusion between those who are supposed to be protecting us and those who prey upon us.

Mr. BIAGGI. Whenever you are dealing with personnel there is always the possibility of human failure and corruption and no agency is immune to that. My regard for the Customs Bureau—and it is a high regard—is based on decades of experiences. My lesser regard for the Bureau of Narcotics has developed as a result of decades of experience which is shared by many of my colleagues in the police department.

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Mr. PETTIS. I have no further questions.

Mr. VANIK. The gentleman from California, Mr. Corman.

Mr. CORMAN. I want to join my colleagues in expressing my appreciation for our colleague, Mr. Biaggi, for bringing to us his background and experience.

Do you think we ought to under the law try to treat marihuana and heroin separately? I think we share the view that we should not legalize marihuana at all and I am not suggesting that. But is there any purpose in our attempting to distinguish it from heroin or the other kinds of hard drugs that we know are much more destructive? If we did that, would we be more apt to discourage young people from moving from marihuana to heroin? I strongly suspect young people move from cigarettes with tobacco in them to cigarettes with marihuana in them and then to the other kinds of experimentation.

Mr. BIAGGI. I think you should do that, and I have included that in my statement. I think the experience of an arrest is traumatic, especially among the young. As the Chairman said, it is all right getting your jollies unapprehended, but once the shock of arrest comes home, these young people are reduced to a normal status. They are frightened young men and they see the possibilities of an impaired future. They are going to have to deal with their family and they don't know the outcome and perhaps that could serve as a deterrent for the future.

In the process—I recommended a little different treatment for them in that area—not to impede them by virtue of that arrest. Frankly, we are dealing with a situation that has assumed enormous proportions, we have had rock festivals where they are there for the purpose of listening to music, but I think they have developed their own ecologic persuasion by the aroma of marihuana, but specifically that was to deal with the marihuana user offender in the lesser fashion.

If he is not a seller, of course, a simple individual who uses it and is caught and is under 18, should be dealt with separately. There is no question about that. The only interrelationship that I see regarding marihuana is that it introduces you to hard drugs. As the testimony has stated today and as has been stated time and time again—and it is obvious—marihuana puts you not only in the whole family of drugs, but the whole family of drug users.

Essentially one fellow is smoking marihuana and the other fellow is on heroin and they will start to gibe them—what are you doing with that stuff—you know the chicken approach, and before you know it he is trying it and he is with the crowd and now he feels a little better. It is a simple psychological development. We have seen it in our own youth. We have done things in our hearts we knew were not right, it was foolish or wrong, but you were chided into it by someone else calling you chicken and that is what happens here.

There is no question it should be treated differently. It should not be made legal, but it should be treated differently.

Mr. CORMAN. Thank you very much.

Mr. VANIK. Thank you very much for your valuable presentation based so much on your personal experience and we thank you very much.

The committee stands adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 4:25 p.m. the committee adjourned, to reconvene at 10 a.m., Wednesday, July 22, 1970.)

CONTROLLED DANGEROUS SUBSTANCES, NARCOTICS AND DRUG CONTROL LAWS

WEDNESDAY, JULY 22, 1970

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

We are pleased to have as our first witness today our colleague from California, the Honorable Bob Wilson. Please come forward; we look forward to hearing your statement.

STATEMENT OF HON. BOB WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WILSON. Mr. Chairman and members of the committee, I appreciate the opportunity to present testimony in support of the drug control legislation I have introduced, H.R. 14775.

As emphasized during the course of the committee's hearings, the ready availability of illegal narcotics to our young people and their increasing experimentation with drugs of all varieties have reached crisis proportions. Each young person who becomes psychologically dependent or permanently addicted to narcotics is indeed a tragic loss of valuable human potential.

My district is in San Diego, Calif., which is only a short distance from the Mexican border. Because of the proximity to the border the problem of illegal narcotics is considerably magnified.

"Operation Intercept" was a determined effort on the part of our Government to crack down on the smuggling of drugs of all types across the border. Aside from illegal smuggling activities, however, we face a serious problem in the diversion of legitimate narcotics on both sides of the border.

A number of parents and teachers in San Diego have been particularly concerned because of the ready availability of amphetamines and barbiturates in the area. These drugs were destined for a pharmacy or narcotics warehouse in Mexico, but somewhere between the U.S. supplier and the Mexican purchaser, were diverted to the illegal market. Although these drugs may be transferred as far as Chicago or points further east, a great many are retained in southern California. The number and variety of amphetamines and barbiturates in the San Diego area is quite staggering.

In addition, drugs of all types are shipped by legitimate U.S. pro-

ducers to drug dealers in Mexico. In these cases, the drugs do cross the border; however, the U.S. producer has failed to check out his purchaser. I believe Mr. Ingersoll cited in his testimony the case of a drug company in Chicago which shipped several hundred thousand amphetamines to an address in Tijuana, Mexico, which later turned out to be the 11th hole of a golf course. Needless to say, a great many of these "uppers and downers" are smuggled back across the border into southern California.

In discussions with officials of the Bureau of Narcotics and Dangerous Drugs, I have been most impressed by the provisions contained in my bill and H.R. 17463, which the committee is presently considering, to deal with these two situations. In the case of the golf course, the export provisions of H.R. 17463 would have required that the Justice Department be provided with advance notice of the export shipment, which would then in turn make it possible for the Attorney General to verify that the intended purchaser was indeed a legitimate establishment.

By requiring every person dealing with dangerous drugs—manufacturer, distributor, or dispenser—to register, it will be possible for the Attorney General to monitor the entire distribution system of drugs in this country and to identify promptly the point of diversion and apprehend the guilty parties. These registration provisions would in effect leave a "paper trail" by which Federal narcotics agents could track down the exact source of illegal diversion.

In my presentation, I have concentrated on only one portion of this complex piece of legislation because diversion is an area of particular pertinence in communities near the border. No less important are the sections reorganizing and streamlining the present diversity of Federal narcotics laws, limiting the production of dangerous drugs to prevent oversupply, and restructuring the present penalty system to take into account the rapid changes in the past few years.

I would like to again express my appreciation to the chairman and members of this committee for your detailed consideration of this legislation. I hope that final action can be completed on H.R. 17463 and its companion bill in the House Commerce Committee, so that this important legislation can be enacted before the end of this session.

The CHAIRMAN. Are there any questions? If not, we thank you for being with us today.

Our next witness today is the Honorable Joseph P. Addabbo from the State of New York. If you will come forward, you may proceed as you wish.

STATEMENT OF HON. JOSEPH P. ADDABBO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. ADDABBO. Mr. Chairman and members of the committee, I welcome this opportunity to present to you my views on H.R. 17463 and on the subject of alarming increases in the use of drugs across the country. More than any other subject, the drug problem has caused tragedy and grief to thousands of Americans at all economic levels and in all sections of the Nation. There is a clear mandate for congressional action to control this terrifying spread of dangerous drugs.

In New York City, narcotics addiction is the No. 1 killer of young people between the ages of 15 and 35. This in itself is a frightening statistic. Narcotics addiction has surpassed accidents and disease as the greatest cause of death. The stories of heroin addiction among children and adolescents in New York City have alarmed the entire Nation and the situation cries out for immediate action.

As a member of the House Appropriations Committee, I have made every effort to gain support for increased funds to hire additional customs agents to deal with the source of heroin traffic. We know the origin of heroin distribution and we know the route of distribution from the point of origin in Turkey. For these reasons, I have recently joined with more than 100 Members of the House in sponsoring legislation directing the President to cut off both economic and military assistance to nations which fail to cooperate with the United States in stopping the importation of heroin and other narcotics.

I believe that the single most important step which Congress could take in meeting this problem is to appropriate adequate funds for a major effort by the Customs Bureau to cut off the supply of heroin. To do this Congress should also make clear the scope of authority of the Customs Bureau, reversing where necessary recent Executive actions transferring much of the power in this area to the Department of Justice. The Custom Bureau is the natural agency to investigate, with the required flexibility and authority, the sources and distribution routes for heroin. Congress should end the bureaucratic squabbling over authority in this area by directing the Customs Bureau to take charge of this objective and by bolstering the manpower levels at the Bureau.

With respect to criminal penalties for heroin trafficking, I would recommend an amendment to H.R. 17463 making major trafficking in heroin a nonbailable offense. As a part of this provision, I would also recommend the adoption of a speedy trial requirement, perhaps within 60 days of arraignment. This will assure that major offenders are not allowed to continue their trafficking activities pending legal action.

The international efforts to control heroin distribution should be stepped up at all levels, including the United Nations. The best chance for curbing the heroin traffic is to attack the problem at its source abroad and provide incentives for other nations to cooperate in this attack.

I have intentionally concentrated on the area of law enforcement activities because that is the principal area of jurisdiction to which the legislation now under discussion is addressed. It is of course imperative that we place equal importance on the areas of education and rehabilitation. It is my hope that the appropriate committees of Congress will make forceful recommendations in these areas as soon as possible.

With respect to Federal laws on marihuana, I recommend that the committee propose a reduction in Federal penalties for simple possession to a misdemeanor pending the results of Federal research studies on the long-range effects of marihuana. This recommendation is in line with the current trend of State laws and the opinions of a majority of expert witnesses. There is adequate scientific testimony on short-range health effects of marihuana to support such a change in the Federal law while we await the findings of qualified experts on the long-term effects.

Mr. Chairman, the severity of the drug problem in America cannot be exaggerated. It threatens to destroy the lives of millions of people unless we find a way to stop the spread of this crippling disease. I urge this committee to act swiftly and urge speedy congressional action to bolster enforcement activities in this area.

The CHAIRMAN. If there are no questions, we appreciate your taking time to present your statement to us today.

We are happy to have with us today the Honorable Frank Horton from the State of New York. Please come forward and give us your statement.

STATEMENT BY HON. FRANK HORTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. HORTON. Mr. Chairman, I am pleased to have this opportunity to express my support of H.R. 13686. I want to commend the chairman and members of the committee for holding hearings on this very timely and important matter of drugs.

As you know, I cosponsored H.R. 13686, the bill pending before the Ways and Means Committee which would increase the penalties for the unlawful transportation of narcotic drugs and make it unlawful to solicit the assistance or use a person under the age of 18 in the unlawful trafficking of any drug.

Our colleague Cornelius E. Gallagher is the original sponsor of this legislation and he was joined by 30 of our colleagues who recognized the vital necessity for this measure.

There is presently no Federal law which makes it illegal to transport narcotic drugs across State lines. Even worse, there is no Federal law which makes it illegal for an adult to employ a juvenile in illegal drug transactions.

One of the most tragic situations of our era is that of a youngster, not even beginning to experience life, who is hooked on drugs.

This bill imposes a maximum sentence of life imprisonment and a minimum of 10 years on the adult who uses a juvenile to sell, distribute or transport narcotics.

This bill is essentially directed against the pusher. It provides a maximum sentence of life imprisonment for the nonaddicted person transporting drugs across State lines. The drugs specified are narcotics such as opium, heroin, and cocaine. Marihuana and LSD are excluded.

The bill extends compassion to the addict who transports drugs. It provides a mandatory commitment to a Federal hospital for therapy and cure.

Mr. Chairman, it is extremely necessary that this bill be favorably reported out of committee. The alarming traffic in narcotic drugs is one of the basic causes of the increase in crime across the Nation.

Addicts, too many of them teenagers and young men and women in their early twenties, desperately need money to support their habit, and they turn to crime to support it.

For the victim of addiction, we must extend compassion, understanding and treatment. For the pusher, we must bring down the full weight of the law.

Mr. Chairman, the drug epidemic is of great concern to me. I have introduced several bills aimed at this problem. One, H.R. 10054, would launch a Federal attack on the problem through education, treatment

and rehabilitation. Another, H.R. 18503, would suspend in part or all, economic and military assistance to any country which fails to take appropriate steps to prevent narcotic drugs from unlawfully entering the United States. Although these bills are not pending before your commitee, I mention them to point out the broad approach to the problem.

Mr. Chairman, we are faced with a crisis. I feel H.R. 13686 certainly would reach the insidious offender who trades on the misfortune of others. I again urge the committee to favorably report H.R. 13686.

The CHAIRMAN. If there are no questions, we are pleased to have heard your testimony and appreciate your coming before us today.

Our next witness this morning is Dr. Henry Brill, chairman of the Committee on Alcoholism and Drug Dependence, American Medical Association.

We are pleased to have you with us this morning.

STATEMENT OF DR. HENRY BRILL, CHAIRMAN, COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE OF AMERICAN MEDICAL ASSOCIATION'S COUNCIL ON MENTAL HEALTH; ACCOMPANIED BY HARRY N. PETERSON, COUNSEL, LEGISLATIVE DEPARTMENT

Dr. BRILL. Thank you, sir.

Mr. Chairman and members of the committee, I am Dr. Henry Brill, of West Brentwood, Long Island, N.Y. I am chairman of the Committee on Alcoholism and Drug Dependence of the American Medical Association's Council on Mental Health. With me is Harry N. Peterson, an attorney in the AMA Legislative Department.

The CHAIRMAN. We are pleased to have you with us also, Mr. Peterson. We recognize Dr. Brill.

Dr. BRILL. We will direct our comments, Mr. Chairman, to H.R. 17463, the second of your bills before the committee. It is more comprehensive than H.R. 13742, which excludes from consideration the stimulant and depressant drugs. H.R. 17463 is comparable to S. 3246, passed by the Senate.

The American Medical Association regards drug abuse as a major problem which requires effective measures of prevention, treatment, and rehabilitation. Implicit in this view is recognition of the need for vigorous and enlightened enforcement on the one hand, and resourceful and imaginative programs of education, research, and medical management on the other. We believe that law enforcement and health agencies each have a necessary and legitimate role to play in the control of substances which have abuse potential. Many of these substances are used in a beneficial therapeutic way in everyday medical practice, even though they are subject to abuse by some individuals. Consequently, it is also important that in our concern for the enactment of controls we do not precipitate measures which would interfere with the legitimate use of such drugs and the practice of medicine.

Mr. Chairman, during this Congress I and other physicians on behalf of the American Medical Association have been before various committees of the Congress on seven occasions speaking to the problem of drug abuse. To appear with such frequency on the same subject is most unusual, but it indicates our concern for the need for more intensified efforts to deal with the problem of drug abuse.

We shall examine health and enforcement components involved in several aspects of the legislation before you with a view toward conforming those components to provide for effective legislation.

The elements which are of special significance to us are: (1) the scheduling of drugs; (2) the conduct of education and research; (3) the registration of physicians; (4) recordkeeping; (5) the inspection of records; (6) the penalties for technical infractions; and (7) the handling of offenders.

I will not comment upon each of these points in relation to the provisions of H.R. 17463 and suggest certain modifications.

SCHEDULING OF DRUGS

The bill gives the Attorney General authority to control dangerous substances. This authority includes the scheduling of drugs. Although the bill provides that before the Attorney General adds, deletes or reschedules a drug he shall request the advice of the Secretary of HEW and of a Scientific Advisory Committee, there is no requirement that he act in conformity with such advice.

There are several considerations which go into a decision to control a drug, and the bill, in fact, lists nine of them. Many of these considerations are exclusively medical and scientific in nature—for example, dependence liability and pharmacological effects. Others are exclusively in the area of police power—for example, international treaties. Still others involve both medico-scientific and enforcement aspects—for example, the scope, duration and significance of abuse.

We believe the Secretary of HEW is in a favorable situation to provide for the necessary basic studies and to evaluate recommendations for classifying drugs. He should have the final decision on the medical and scientific aspects of scheduling, and scheduling should be predicated on his decision. We therefore recommend that the legislation before you be amended to give such authority to the Secretary of HEW.

EDUCATION AND RESEARCH

The bill contains a very brief section on education and research, authorizing and directing the Attorney General to carry out programs necessary for the effective enforcement of this act.

We believe the bill should specify that such programs be concerned strictly with matters of law enforcement. The authorization given the Attorney General to establish methods to assess accurately the effects of controlled substances and to enter into contracts * * * for the purpose of conducting research, or special projects which bear directly on misuse and abuse of controlled dangerous substances is, in our opinion, too broad a mandate. It can cover the entire gamut of scientific and medical inquiry.

Because of the significance that we attach to education and research as important elements in the solution of any drug abuse problem, we wish to stress the importance of retaining the main efforts in research and education within the Department of Health, Education, and Welfare.

The scientific and medical aspects of such education and research programs should be the responsibility of the Secretary of HEW. The Secretary of HEW should stimulate and conduct public information

programs and programs for dissemination of drug abuse information in the schools. We favor the expansion of these programs within HEW. The Secretary of HEW should, with appropriate peer review, pass upon all applications for research in this field which do not pertain exclusively to law enforcement.

THE REGISTRATION OF PHYSICIANS

H.R. 17463 provides that "every person who manufactures, distributes, or dispenses any controlled dangerous substance * * * shall obtain annually a registration issued by the Attorney General." In effect, by reason of broad definitions of "distribute" and of "dispense" which includes "prescribe" and "administer" the registration requirement would apply to almost every physician.

The hazards to society of diversion or misuse of drugs in the schedules I and II are especially great. Even if diversion by physicians is not extensive, there are therefore good enforcement reasons for physician registration insofar as those schedules are concerned. However, Mr. Chairman, we are not aware of any reason to apply registration to practitioners who dispense drugs other than for those in schedule II.

We also recognize the need for the registration of manufacturers and distributors, in the ordinary sense, of any of the dangerous drugs. Controls must be exercised to stop illicit production and to prevent illegal diversion of potent psychoactive substances. Stimulents and depressants so produced and diverted make up the preponderance of the supply of such drugs being utilized by abusers today. Consequently, the control provisions should be concentrated on those points of origin and distribution, rather than on the practice of medicine.

The practice of medicine, as a matter of fact, involves the daily use of substances in schedules III and IV, yet there is not, to our knowledge, any significant diversion by or through medical practitioners. In our judgment, there is no need for registration for physicians under schedules III and IV.

RECORDKEEPING

H.R. 17463 calls for recordkeeping by registrants manufacturing, distributing or dispensing controlled drugs. Records, required by the bill, would need to be complete and accurate and contain such information as shall be required by regulations of the Attorney General.

Mr. Chairman, we do not believe there is justification for extending physician recordkeeping requirements beyond those called for in existing laws.

The bill provides that the subsection dealing with records and reports "shall not apply to practitioners who lawfully prescribe or administer, but not otherwise dispense, controlled dangerous substances."

Although it may well be the intention to exclude most physicians from the requirements of this subsection, the definitions of "administer" and "dispense" contained in the bill would in fact exempt very few physicians. For example, any physician who provided small starter dosages to a patient in his office, or who left a small amount of a controlled drug with a patient upon visiting him in his home, would thereby "otherwise dispense" and thus be subject to the recordkeeping and reporting requirements.

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We believe it is the intent of the bill to cover only those who regularly dispense drugs to patients and charge for them. Such coverage we believe is appropriate. This limitation would be similar to the provisions of the present drug abuse control amendments of 1965. We are not aware of any developments since 1965 which would require the removal of the exemptions contained therein.

Accordingly, we urge that the last sentence of section 307(a) be modified to provide as follows:

> As to controlled dangerous substances in schedules III and IV, this subsection shall not apply to a physician acting in the course of his professional practice unless he regularly engages in dispensing such substances to his patients and charges an amount in addition to regular charges for other professional services.

INSPECTION OF RECORDS

The bill gives enforcement officers the right, when authorized by an administrative inspection warrant, "to inspect and copy records required by this act to be kept" as well as inspect other records, files and papers. Exempt from such inspection are financial and pricing data.

We recommend in the case of physicians' offices and of hospitals and clinics, that patients' records also be exempt from inspection, and be protected as well from the broad subpoena powers granted the Attorney General. Such records contain information concerning individuals which is of no relevance to drug law enforcement, and which should be regarded as privileged.

Information which a physician is required to give concerning the dispensing of a controlled substance to a patient should be limited to the name of the drug administered or prescribed, the amount so administered or prescribed, the date or dates given, and the name and address of the patient. Protection should also be provided to preclude any public disclosure of information obtained concerning a patient.

PENALTIES

The penalties concerning dispensing and recordkeeping are, in our opinion, unduly severe. For example, the mere failure, unintentional in nature, of a physician to make an entry in his records concerning a small amount of a controlled drug, could place him in violation of the law and subject him to a fine of up to $25,000. If the violation is intentional, he may be jailed for up to 1 year in addition.

Under the bill, the physician is subject to the same penalties as a manufacturer who might produce large quantities of narcotics in excess of his assigned quota. We do not believe this is equitable or warranted.

THE HANDLING OF OFFENDERS

Many cases of drug abuse involve a medical problem on the part of the individual who possesses and uses a psychotropic drug. Such a person should be treated as a patient rather than as a criminal.

We believe that the court should appoint one or more medical experts in each case where a drug abuser is brought to trial on a charge of illegal possession and where, in the court's opinion, medical treatment may be indicated. A medical determination would then be made as to whether the defendant has a medical problem associated with

his abuse of drugs—a physical or psychological disability, or drug dependence. If medical treatment is indicated, the experts would recommend to the court the type of treatment needed—that is, general-medical or psychiatric care; inpatient care or clinic treatment; group therapy; halfway house; et cetera. If medical treatment is not indicated, or if measures in addition to medical treatment are needed, the court could then consider nonmedical handling of the case.

We recommend that such a procedure be specifically authorized in this legislation.

In summary, Mr. Chairman, I would like briefly to restate the following:

1. In matters of medical decision in drug control legislation, Federal jurisdiction should be vested in the Department of Health, Education, and Welfare.
2. While the Department of Justice has a responsibility to conduct research in matters that pertain to drug abuse law enforcement, the principal efforts in education and research should remain in the Department of Health, Education, and Welfare.
3. Physicians should not be required to register in order to dispense drugs in schedules III and IV.
4. Physician recordkeeping requirements should not be expanded beyond those in present law.
5. Confidentiality of patients' records should be respected.
6. Penalties applicable to physicians for infraction of dispensing and recordkeeping requirements should be reduced.
7. Medical procedures should be provided for the handling of drug abusers where medical treatment is indicated.

We began our testimony by saying that the problem of drug abuse has medical as well as law enforcement considerations. The legislation before you is primarily a law enforcement measure.

There is no large-scale commitment to scientific research or to education regarding the prevention of drug abuse and concerning the proper use of drugs.

There is no provision for initiating, promoting and coordinating programs and facilities for diagnosis and treatment of drug dependence and for rehabilitation of those persons who suffer from this illness.

I mention this, Mr. Chairman, because without adequate programs of these kinds, we believe the total problem of drug abuse and dependence cannot be successfully attacked. The American Medical Association will support measures which appropriately meet such additionally needed programs of research, education and treatment.

We shall now be pleased, Mr. Chairman, to attempt to answer any questions which you and members of the committee may have.

The CHAIRMAN. Dr. Brill, we thank you very much for your statement and also for taking your time to come to the committee to deliver it.

Mr. Burke?

Mr. BURKE. On page 9, item No. 6, what has the record been? What has been the history of the recordkeeping requirements under the present law with physicians?

Dr. BRILL. As far as I know, there has been no significant problem.

Mr. BURKE. Why then should it be reduced? Why do you recommend that the recordkeeping requirements should be reduced?

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Dr. BRILL. Reduced in the proposed bill.

Mr. BURKE. You are referring to the proposal?

Dr. BRILL. Yes, sir.

Mr. BURKE. The legislation?

Dr. BRILL. Yes, sir.

Mr. BURKE. What hardship do you think will be caused by the recommendations for recordkeeping?

Dr. BRILL. If a physician has to keep a record of every tablet or a sedative which he gives to a patient who comes to the office, and this occurs irregularly when it is necessary to start the patient on medication, and has to keep these records for 2 years, I believe that this is a burden on the physician. If such records then are subject to penalties—that is, if any technical failure or if a loss of a piece of paper subjects him to a fine, a potential fine of $25,000—I believe this could be a serious problem because in the ordinary daily practice of medicine, there is a great deal of use of minor tranquilizers and sedatives. To keep special books for this purpose would add to the overhead and interfere with ordinary practice, especially if there is a hazard of technical infraction with all the penalties that are attached.

Mr. BURKE. Would you have that apply to all drugs?

Dr. BRILL. Schedule III and IV, sir; not to the narcotics, because we recognize that here the hazards are greater and there are problems which justify the recordkeeping. But even more important, the volume of use of narcotics is trivial compared to the volume of use of these other drugs, so that the amount of work involved with respect to narcotics is minimal compared to the amount of work which this would involve.

Mr. PETERSON. A further point, Mr. Burke: As we read the language of the bill it would indicate that a mere failure or an unintentional failure to record and make such a record would subject the physician to this particular fine.

Then it adds an additional provision of course, that if it is intentional there would then be provision to jail the individual for up to 1 year in addition. We think that for the unintentional act of the physician with respect to drugs that he uses in his daily practice this is a hazard and a very severe fine, particularly when the same fine is applicable, say, to the manufacturer who might be manufacturing large quantities, not only of the more common drugs, but the narcotic drugs and even for the manufacturer then of narcotics in excess of appropriate quotas assigned to the manufacturer.

The same penalty would apply. It would just seem that that would be a harsh equation under this bill. It is up to a $25,000 fine.

The CHAIRMAN. Are there any further questions of Dr. Brill?

If not, Dr. Brill, again we thank you, sir, and appreciate your bringing Mr. Peterson with you.

(The following letters were received for the record:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 25, 1970.

HON. WILBUR D. MILLS,
Chairman, Ways and Means Committee,
Longworth Building.

DEAR MR. CHAIRMAN: Enclosed is a copy of a letter I have received from a resident of the First Congressional District of New Mexico.

Dr. Ferraro could certainly be classified an expert witness, and I believe his letter may be of some benefit to you and the other members of the Committee during deliberation of H.R. 13742, presently pending with no schedule.

The Senate passed a revised version of the measure originally introduced, on January 28. I understand that a question of jurisdiction has arisen involving the House Committees on Interstate and Foreign Commerce and Ways and Means; and the measure remains unassigned.

I am hopeful that accord can be reached very soon to permit consideration of the Senate-passed version by the entire House; or that both parts of the original measure introduced in the House be cleared for consideration. I expect to enter remarks in the Record about this shortly.

In the meantime, I will appreciate Dr. Ferraro's letter being included in the Hearing Record on either or both bills. Your kind consideration and cooperation are appreciated; if ever I can be of any assistance, please do not hesitate to call.

Sincerely yours,

MANUEL LUJAN, Jr.

Enclosure:

THE UNIVERSITY OF NEW MEXICO,
Albuquerque, N. Mex., March 11, 1970.

Representative MANUEL LUJAN,
Longworth Building,
Washington, D.C.

DEAR REPRESENTATIVE LUJAN: I should like to urge your support of Senate Bill 3246, "The Controlled Dangerous Substances Act of 1969," which is presently before the House for its consideration. This measure, although essentially a law-enforcement bill, has certain provisions with implications for education and research programs which I consider essential.

The bill has been criticized because it gives the Attorney General authority to control dangerous substances after considering the advice of the Secretary of Health, Education and Welfare. Many researchers are of the opinion that authority for control of these drugs should come directly from Health, Education and Welfare. This is because the present bill also authorizes the Attorney General to carry out necessary education and research programs. Thus, it is argued that the bill would create another scientific bureaucracy which is unnecessary given the existence of Health, Education and Welfare.

My reason for support of the bill in its present form is that I do not feel that the law-enforcement responsibilities regarding drug abuse, now the responsibility of the Department of Justice, should be separated from the educational and research responsibilities for drug abuse. It is clear that the control of drug abuse must include educational and research attempts to deal with the treatment and rehabilitation of narcotic abusers. Putting the research and educational responsibilities under Health, Education and Welfare would serve to separate what should be parallel programs.

I strongly support the establishment of the Advisory Committee on Marijuana called for in the bill. I should like, also, to add my voice of disapproval to the bill's "No-Knock" provision. However, it is clear that sufficient restrictions upon the "No-Knock" provision have been written into the law to make it workable if necessary.

Sincerely,

DOUGLAS P. FERRARO, Ph. D.,
Associate Professor.

STATE OF NEW YORK,
DEPARTMENT OF MENTAL HYGIENE,
New York, N.Y., July 22, 1970.

Hon. WILBUR MILLS,
Chairman, Ways and Means Committee, House of Representatives,
Washington, D.C.

DEAR MR. MILLS: I strongly urge you to oppose Bill H.R. 17463 as currently drafted, since it confuses drug abuse problems in the sphere of law enforcement with those in the sphere of health, education and research. The bill must be amended to permit the health, education and research functions to be exercised by that agency which is established for this purpose. There must be a separation of medical and research responsibility from that of law enforcement. Thus:

1. Power over drug classification should not be given to the Attorney General. The opinion of the Secretary of Health, Education and Welfare, acting upon the advice of the Scientific Advisory Committee should be final, with the Attorney General acting in an advisory capacity where it appears that questions involving law enforcement are involved.
2. The criteria used in dealing with chemical substances under this bill are improper and inappropriate and lead to illogical results.
3. The inspection of practicing physcians and researchers will lead to harassment.
4. The examination of researchers' procedures should be enforced by the Secretary of HEW rather than the Attorney General.
5. The "no-knock" provision of the bill as well as its euphemistic conversion into "quick entry" is very offensive since it sacrifices the right of privacy of every citizen.

I am extremely concerned about the present version of Bill 17463 and I would urge you to oppose it.

Sincerely yours,

JOSEPH ZUBIN,
Chief of Psychiatric Research.

The CHAIRMAN. Our next witness is Dr. Freedman. Dr. Freedman is chairman of the Task Force on Drug Abuse in Youth of the American Psychiatric Association. Mr. Collier?

Mr. COLLIER. Thank you, Mr. Chairman. I want to take this opportunity to welcome Dr. Freedman to the committee. Without question, he is eminently qualified in this field, Mr. Chairman, as any witness we could have. He is the author of a book titled "The Theory and Practice of Psychiatry."

Presently, he is chairman of the American Psychiatric Association Task Force on Drug Abuse. I am certain that Dr. Freedman will provide valuable information before this committee in considering this legislation.

The CHAIRMAN. Thank you, Mr. Collier.

We are pleased to have you with us this morning, Dr. Freedman. You are recognized, sir.

STATEMENT OF DR. DANIEL X. FREEDMAN, CHAIRMAN, TASK FORCE ON DRUG ABUSE IN YOUTH, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. FREEDMAN. Thank you, Mr. Chairman. Thank you, Congressman Collier.

I am testifying in behalf of the American Psychiatric Association.

In December of 1968, we publicly pointed out that the Omnibus Drug Bill misconstrued the Nation's dangerous and distressing drug problem, misassigned functions and authorities within government, inserted unnecessary, costly and impractical encumbrances on the tasks of research, education, prevention and rehabilitation, as well as the very practice of medicine, intruding upon the confidential relationship of patient and doctor.

We believed that the practical administration of the bill could well dilute the thrust of necessary law enforcement in controlling illicit drug supplies, that the bill was essentially a health rather than an enforcement measure and one which overturned the intent of Congress.

In the Congressional Reorganization Act No. 1 of 1968, Congress expressed its wish to streamline drug enforcement functions but not to confound the appropriate missions of the Departments of Health,

Education, and Welfare, on the one hand, and Justice, on the other. This bill empowers a law officer to make the delicate technical decisions involving a huge number of medicines.

Finally, and reluctantly, we saw in the initial drafts of this bill the re-emergence of the historical monopoly of the old Bureau of Narcotics, a classic failure in effective drug control. For over 40 years, it was responsible for policing traffic in narcotics, marijuana and cocaine. The Bureau was practically the sole source of information to Congress, the sole negotiator in international arrangements and treaties, and, with the exception of a select handful, it succeeded in isolating the health and scientific professions from research into the causes and cures of addiction and their medical treatment. Its operations and priorities remained unquestioned in the face of evidence that drug victims were unaided and drug-related crime unchecked. We cannot return to an approach which failed. This bill does not in fact deliver total control, it merely lures one into the false belief that it can do so.

A NEW PROBLEM

In the face of drastic mandatory penalties for illicit possession and traffic, we face today epidemics of drug experimentation, an alarming disbelief not only in the dangerousness of marijuana and the veracity of the Bureau's data about it, but also an attitude of general carelessness and casualness towards experimentation with many drugs on the part of increasing numbers of young people.

Drug abuse has emerged from the slums into the upper classes, and has an epidemic pattern, spreading from the coasts to the heartland, from urban centers to campuses, to county seats, from college-age groups to junior high schools—a vastly diverse, rapidly changing pattern involving quite variable categories of drugs and very different kinds of dangers for each pattern of abuse.

While there are an alarming number of drug trials and a much smaller number of actual victims, there is clearly since 1966, a new phenomenon. Across this land we find a vast perturbation about the whole issue of the social use of drugs. It touches every community, compels discourse between most parents and children, and the attention of most schools and multiple concerned community groups.

Few could have wished that such topics would have occupied our time and concern. But national recognition, discussion and effort are now a fact of our life and point to the impossibility of isolating issues about the regulation and control of drugs totally within a policing bureau. Increasing numbers of health scientists in the past 10 years have begun to attempt to grapple seriously with the victims of addiction and drug misuse, and to undertake research and treatment measures which might promise prevention and effective approaches.

I do not believe that either the public or the vast majority of educators and health workers wish to return to the bureaucratic style of the past which, for 40 years, stifled and distorted research, information and innovative medical treatment.

It is no accident that within Government, and without, this community of experts is opposed to this bill—a community thoroughly dedicated to trying to reduce the dangers of drugs and alcohol to our youth and society.

THEORY VERSUS PRACTICE

We all welcome the streamlining of law enforcement, if it can prove to make enforcement more efficient, more precisely on the target of primary problems of drug traffic. This bill began as an attempt of the BNDD to complement the enforcement measure by a codification of our country's necessarily complex drug regulations.

We do not believe such omnibus codification is in fact entirely feasible, nor that it has yet been approached with the appropriate information and consultation. Its passage at this juncture does not directly bear at all on the current issues of control of drug traffic, an urgent operational task which should not be masked by legal maneuverings.

The bill is a theoretical exercise attempting to control the life cycle of each and every pill from its conception on the drawing board to its final consumption in the sick patient or illicit consumer. Mesmerized by its aims, we all seem to have forgotten that there are a number of laws, such as the Drug Abuse Control Amendments, which entitle our police agencies to do their business of enforcing actual diversions of dangerous drugs.

This current attempt to codify all drugs which might conceivably be a public health danger is a legally difficult one and one which is unwise in its allocation of authorities. Strong and effective enforcement should not stop.

Rather, we urge Congress to direct that enforcement should occur without any more diversions of effort and involvement of the time of so many of us trying to cope with our epidemic of drug interest and drug abuse.

Congress could well direct the Department of Health, Education, and Welfare to honestly request the funds it needs for the agencies it already has, and to get to work. The control agency for evaluating new drugs already exists at FDA; the educational and research apparatus for drug abuse at NIMH has remained underfunded for 3 years while the epidemics increase. Congress could also direct the BNDD to request and justify the agents and machinery it needs to focus on its primary policing task.

ANALYSIS OF THE BILL

The bill before you contains sweeping new powers allocated to the Bureau of Narcotics and Dangerous Drugs. These new powers are not simply the authority to prosecute drug abusers and traffickers. Rather, there is new power to initially and finally decide—to judge—with respect to a range of drugs enormously wider than the narcotics, cocaine and marihuana: (1) what is or is not a dangerous drug; (2) what is or is not acceptable medical practice; (3) what is or is not acceptable research, and (4) who can do it.

The new power is to adjudicate the abuse potential and medical usefulness not only of old, but of newly discovered substances, and the conditions under which they may be used—not only in everyday medical practice, but for any conceivable kind of health-related investigation and treatment.

The bill has always contained language that left the Attorney General thoroughly uninspected, absolutely unvetoed at every step regulating these issues. There simply are no realistic checks and balances. There is no weighing of costs and benefits of the proposed procedures.

We do not believe that the major illicit supplies involved in drug abuse come either from narcotic officers or physicians, or patients, though each group has produced a few delinquents. It should be clear that approximately one-third of legally prescribed drugs are currently encompassed in this bill.

The bill is used as a model for State bills. BNDD agents have been vigorously proposing this to Governors throughout the country. Considering the powers that patrolmen, sheriffs, State officers, as well as Federal officers will have to police suspected minor transactions in commonly used and, in general, appropriately prescribed and consumed drugs, we will find the scenario will have truly shifted—from illicit factories, smuggling, hijacking and street vending operations, into the bathroom medicine cabinet and the physician's consultation room.

This shift has not occurred because Congress, with thorough examination, has found such powers and forces for policing to be necessary. Rather, we all have simply been told that such extraordinary powers would not ordinarily be used, and that the real targets are elsewhere.

Why, then, such extraordinary powers, such careless balancing of risks and gains, such intransigent lobbying?

We cannot agree that the new powers are targeted on the real problems, nor that the public health dangers of medicines ought finally to be adjudicated by the Attorney General as proposed in title II of this bill. The criteria for scheduling would require marihuana to be in the same schedule as heroin because there is presently no medical utility for marijuana.

Whatever opinion one holds concerning the potential harm it represents—and I personally do believe potent marihuana is a drug which holds a risk, especially for youthful users—it is clear that its effects and consequences cannot be classified for control in the same manner as heroin. This will not compel either scientific or public belief; it will promote dissension and flaunting of the law rather than heal our society.

The criteria for scheduling also forces the classifiers to include methamphetamine, "speed" with mild sedative agents, such as chloralhydrate and chlordiazepoxide, medically useful and not widely abused drugs.

Methamphetamine is also far more dangerous than marihuana to personal health and public safety, but receives a lesser classification. The effects of medically useful short-acting sedative barbiturates, which are abused, and long-acting barbiturates which are not abused (and are useful as sedation in the treatment of many neurological diseases) are not properly distinguished.

Since the schedule in which a substance is placed determines the penalties for possession and transfer, restrictions on research, registration recordkeeping and reporting, it is essential that the issue of classification be fundamentally reconsidered. No knowledgeable scientific person in the field of drug abuse can make sense of the current proposals. The World Health Organization has attempted one classification which might be useful to us.

But the easiest and most flexible approach is to be able rapidly to assign a drug for which an actual pattern of abuse can be reliably detected to the most efficient control measures.

In some instances this may simply be the formal or informal institution of quota regulations, or possibly tightened regulations on pre-

scriptions and refills. But, to preclassify every conceivable pill that might present a varying degree of public health danger, to impose both illogical scheduling and hence enormous consequences on the total population of legitimate drug users, must be a theoretical rather than a practical exercise in government. Why do it? No major diverter of supplies of a dangerous drug is currently immune to prosecution under the curent laws, whether he is a researcher, a teacher of physiology or zoology, or a physician delivering health services. What will be the gain in the new controls versus the costs to all of these persons, their patients and students?

Examining the real scene of current drug abuse, we cannot believe that if the entire medical profession and their law-abiding clients, and the entire group of researchers who employ a medicine, were actually abolished—that their absence would remove the source of the real epidemics of drug interest and misuse, or their nature and their causes.

Accordingly, we have far preferred proposals such as the Staggers bill, House bill H.R. 11701, or Senate bill 3562, which are limited, feasible and modest.

H.R. 11701 uses the most convenient device of permitting the Secretary of HEW—with appropriate advice—to make ongoing—not prior—determinations of public health dangers and to selectively employ those regulatory devices which saliently go to the point.

In title III, we have no objection to the Attorney General registering and inspecting manufacturers of drugs or places where there are large depositories of controlled substances. But the doctor's private patient records, as we have repeatedly pointed out, are also to be open to inspection. Language should be inserted which would explicitly protect the privacy and confidentiality of the patient-physician relationship.

The exact meaning of dispensor and distributor should also be clarified. If it is not restricted to drugs listed in schedule I and II. The term would apply to any physician who gives a starter dose of a minor tranquilizer and to every medical student who utilizes a barbiturate in a rat in the course of his routine training in physiology laboratories. This is an unnecessary burden.

It is usually unnecessary for BNDD in labs to review each research or teaching protocol simply to examine proposed procedures which will safeguard against diversion. The routine of control for morphine is well established and could apply to other dangerous drugs without special prior documentation.

A wide number of drugs are included and the wide range of scientific and educational enterprises in which chemicals are safely employed do not seem to be clearly appreciated by the bill drafters.

Section 306 of H.R. 17463 allows the Attorney General to determine the Nation's needs and production quotas. We believe that the medical, scientific and industrial needs of the United States can best be assessed by the Department of HEW, in consultation with all the affected parties, and simply enforced by the Department of Justice.

The wording of the first portion of section 307 really is quite confusing and without going into it, I call your attention to it. Precisely what procedures legitimate practitioners, researchers and teachers in the biomedical sciences are supposed to follow is not clear. It never has been, even after repeated questions concerning this wording. Dr. Brill addressed himself to that point.

RESEARCH AND EDUCATION

Section 602–A on research and education should be explicit: it should limit research and educational programs to operations research concerning the effectiveness of policing supplies and the authority preferably to contract for laboratories to identify seized contraband and street substances. We entirely support the Bureau in its attempts to search out major diversions of drugs and to determine why they cannot be controlled.

We believe that if international agreements on drug control are needed, we should proceed with them after public debate. We believe that if there are not enough agents, that we should have more. We cannot believe that the problem of ineffective control of drug traffic is because Federal agents need more time to do research or to go into classrooms.

The fact is that the Bureau of Narcotics and the new BNDD have long been educating their own officers and enforcement officers at every level in this country, although under what line-item in the budget I am uncertain. While there has been improvement since Mr. Ingersoll has been in charge, some of the documents distributed by the agency would not pass scientific muster and, in this day and age, this does not help to win public belief and compliance, which is so necessary in the area of drug abuse education. We do not believe the Bureau should ever be led to believe that it has the primary mission for education or research, that its personnel are so trained or its leadership so equipped. We do not think that police agencies should or can maintain a clear sense of mission if they take upon their shoulders all the many complex functions involving judgments and decisionmaking about drugs.

PROPER FUNCTIONS OF BNDD

We do believe that the Bureau of Narcotics and Dangerous Drugs should be fully informed of potentially dangerous substances, of actual patterns of abuse and their specific dangers, and of the location of major supplies of clearly dangerous drugs—not of all substances which might possibly be abused by a few. They should prosecute any criminal diversion committed by anyone, and they should be focusing primarily on major supplies and epidemics as they occur.

They should reliably inform a variety of involved health experts and agencies, the Congress and the public about their confirmed observations on drug traffic and use, and they should be charged with advancing effective and efficient enforcement rather than retarding the work of legitimate health and education agencies.

ESSENTIALS FOR EFFECTIVE LEGISLATION

Mr. Chairman, this is, I believe the fourth occasion on which I have spoken to various congressional committees about the omnibus drug bill. Since this testimony could not be presented and amplified before the committee hearings on S. 3246 we especially appreciate your courtesy and interest. I regret the fact that drug abuse is a complicated area, and that a hasty solution does not seem possible. What should not have been true for narcotics is patently insupportable with the enormous range of the pharmacopea for which the BNDD now asks to be sole custodian, judge, prosecutor, police and legislator.

It is precisely this confusion of competency and function which brings us to the heart of the matter. For the facts are that the community of involved and competent people are made up of law enforcement agents, regulatory agents (such as Food and Drug Administration), pharmaceutical manufacturers, wholesalers and distributors, hospital administrators, experts in clinical investigations, medical practitioners, and basic scientists, educators, social scientists, prosecutors, judges, parole officers—these are the informal individuals affected by any act affecting medicines which may be taken without prescriptions.

They have never been brought together to cover the entire enterprise of appropriate regulations in terms of the traffic and use of all manufactured medicines. I am certain we will eventually have to come to this kind of overview and movement toward a National Drug Policy. This will require several years of review and sifting of appropriate measures and weighing of their consequences upon public health and welfare. Such a coordinated review at the level of the National Academy of Sciences is urgent, unless we wish episodes not only of drug abuse, but panic legislation and piecemeal approaches. Some such review should have preceded this bill.

In other words, a system or network of consequences occur when we legislate about drugs. This is precisely what may agitate enforcement officials—it ought to—who are rightly concerned that a regulation about a drug may present them with a problem in enforcement which the regulators did not anticipate. The reverse is also true and for a much larger group.

Between totalitarian control over public health and privacy and freedom, some perspective and balance is required. We should recognize several facts of life in making drug policy. Not only are a wide range of practices and individuals influenced, but the regulation of drug consumption entails many more social practices and regulatory devices than mere enforcement of drug laws.

Prescribing practices: Government and industry controls over manufacturing, distribution and retailing; malpractice and negligence suits: a variety of informal peer group controls; as well as the Food and Drug Administration investigational new drug procedures, all play their role. Taxing practices have vastly changed the pattern of consumption of drugs used for recreation and social purposes. The availability of optional resources—resources other than drugs to occupy the interests and beliefs of men have influenced other epidemics of drug abuse in history.

Our point is that this bill is premature, does not present you with the data upon which clear legislation could be drafted, nor target upon specific and soluble issues in drug abuse. It duplicates existing functions. Taken seriously, it would require an entirely new health establishment to be built into the Department of Justice. It should follow that we move the Bureau of Standards, or the assessment of pollutants and any other technical decision requiring legal action into the Department of Justice.

THE HISTORY OF THE BILL

There is, of course, already a 2-year history of discussion about this bill. Most of us are anxious to see good law enforcement because where there are no drugs there is no drug abuse. The hearings before the

House Subcommittee on Health and Welfare have been exhaustive and document why the bulk of the health professionals, educational experts, those working with rehabilitation of narcotics addicts, and those concerned with the retailing and distribution of drugs, continue to find the bill downright impractical.

Those hearings also document the fact that in their push the BNDD has not won the confidence of health professionals either within or outside of Government. Testimony has been heard concerning harassments of legitimate workers. The control of medical practice envisaged in the early secret versions of methadone guidelines, initially drafted by BNDD, hardly augurs well for the future.

While such widespread opposition could be the result of a failure to apprehend good intentions, it could also be a comment on the way this awkward bill has been constructed and current style of "in camera" legislating by bureaus. We heard testimony that even the scientific advisory groups to the BNDD were not consulted nor could they have been if the many drug misspellings and misclassifications contained in various versions of the bill were to be taken as evidence.

Members of BNDD's committee commented to me that they did not know how they were to be used. In other areas affecting crucial public health matters and policy (such as in the National Institutes of Health), professional lay advisory bodies have mandatory review of decisions involving grants and contracts.

No meaningful review is sought or envisaged by BNDD. Dr. Egeberg had previously said conversation was easy between the agencies; I have previously said he does not know what he is talking about or won't talk about what he knows. Dr. Yolles is now free to, and might be consulted. The point is that HEW has been backing away from its duties.

I will not further burden you with what is readily available for your view. I regret that the lack of communication over the last 2 years has meant a lost golden opportunity for a new, open and health collaboration amongst the variety of professionals involved in the attempt to regulate the abuse of drugs. We could well have a constructive dialog and I believe some of the individuals within BNDD are temperamentally available for it—but they should not be encouraged to continue the long and exhausting push for this unfortunate bill.

We would hope that the public's new-found concern and thirst for knowledge, information, and help not be politically exploited. We do not want to see concern converted into panic. We are disinterested in covert or overt interagency power struggles. We request your help in moving realistically to implement the various steps required to control drug abuse.

For that aim, we find this bill unwieldly, untimely, and regressive. No bill at all would do more good than this bad bill.

The CHAIRMAN. Thank you very much for taking the time to come to the committee to deliver your very fine statement.

Mrs. Griffiths?

Mrs. GRIFFITHS. Congressman Pepper testified before this committee yesterday afternoon in which he pointed out that in truth, the Customs Department by the direction of the President had not hired the 915 people that should be available to it, and had not used the money that had been provided, because the work was really being given over to the Bureau of Narcotics.

Do you know anything about this?

Dr. FREEDMAN. I do not, Congresswoman. But I have one observation that probably would answer many questions. It is my own belief that if the people were hired and trained that we need, we would need less encumbering bills.

Mrs. GRIFFITHS. He also pointed out that Customs now has hundreds of offices throughout the world and the BNDD has only 12. But if they are to be given the power to enforce this bill, then it will require a tremendous additional bureaucracy to be built up.

Dr. FREEDMAN. Yes. The problem is you would think that some law enforcement agencies could collaborate. I know how hard it is to get certain people in my own department to collaborate. So, it is easy to be critical. But that is what is needed.

Simply because a drug is involved to have everything to do with it centralized in one bureau I don't think is practical. Customs is a very good example.

How do you operationally get enforcement going? There are ways to get teams working between agencies to do this that I think would really help an enormous amount.

Mrs. GRIFFITHS. Thank you.

The CHAIRMAN. Are there any further questions?

If not, again, Dr. Freedman, we thank you for your very fine statement.

Our next witness is Dr. John J. Boren, president of the Division of Psychopharmacology, American Psychological Association. We are pleased to have you with us today. You are recognized, sir.

STATEMENT OF DR. JOHN J. BOREN, DEPARTMENT OF PSYCHOLOGY, AMERICAN UNIVERSITY

Dr. BOREN. Mr. Chairman and members of the committee, I am John J. Boren, Ph. D., Professor, Department of Psychology, The American University, Washington, D.C.

I am the president of the Division of Psychopharmacology of the American Psychological Association.

SUMMARY

1. Important and valuable information on the effects and the toxicity of drugs listed in pending legislation is produced by laboratory research. Legislation which would restrict research on these drugs is not likely to be in the public interest.

2. The intent of the proposed legislation (H.R. 17463) is to regulate the use of dangerous substances in humans. Since the laboratory research scientists studies drugs in animals or *in vitro*, certain of the restrictions placed on practitioners who dispense drugs to humans are without useful purpose in the case of the laboratory scientist.

3. The present bill (H.R. 17463) presents the following major difficulties for the research scientist:

(*a*) The bill does not clearly provide for a research scientist (either a Ph.D., or a M.D. who is not licensed to practice medicine) to have access to the drugs for laboratory research.

(*b*) The bill burdens a scientist with annual registration procedures, approval of the merits of each experiment on schedule I substances by a government committee, and extensive record keeping.

4. I recommend that the bill define a "laboratory research scientist" who uses drugs in the conduct of laboratory research, which does not involve administration to humans I also recommend for such a scientist a simpler registration

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procedure which would remain valid for a number of years, deletion of the requirement that each experiment be reviewed by a government committee, and exemption from certain records and reports.

Dr. BOREN. I am testifying because of my responsibility as the President of the Division of Psychopharmacology, the American Psychological Association. The Division is composed largely of Ph. D. psychologists who teach courses in pharmacology and who conduct scientific research in pharmacology. A number of Division members have expressed concern that pending bills (H.R. 17463 and others) will have adverse effects upon scientific research on the drugs to be controlled. The purpose of my testimony is to point out the basis for this concern and to suggest that alternatives be considered which would not have such adverse effects on research into highly important drugs.

1. IMPORTANCE AND VALUE OF RESEARCH ON DRUGS

The bill would regulate many classes of drugs, including drugs widely used in medical practice and in scientific research (barbiturates, amphetamines, and morphine derivatives) and new substances of social concern (marihuana, LSD, and others). My major point is that research on these classes of drugs is important. I submit that agencies of the U.S. government and society as a whole could behave very much more intelligently with respect to drugs of social concern if we knew more about their many effects including their long term chronic toxicity. Therefore, legislation which would severely reduce research on these drugs is not likely to be in the public interest. Knowledge concerning these drugs can be an extremely valuable thing. There is no evidence, as far as I know, that any substantial quantity of drugs find their way from the scientific laboratory into illegal channels. Although there may be a case somewhere in which a drug was taken from someone's laboratory and sold (I know of no such case personally), I doubt that anyone has evidence that the laboratory is a substantial source of illicit traffic in drugs. Therefore, it seems unlikely that even severe regulation of the activities of the laboratory scientist would have any effect upon illegal access to drugs.

2. THE LABORATORY RESEARCH SCIENTIST AS DISTINGUISHED FROM THE PETITIONER

The intent of the proposed legislation, as I interpret it, is to regulate the use of dangerous substances in humans. In order to protect the public health, the pending legislation places a number of restrictions upon practitioners, who have access to large amounts of drugs and who dispense drugs to patients. However, the bill draws no distinction between the practitioner with humans and the laboratory research scientist who uses small quantities of drugs in biochemical studies *in vitro* or in pharmacological studies in animals. Certain of the restrictions placed on practitioners, I maintain, are without useful purpose in the case of the laboratory scientist.

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3. PROVISIONS OF H.R. 17463 WHICH RESTRICT SCIENTIFIC RESEARCH

Although I am far from being expert at understanding the implications of such a complex piece of legislation, my reading of H.R. 17463 indicates the following difficulties for the research scientist:

(*a*) The bill does not make clear how a research scientist, such as a Ph. D. who is not licensed by his state, can have access to drugs for laboratory research. In the case of a "practitioner," such as a physician, who is already licensed by his state to dispense drugs, the bill *does* indicate (in Sections 303 and 309) that such a person shall be registered to dispense substances in Schedules II through IV. Unfortunately, most laboratory research workers are either M.D.'s who do not practice medicine and are therefore not licensed, or they are Ph. D.'s who are not licensed by any state to dispense drugs. A statement in the bill which would specifically authorize laboratory research workers to have access to the controlled substances for purposes of scientific research would greatly clarify this situation.

(*b*) The bill (H.R. 17463), as it is now written, would put certain obstacles in the way of a scientist who is trying to carry out research with the controlled drugs. First, he would have to undergo a registration procedure with the Attorney General every year (Section 302); second, if he wished to study any Schedule I substance, such as the socially important LSD or marihuana, he would have to make special application to the Attorney General who would then seek the advice of the Secretary of H.E.W. who would then evaluate not only the scientist's competence but also the merits of the research (Section 303); finally, he would presumably have to keep complete records of all controlled substances and maintain the records with complete accuracy for two years (Section 307). Considering that the laboratory scientist has been carrying out his research activities for many years without such restrictions and without menacing the public health, I maintain that these restrictions are unnecessarily severe in the case of the laboratory scientist. These restrictions will serve largely as obstacles slowing the progress of legitimate research, whereas what I think we vitally need is *more* research to provide reliable information on these drugs of social concern. I would like, therefore, to suggest that the wording of the bill be changed so as to reduce the severity of these restrictions and to free the scientist to carry out his work.

4. SPECIFIC RECOMMENDATIONS FOR CHANGES IN THE WORDING OF H.R. 17463

Since I do not claim to have any expertise at devising language for legislation, I hope the Committee will accept my suggestions for rewording largely as an effort to be clear and specific. With this in mind, I would like to recommend the following revisions:

(*a*) In Section 102 entitled "Definitions," I recommend that the following definition be added: "Laboratory research scientist means a qualified scientist who uses controlled dangerous substances in the conduct of scientific research which does not involve administration to human subjects."

The purpose of this change is to establish a definition of a laboratory research scientist (as distinct from a "practitioner") so that the term can be used in other places in the bill.

(*b*) In Section 303 entitled "Registration", I recommend that the following paragraph be added (on page 42); "Laboratory research scientists shall be registered to use substances in Schedules I through IV in bona fide research not involving administration to humans. A registration application to the Attorney General by a laboratory research scientist shall be referred tto the Secretary of H.E.W. for advice. The Secretary shall promptly advise the Attorney General concerning the qualifications and competency of each applicant.

Registration of a laboratory research scientist deemed qualified by the Secretary may be denied by the Attorney General only on a ground specified in Sec. 304(a) or on the ground that the proposed procedures are inadequate to safeguard against diversion of such substances from legitimate scientific use. The registration of a laboratory research scientist to use substances in Schedules I through IV for research not involving administration to humans shall be granted far a period of ten years."

The purpose of this paragraph is to specifically authorize laboratory research scientists to use the controlled substances for research purposes and to remove certain obstacles to research. Most of the above wording is copied from paragraph (f) referring to practitioners, except the laboratory research scientist is permitted access to all four schedules of substances (assuming that there need be no governmental concern about administering a Schedule I substance to animals). There is also no requirements that the Secretary of H.E.W. review the "merits of the research protocol". My reason for this deletion is straightforward: putting a government committee between a scientist and the conduct of his experiments imposes a massive obstacle to productive research. Furthermore, in the case of *in vitro* or animal research, there seems to be no public health hazard. Finally, registration is required only once every ten years. I can see no useful purpose of frequent registration for a laboratory scientist, once his qualifications and competence have been established. As a precedent, one might note that physicians are licensed to practice for life in most states, once their qualifications and competence is established.

(*c*) In Section 307(a) entitled "Records and Reports of Registrants", I suggest that the same exemption given to practitioners on lines 17–20 be given to laboratory research scientists. This could be done by adding the following sentence to Section 307(a), line 20: "This subsection shall not apply to laboratory research scientists who lawfully use controlled dangerous substances in Schedules I, II, III, and IV of this Act in scientific research not involving administration to humans."

This change would reduce the amount of bookkeeping for scientists in the same way and for the same reasons as the bill does for the practitioner.

I hope that the Committee will see fit to change in the pending legislation the items which unduly restrict the conduct of scientific research. I would like to thank the Committee for being given the opportunity to testify on this important legislation.

Thank you.

The CHAIRMAN. We want to thank you very much, Dr. Boren, for coming to the committee and delivering your statement.

Are there any questions?

Thank you, sir, for coming.

Our next witnesses are Mr. Lawrence Speiser and Mrs. Hope Eastman, Washington, D.C., Office, American Civil Liberties Union.

Mr. Speiser is not here. We are glad to have Hope Eastman with us. We will be glad to recognize you.

STATEMENT OF HOPE EASTMAN, ASSISTANT DIRECTOR, WASHINGTON, D.C., OFFICE, AMERICAN CIVIL LIBERTIES UNION

Mrs. EASTMAN. My name is Hope Eastman. I am the assistant director of the Washington office of the American Civil Liberties Union and I am a lawyer. I am here this morning to talk primarily about H.R. 17463, H.R. 13742, and H.R. 16901, all of which contain roughly the same enforcement provisions.

Before I talk about those in some detail, I would like to comment briefly on all of these bills. We believe that they reflect an attitude which says that the problem of drug abuse is one which should be dealt with through augmented law enforcement techniques and through a law enforcement oriented approach.

We agree with many of the other witnesses who have spoken here that not enough attention is paid to the medical problems of drug abuse and to the rehabilitation questions, and that the bill overly emphasizes law enforcement.

Before examining these enforcement provisions in some detail, I would like to comment briefly on the status in which these bills treat the question of marihuana use.

The American Civil Liberties Union by action of its board of directors in 1968 adopted a policy statement which recommends against the use of criminal sanctions on the use and possession of marihuana.

The American Civil Liberties Union believes that criminal sanctions against the use and possession of marihuana represent unconstitutional interventions into personal and private rights. The basis of this position is in large part a belief that the government has not met its burden of demonstrating through scientific evidence that the use of marihuana is intrinsically harmful, causes antisocial behavior, or leads to the use of stronger drugs.

We would like to see attention paid to the elimination of all penalties on marihuana use. For that reason, we urge you to reject the approach of H.R. 13742 which leaves marihuana as a category 1 drug and makes no change in the penalties on its use and possession. However, recognizing that one does not go all the way at one time, we would favor the adoption of the approach in H.R. 16901, which regognizes that marihuana is different from category 1 drugs, such as heroin, and moves it to the least dangerous category of controlled drugs and at the same time, reduces the penalty on its use to up to 1 year and a fine.

My discussion of marihuana leads me into a discussion of the other penalty provisions of these bills. A comparison of the three bills reveals that two of the three bills give the authority to classify, or to change, the classification of drugs to the Attorney General. Again, we agree with many of the witnesses who have spoken here that this is properly a function for the Secretary of Health, Education, and Welfare. The

law enforcement aspects of the problem of controlling drug distribution are certainly for the Attorney General, but the initial decision that something is a dangerous drug, and the evaluation of valid medical uses aand the likelihood of abuse should be made within the health-oriented context of HEW.

In addition, unlike the other two bills, H.R. 13742 provides for mandatory minimum penalties on the sale and use of category 1 and 2 drugs. We are opposed to the use of mandatory minimum penalties. We are joined in that view by a number of experts—the National Crime Commission, Dr. Stanley Yolles, former Director of the National Institute of Mental Health, and in some instances, Attorney General Mitchell, who in his testimony on S. 3246 spoke in favor of elimination of mandatory minimum sentences under some circumstances as a means to allow the judge to tailor the penalty to the offender.

In this connection, I would like to bring to your attention a case decided last week in the U.S. Court of Appeals for the District of Columbia. The case is *Albert Watson* v. *United States*, which is Circuit Court No. 21,186 (decided July 1970), in which the court of appeals, while not holding this squarely because of certain ambiguities in facts of the case, quite clearly indicated that there was grave doubt that the Constitution would support punishment for use and possession of drugs when someone is an addict. This decision follows the rationale of the case of *Robinson* v. *California* (370 U.S. 660 (1962)), which held, as I am sure you know, that addiction is an illness which cannot be punished consistently with the constitutional guarantee against cruel and unusual punishment.

I think the court of appeals made it quite clear that in the next case which squarely presents the issue of an addict being prosecuted for possession, it will indeed hold that this scheme violates the Constitution.

I would like to talk now about the enforcement provisions contained in the three major bills. We believe that these enforcement provisions, which increase existing law enforcement powers, greatly undermine the constitutional restrictions against arbitrary government. We further believe that this willingness to bend the Constitution in the name of effective law enforcement, in an effort to deal with what all recognize as a serious problem, is nevertheless a serious threat to individual liberty.

I would like to just speak briefly about the provisions which do cause us concern. I would like to start first with section 702(b), which authorizes the controversial no-knock warrants which have been the subject of so much discussion in the context of the District of Columbia crime bill.

Although the standards in these bills are in some respects stronger than the standards for no-knock warrants contained in the D.C. crime bill, we firmly believe that authorization of no-knock searches under the circumstances which are contemplated in this bill violates the fourth amendment. Much has been made again in another context of the notion that the no-knock search warrant, which does not give notice to the people that the police are about to break in, is nothing more than a modification of existing law, that it is nothing new.

In that connection, I would like to read from the decision of the Supreme Court in *Ker* v. *California* (374 U.S. 23 (1963)), in which

Mr. Justice Brennan set out his explanation of the types of situations under which no-knock searches are currently permitted under the common law. The one that is of interest for this purpose is the one which deals with the destruction of evidence. I am reading from the top of page 9 of my written statement and would like to quote Mr. Justice Brennan:

> Exceptions are permissible where those within are made aware of the presence of someone outside . . . I am reading from the top of page 9 of my statement. ". . . because, for example, there has been a knock at the door, are then engaged in activity which justifies the officers in the belief that an escape or the destruction of evidence is being attempted. (374 U.S. at 47.)

This is what the current law authorizes. It contemplates that there has been a knock at the door and then there is activity which, even though the officers have not given notice that they plan to enter, permits them to enter. But the people who are inside already know someone is there. It precludes no-knock searches where the person inside is asleep in his bed and the police break in. This bill would permit such searches, a step which I firmly consider to be a very dangerous as well as an unconstitutional change in existing law.

Further, the no-knock warrant is especially dangerous in the context of H.R. 13742, which leaves marihuana in the category 1 drug penalty, and which, of no-knock warrants unlike the other bills, does not limit the use of such warrants to felonies or crimes which carry a penalty of more than 1 year. Thus, under H.R. 13742, this method of entry can be used against ordinary marihuana offenses. It is not the limited tool which its sponsors suggest is only necessary to go after the great purveyors and sellers of narcotic drug. Even if it were, we do not feel that it is constitutional and are opposed to its adoption.

I would also like to speak about section 703 which authorizes administrative inspection warrants. In talking about this provision, the most important thing to remember is that section 702 of the bill, and of course traditional law already authorize the use of standard search warrants where there is probable cause to believe that an offense has been committed and evidence fruits or contraband will be found at the place to be searched. Thus the provision for administrative inspection warrants must be viewed as designed for those cases where there is no probable cause to enter and thus, without a new device, there would be no authority to enter and search.

It is clear from the language of the bills that the drafters are attempting to rely on the case of *Camara* v. *San Francisco* (387 U.S. 523 (1967)), where the Supreme Court reversed the State court conviction of a homeowner who refused to permit a municipal health inspector to enter and inspect his premises. The Court in that case held that probable cause as it is normally defined was not necessary and that all that was necessary was a "valid public interest in the enforcement of the act."

That is the standard which these bills adopt. However, there are fundamental differences between the situation in *Camara* and the one we are talking about here. In *Camara*, the Court made it very clear that they weren't talking about something which was incidental to a criminal investigation, a steppingstone to the imposition of criminal penalties. They were looking for even unintentional violation of the public housing code which made it unsafe for others to be around. They did not feel that it was necessary to pinpoint a particular house.

It was part of a general communitywide search. It is very different from what is involved here, where the administrative inspection warrant is the means of gathering evidence which certainly will be used against any individual who is found to have engaged in criminal violations.

There is no limitation in the bill which would prevent this evidence from being used against them and so, clearly, it is the beginning of the prosecution. We share with the medical people who have testified a fear that these provisions, along with the provisions giving the Attorney General control over research and the use of drugs therein, present a very clear danger to people who are engaged in both medical practice and research in drugs.

The danger is compounded by the fact that section 703 contemplates that in many circumstances these administrative inspections will be allowed without warrants and, again looking to the fact that 702 already authorizes regular search warrants, that this will be in circumstance where regular search warrants could not even be obtained. This looks very much like a way of expanding what the use of warrantless searches which the courts have very traditionally limited. The Supreme Court has almost never, except in the cases of speeding automobiles and to a very limited extent incident to arrest authorized warrantless searches. The catch-all provision under that they are allowed to the extent the Constitution does not prohibit them, does not offer much guidance to the officers who are going to be given the authority to use this technique.

I would like to speak briefly about section 606(a), which authorizes the Attorney General to subpena witnesses and documents and hold hearings. We believe that this provision does not give adequate attention to the fourth amendment requirement that warrants be specific. It only requires that the information that they are looking for be relevant. There is no limitation that the items that they are looking for must be specified.

Even more serious, the Attorney General is given the power to hold hearings. He is given the power to issue warrants. There is no neutral magistrate which comes between his acting as the prosecutor in seeking a warrant and in acting as the judge in holding a hearing on the evidence and the documents which are subpenaed. It seems to me that this is a bad blending of functions. The traditional intervention of a neutral magistrate in the authorization and utilization of warrants is very important and should not be overlooked.

Section 707 of one of the bills (H.R. 13742) contains a provision which offers a grant of immunity from prosecution to witnesses who are compelled to testify. The other two bills contain a different, more limited version of the immunity provision.

We have reservations about one and strong objections to the other. In one version, a person who asserts his constitutional right to remain silent under the privilege against self-incrimination can nevertheless be compelled to testify and he will be given immunity from prosecution. This is a much more complete immunity than the other bills give. It is a much more desirable immunity. Yet, I think more attention needs to be paid to the language of this version. There are some things which do not come under the phrase "criminal prosecution" for which the individual ought to be given immunity as well, such as

United States Senate

WASHINGTON, DC 20510

July 25, 2018

The Honorable Jeff Sessions
Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Dear Attorney General Sessions:

We write to encourage you to finalize your review of applications submitted to the Drug Enforcement Administration (DEA) for licenses to manufacture marijuana for scientific research. Our nation's need for meaningful federally sanctioned research is critical. Research and medical communities should have access to research-grade materials to answer questions around marijuana's efficacy and potential impacts, both positive and adverse. Finalizing the review of applications for marijuana manufacturing will assist in doing just that.

For nearly fifty years, the University of Mississippi has had the sole contract with the National Institute on Drug Abuse (NIDA) to grow cannabis for research purposes. To expand the number of manufacturers, the DEA submitted a notice in the Federal Register on August 11, 2016, soliciting applications for licenses to manufacture marijuana for research purposes. Under this notice, DEA explained its legal authority to "increase the number of entities registered under the Controlled Substances Act (CSA) to grow (manufacture) marijuana to supply legitimate researchers in the United States."[1] However, almost two years have passed since the DEA's notice without any new schedule I marijuana manufacturer registrations.

On April 25, 2018, during testimony before the Senate Appropriations Subcommittee on Commerce, Justice, Science, and Related Agencies, in response to questioning you stated: "We are moving forward and we will add, fairly soon . . . additional suppliers of marijuana under the Controlled [Substances Act]."[2] In a prior hearing, you testified: "It would be healthy to have some more competition in the [marijuana] supply."[3]

Additional registered marijuana manufacturers in the United States will assist not only in expanding legitimate research opportunities, but also will act in a way that allows for the United States' continued compliance with the United Nations' Single Convention on Narcotics Drugs. Specifically, in DEA's August 2016 notice, the agency explained, "DEA believes it would be consistent with the purposes of articles 23 and 28 of the Single Convention for DEA to register

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[1] https://www.federalregister.gov/documents/2016/08/12/2016-17955/applications-to-become-registered-under-the-controlled-substances-act-to-manufacture-marijuana-to.
[2] "Attorney General Sessions on Justice Department Budget Request," C-SPAN, 25 April 2018, https://www.c-span.org/video/?444368-1/attorney-general-declines-resign-mueller-rosenstein-fired.
[3] "Justice Department Oversight Hearing," C-SPAN, 18 Oct. 2017, https://www.c-span.org/video/?434413-1/attorney-general-interviewed-special-counsel.

marijuana growers outside of the [National Institute on Drug Abuse]-contract system to supply researchers, provided the growers agree that they may only distribute marijuana with prior, written approval from DEA."

To prevent further delays in approving the at least twenty-six pending DEA applications for licenses to manufacture marijuana for research purposes, we ask you to respond to the following questions and requests by August 10, 2018:

1) What is the currents status of the twenty-six marijuana manufacturer applications?

2) What steps have both DEA and DOJ taken to review the twenty-six marijuana manufacturer applications currently pending?

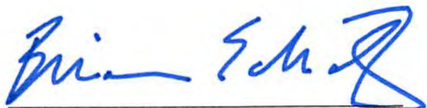
3) By what date do you estimate the DEA will have completed its review of the twenty-six marijuana applications and commence registration of new marijuana manufacturers?

4) Please share DOJ's analysis of the Single Convention and if the opinion of the Justice Department is the same or similar to that of DEA's.

5) If there are legal barriers to licensing multiple schedule I marijuana manufacturers under the Single Convention, please identify and explain them.

Thank you for your attention to this matter.

Sincerely,


BRIAN SCHATZ
United States Senator

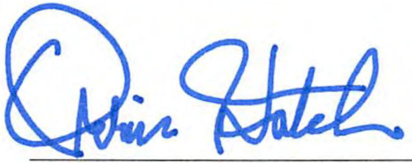
CHUCK GRASSLEY
United States Senator

CORY GARDNER
United States Senator

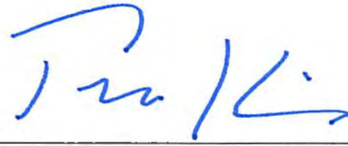
KIRSTEN GILLIBRAND
United States Senator

AMY KLOBUCHAR
United States Senator

CHRISTOPHER A. COONS
United States Senator



ORRIN HATCH
United States Senator



TIM KAINE
United States Senator

Congress of the United States
Washington, DC 20515

August 31, 2018

The Honorable Jefferson Sessions
Attorney General
U.S. Department of Justice (DOJ)
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Dear Attorney General Sessions:

In light of the fact that August 11, 2018 marked two years since the Drug Enforcement Administration (DEA) stated that they would accept registrations for manufacturers of marijuana for research usage, we write to encourage you to finalize your review of the submitted applications.

As we expressed to you nearly four months ago, in our letter dated April 30, 2018, compliant manufacturers are attempting to provide state and federal governments and medical professionals with rigorous research on cannabis' effects, both adverse and therapeutic, but their applications to do so have not been assessed. Our nation needs scientific research to analyze the medical applications of cannabis so we may determine appropriate federal marijuana policy in accordance with federal law. It is good policy, it is simply the right thing to do, and it falls within our national controlled substances regulatory framework.

As a bipartisan group of Members of Congress, we feel obliged to make clear our position on marijuana research:

1. The production of marijuana for compliant research should be apolitical.

2. Lawmakers, regulators, law enforcement officials and patients must be able to draw from a robust body of scientific research to make informed decisions about marijuana usage.

3. The need for expanded marijuana research in the United States is critical and urgent.

To prevent further delays in approving pending DEA applications for licenses to manufacture marijuana for research purposes, we ask you to respond to the following questions at your earliest convenience:

1. What is the current status of the twenty-six marijuana manufacturer applications?

2. In the past twelve months, excluding Schedule I Bulk Manufacturer registrations for marijuana, how many new DEA registrations has DOJ reviewed?

3. What steps have both the DEA and DOJ taken to review the twenty-six marijuana manufacturer applications currently pending?

4. By what date do you estimate the DEA will have completed its review of the twenty-six marijuana applications and commence registration of new marijuana manufacturers?

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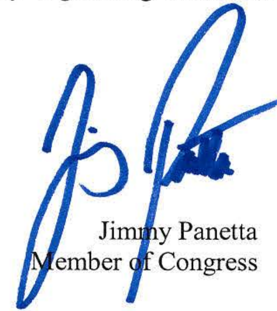
We look forward to your department addressing these questions and swiftly registering additional producers of marijuana for research. Thank you for your attention to this matter.

Sincerely,

Carlos Curbelo
Member of Congress



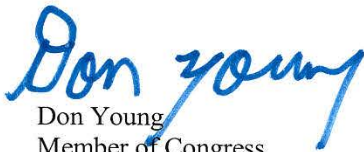
Jimmy Panetta
Member of Congress

Matt Gaetz
Member of Congress

Earl Blumenauer
Member of Congress

Dana Rohrabacher
Member of Congress

Steve Cohen
Member of Congress



Don Young
Member of Congress

Charlie Crist
Member of Congress

Tom Garrett
Member of Congress

Eleanor Holmes Norton
Member of Congress

Ryan Costello
Member of Congress

Anna G. Eshoo
Member of Congress

Zoe Lofgren
Member of Congress

Jared Polis
Member of Congress

United States Senate
WASHINGTON, DC 20510

December 11, 2019

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable James W. Carroll
Director
Office of National Drug Control Policy
750 Seventeenth Street, N.W.
Washington, D.C. 20503

The Honorable Uttam Dhillon
Acting Administrator
U.S. Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

Dear Secretary Azar, Director Carroll, and Acting Administrator Dhillon:

We write to inquire about your respective agencies' ongoing efforts with regard to scientific research on the potential health and therapeutic benefits of marijuana when used for medical purposes ("medical marijuana"). In light of the Drug Enforcement Administration's (DEA) most recent announcement that it will issue additional marijuana manufacturing licenses for research purposes — an announcement that comes three years after a similar yet unfulfilled DEA commitment — we are also requesting written guidance on how the DEA will make these licenses available to qualified researchers in a timely manner.[1]

Several of us wrote to your respective agencies in December 2015 and June 2016 to request detailed information regarding medical marijuana research and highlight the federal government's unique responsibility to coordinate these efforts.[2] Since we last wrote, an additional eight states have legalized marijuana for medicinal purposes, bringing the national total to thirty-three states plus the District of Columbia.[3] More than fifty-nine percent of Americans now believe marijuana use should be legal, and this number continues to grow.[4] To

[1] United States Drug Enforcement Administration, "DEA announces steps necessary to improve access to marijuana research," August 26, 2019, https://www.dea.gov/press-releases/2019/08/26/dea-announces-steps-necessary-improve-access-marijuana-research.
[2] Letter from Senator Elizabeth Warren et al. to Drug Enforcement Administration, Department of Health and Human Services and Office of National Drug Control Policy, December 21, 2015, https://www.warren.senate.gov/files/documents/2015-12-21_Letter_to_HHS_ONDCP_DEA.pdf; Letter from Senator Elizabeth Warren et al. to Drug Enforcement Administration and Department of Justice, June 23, 2016, https://www.warren.senate.gov/files/documents/2016-6-23_Letter_to_DOJ_and_DEA_on_rescheduling.pdf.
[3] Pew Research Center, "6 facts about marijuana," A.W. Geiger and John Gramlich, November 22, 2019, https://www.pewresearch.org/fact-tank/2019/06/26/facts-about-marijuana/.
[4] *Ibid.*

date, eleven states allow for the legal recreational adult-use of marijuana, and more than a dozen states have passed laws specifically allowing for access to cannabidiol.[5]

While millions of Americans are now lawfully able to use marijuana for recreational and medicinal purposes, there remains limited research on its therapeutic benefits. With an ever-growing number of Americans consulting their doctors about marijuana treatment options for conditions such as chronic pain, post-traumatic stress disorder, and terminal illnesses, it is imperative that your agencies make a concerted effort to improve our understanding of cannabis, its potential health benefits, and its health risks.

Several barriers, many of which have existed for decades, continue to limit this critical research. Under the Controlled Substances Act of 1970, marijuana remains a Schedule 1 substance, alongside dangerous and lethal substances such as heroin and methamphetamine; meanwhile, substances such as cocaine and Oxycontin are Schedule II substances. Marijuana's Schedule I classification as a drug with "no currently accepted medical use and a high potential for abuse," is, in itself, a significant barrier to conducting research.[6] Hampering these research opportunities and discouraging qualified, independent researchers attempting to conduct studies on the benefits of medical marijuana is detrimental to states that wish to thoughtfully implement their own marijuana laws. This research is crucial to developing a thorough understanding of medical marijuana and would be invaluable to doctors, patients, and lawmakers across the nation.

We appreciate the DEA's recent actions to begin to close this gap in knowledge and lack of access for qualified researchers and welcome its August 2019 announcement pledging to issue additional marijuana manufacturing licenses for research purposes. To better understand both the DEA's decision-making, as well as its work in conjunction with the U.S. Department of Health and Human Services (HHS) and Office of National Drug Control Policy (ONDCP) to expand medical marijuana research, we request answers to the following questions:

1. The DEA is responsible for issuing permits for the bulk manufacturing of marijuana for research and scientific purposes. The DEA recently issued notice of pending applications in order to increase the variety of marijuana available for these purposes.
    a. As of today, how many pending applications are currently awaiting DEA consideration?
    b. How many of these applications does the DEA expect to approve?
    c. How many of these applications have been withdrawn?
    d. What is the timeline for DEA to act on these applications?

2. In the past, ONDCP and DEA have suggested that the current supply of marijuana for research purposes was not a significant barrier.[7] Please provide detailed information on the current supply of marijuana, including a breakdown of all strains, amounts available in each strain, amount of each strain researchers have requested, and the amount of each

[5] *Ibid.*
[6] Drug Enforcement Administration, "Drug Scheduling," https://www.dea.gov/drug-scheduling.
[7] Letter from Senator Elizabeth Warren et al. to Drug Enforcement Administration, Department of Health and Human Services, and Office of National Drug Control Policy, December 21, 2015, https://www.warren.senate.gov/files/documents/2015-12-21_Letter_to_HHS_ONDCP_DEA.pdf

strain that is in surplus. How many new strains of marijuana does the DEA hope to gain access to the supply of through its August notice?

3. Marijuana is currently classified as a Schedule I drug, which, according to DEA and HHS, means it has "no currently accepted medical use and a high potential for abuse." Under the authorities outlined under the Controlled Substances Act, does DEA or HHS have plans to review the scheduling of marijuana?

4. Please describe the application process for qualified researchers who wish to conduct research using marijuana. How do your agencies plan to work together to encourage qualified research applicants to grow marijuana for research purposes?

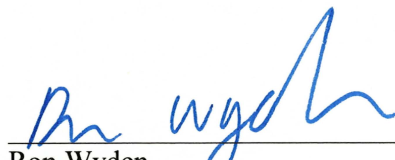
5. Many states that allow for the medicinal use of marijuana, including Massachusetts, permit physicians to prescribe it for the treatment of chronic pain. Do your agencies have any plans to support research on the use of marijuana for the treatment of chronic pain, particularly as a treatment alternative to opioids?

With millions of American adults having access to recreational marijuana and a growing number seeking the drug for medicinal purposes, the federal government is not providing the necessary leadership and tools in this developing field. Evidence-based public policy is crucial to ensuring our marijuana laws best serve patients and health care providers. Federal agencies have a unique opportunity to collaborate with one another to expand our nation's understanding of marijuana's potential to create safe and effective therapies. We respectfully request that you provide responses to these questions no later than January 10, 2019.

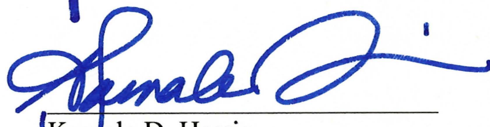
We appreciate your attention to this matter.

Sincerely,

Elizabeth Warren
United States Senator

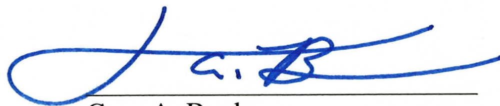


Ron Wyden
United States Senator

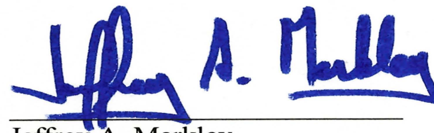


Kamala D. Harris
United States Senator

Kirsten Gillibrand
United States Senator



Cory A. Booker
United States Senator



Jeffrey A. Merkley
United States Senator

Edward J. Markey
United States Senator

Jacky Rosen
United States Senator

ORAL ARGUMENT NOT SCHEDULED

No. 19-1120

IN THE

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

In re Scottsdale Research Institute, LLC,

Petitioner

____

ON PETITION FOR A WRIT OF MANDAMUS TO WILLIAM P. BARR, U.S. ATTORNEY GENERAL, UTTAM DHILLON, ACTING ADMINISTRATOR OF THE U.S. DRUG ENFORCEMENT ADMINISTRATION, AND THE U.S. DRUG ENFORCEMENT ADMINISTRATION

Amended Petition for a Writ of Mandamus

Matthew C. Zorn
Shane Pennington
YETTER COLEMAN LLP
811 Main Street, Suite 4100
Houston, Texas 77002
(713) 632-8000

Counsel for Petitioner
Scottsdale Research Institute, LLC

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GLOSSARY

APA	Administrative Procedure Act
CSA	Controlled Substances Act
DEA	U.S. Drug Enforcement Administration
Decl.	Declaration of Suzanne Sisley, M.D.
DOJ	U.S. Department of Justice
Ex.	Exhibit (Appendix)
FDA	U.S. Food and Drug Administration
HHS	U.S. Department of Health and Human Services
MAPS	Multidisciplinary Association for Psychedelic Studies
NIDA	National Institute on Drug Abuse
PTSD	Post-Traumatic Stress Disorder
SRI	Scottsdale Research Institute, LLC

PRELIMINARY STATEMENT

Dr. Sue Sisley did everything by the book. Over the course of a decade, she ran the regulatory gauntlet, earning the blessing of four federal agencies so that she could do groundbreaking clinical research into the efficacy of cannabis to treat veterans suffering from treatment-resistant post-traumatic stress disorder ("PTSD")—some of whom turn to suicide. Through her company, Scottsdale Research Institute, LLC ("SRI"), the Petitioner in this case, she wants to continue that research and investigate other potential applications for cannabis. But poor-quality government cannabis is preventing that from happening.

To comply with federal law, SRI must use federally-sourced cannabis, grown exclusively on a single 12-acre farm run by the University of Mississippi. SRI used this cannabis for its Phase II trials. It arrived in powdered form, tainted with extraneous material like sticks and seeds, and many samples were moldy. Whatever reasons the government may have for sanctioning this cannabis and no other, considerations of quality are not among them. It is not suited for any clinical trials, let alone the ones SRI is doing. Simply put, this cannabis is sub-par.

Thirty months ago, Sisley thought she had a fix. After the Drug Enforcement Administration ("DEA") announced a new policy designed to increase the number of entities permitted to manufacture cannabis for clinical trials and other research endeavors, SRI applied to grow cannabis for its clinical research. Allowing SRI to grow its own cannabis will improve drug quality and give it tighter control over dosages. But the agency has yet to respond. With new trials around the corner, SRI can wait no longer.

And it shouldn't have to. Before Sisley submitted SRI's application, Congress amended the Controlled Substances Act ("CSA") to address this problem. As part of the "Improving Regulatory Transparency for New Medical Therapies Act," it added a requirement that the Attorney General, upon receiving an application to manufacture a Schedule I substance for use only in a clinical trial, publish a notice of application not later than 90 days after accepting the application for filing. 21 U.S.C. § 823(i)(2).

That date was more than two years ago.

Thus, agency action has been unlawfully withheld. And in view of an express directive to prioritize applications relating to clinical research, agency action has most certainly been unreasonably delayed.

To determine whether to issue a writ of mandamus to compel agency action, this Court applies the six-part "*TRAC*" standard. This case passes

the test: the agency has flouted a non-discretionary deadline to complete a perfunctory—but vitally important—task; significant economic interests and human health and welfare are at stake; it cannot be said that expediting delayed action will interfere with agency activities of a higher or competing priority; and mandamus is warranted regardless of the purity of the motives underlying DEA's unexplained delay.

SRI turns to this Court having exhausted all other avenues of relief. Sisley reached out to the agency no fewer than five times, the media has done a full-court press, and the number of letters from frustrated members of Congress from both parties imploring the agency to act is quickly approaching a dozen. At this juncture, nothing short of a writ from this Court compelling the agency to act will stop the ongoing harm caused by DEA's unlawful and unreasonable delay.

RELIEF SOUGHT

SRI seeks a writ of mandamus directing the Attorney General, DEA, or its Acting Administrator to issue a "notice of application" by 90 days from the date of service of this amended petition or fifteen days after the writ issues, whichever is later.

JURISDICTIONAL STATEMENT

This petition arises under the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 555(b), 702, and 706(1). DEA's failure to issue a notice of SRI's application is agency action both unlawfully withheld and unreasonably delayed.

The Controlled Substances Act, 21 U.S.C. § 801 et seq., authorizes direct review in this Court of all final determinations, findings, and conclusions of the Attorney General or agency decisions, *id.* § 877. Because agency delay can thwart judicial review, this Court may resolve claims of unreasonable delay "to protect its future jurisdiction." *Telecomms. Research & Action Ctr. v. FCC*, 750 F.2d 70, 76 (D.C. Cir. 1984) ("*TRAC*"); *Gottlieb v. Pena*, 41 F.3d 730, 734 (D.C. Cir. 1994). "Were it otherwise, agencies could effectively prevent judicial review of their policy determinations by simply refusing to take final action." *Cobell v. Norton*,

240 F.3d 1081, 1095 (D.C. Cir. 2001). Finally, the All Writs Act, 28 U.S.C. § 1651(a), permits this Court to issue writs of mandamus to cure unreasonable delay. *TRAC*, 750 F.2d at 75.

ISSUE PRESENTED

After DEA announced a new policy designed to increase the number of entities permitted to manufacture cannabis for clinical trials and other research endeavors, SRI applied to manufacture cannabis to support its own FDA-approved clinical trials. Yet thirty months have passed since SRI filed its application, and the agency has done nothing.

Thus, SRI's petition presents two questions:

1. Has the DEA unlawfully withheld or unreasonably delayed agency action under 5 U.S.C. § 706(1)? and
2. Should this Court issue a writ of mandamus under 28 U.S.C. § 1651(a) to compel the agency to issue the statutorily required notice?

STATEMENT OF THE CASE

The CSA regulates the production, possession, and distribution of controlled substances. *See* 21 U.S.C. § 801 et seq. It contains five schedules of drugs, based on their accepted medical uses, their potential for abuse, and their psychological and physical effects on the body, with Schedule I being the most restrictive. *Gonzales v. Raich*, 545 U.S. 1, 13-14 (2005). Schedule I substances cannot be used, except in research. *See id.* at 14.

When Congress enacted the CSA in 1970, it made cannabis a Schedule I drug. *Id.* It did so based, in part, on a recommendation from the Assistant Secretary of the U.S. Department of Health, Education, and Welfare that cannabis be placed in Schedule I "at least until the completion of certain research." *Id.*

Although the CSA provides a mechanism to administratively reschedule cannabis without legislative intervention, *see* 21 U.S.C. § 811, neither DEA nor the Attorney General has ever exercised that prerogative. In fact, DEA repeatedly rejects requests to reschedule. Most recently, in August 2016, it denied a petition from the states of Rhode Island and Washington. *See* Ex. 16 (A157). The agency's rationale for refusing to reschedule is always the same: the dearth of clinical trials demonstrating

cannabis's medical efficacy. *See, e.g.*, *id.* at A154. ("[T]here are no adequate and well controlled studies proving efficacy.").

I. Through a "closed" regulatory regime, DEA tightly controls clinical research with controlled substances.

a. Registration framework.

The CSA establishes a "closed" registration system. *Raich*, 545 U.S. at 13. Manufacture and distribution may occur only among registered handlers of controlled substances, referred to as "registrants." *See id.*; 21 C.F.R. § 1300.02(b) (2017). Thus, anyone seeking to manufacture or distribute a controlled substance must apply to DEA. 21 U.S.C. § 822(a)(1). DEA grants a registration if it determines that doing so is consistent with (1) the public interest and (2) U.S. obligations under the Single Convention on Narcotic Drugs, 1961. *Id.* § 823(a).

DEA has promulgated rules and regulations to implement these registration requirements. *See id.* § 821. 21 C.F.R. § 1301.13 (2014), for example, establishes application fees. Section 1301.14(c) explains how DEA processes applications:

> Applications submitted for filing are dated upon receipt. If found to be complete, the application will be accepted for filing. Applications failing to comply with the requirements of this part will not generally be accepted for filing. In the case of minor defects as to completeness, the Administrator may accept the application for filing with a request to the applicant for additional information. A defective application will be returned

> to the applicant within 10 days following its receipt with a statement of the reason for not accepting the application for filing. A defective application may be corrected and resubmitted for filing at any time; the Administrator shall accept for filing any application upon resubmission by the applicant, whether complete or not.

21 C.F.R. § 1301.14(c) (2010).

DEA's authority over the registration process is not without limits. For example, the agency must register only the number of bulk manufacturers of a Schedule I or II substance necessary to "produce an adequate and uninterrupted supply of these substances under adequately competitive conditions for legitimate medical, scientific, research, and industrial purposes." 21 U.S.C. § 823(a)(1); 74 Fed. Reg. 2,101, 2,127-2,130 (Jan. 14, 2009) (discussing section 823(a)(1)). From the time it was passed in 1970 until 2015, however, the CSA placed no deadlines on DEA's duty to process applications to manufacture controlled substances.

b. Delays in processing applications and scheduling.

Without deadlines, DEA could delay processing applications—even those seeking to facilitate clinical research—for years, with little recourse available to the applicant. These delays can be detrimental to innovation and public health, and they began to cause problems as the CSA moved into the 21st century.

The cases of Belviq and Fycompa are illustrative. *See generally Eisai, Inc. v. FDA*, 134 F. Supp. 3d 384, 387 (D.D.C. 2015) (chronicling the two drugs' stories). The U.S. Food and Drug Administration ("FDA") approved Belviq in June 2012, but the U.S. Department of Health and Human Services ("HHS") recommended the drug for scheduling. With no timetable governing its review, DEA took another year to approve the drug's placement in Schedule IV, delaying its entry into the market. *Id.* at 389. The story with Fycompa, a drug used to treat seizures in patients suffering from epilepsy, is largely the same. *See id.* In fact, the agency's fourteen-month delay led Eisai to seek mandamus from this Court.[1]

Problems with delay were felt all-around, including with controlled substances like cannabis. In one notable instance, an applicant waited more than three years after applying before the agency responded, proposing a denial. *Craker v. DEA*, 714 F.3d 20-21 (1st Cir. 2013). The saga spanned an entire decade, start to finish. *Id.* at 29.

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[1] Eisai filed a petition in this Court on August 13, 2013. *See In re Eisai Inc.*, No. 13-1243, Doc. 1452261 (D.C. Cir.). Eisai argued that DEA's failure to timely schedule Fycompa was unreasonable and asked the Court to intervene. DEA responded that it expected to act by the end of October. *Id.* at Doc. 1454740. Then, through an October 17, 2013 notice, DEA informed the Court that the rule was submitted for publication in the Federal Register. The Court denied the mandamus petition the next week. *Id.* at Doc. 1462438.

c. Congress adds statutory deadlines to address opaqueness and delay in DEA's processing of a single class of applications: those seeking to manufacture for clinical trials.

In 2015, Congress passed the "Improving Regulatory Transparency for New Medical Therapies Act," H.R. No. 639, Pub. L. No. 114-89, 129 Stat. 703 (2015). Relevant here, the Act added section 823(i)(2), which requires the Attorney General to notice applications to manufacture Schedule I substances for clinical research not later than 90 days after the application is "accepted for filing":

> For purposes of registration to manufacture a controlled substance under subsection (a) for use only in a clinical trial, the Attorney General shall, in accordance with the regulations issued by the Attorney General, issue a notice of application not later than 90 days after the application is accepted for filing. Not later than 90 days after the date on which the period for comment pursuant to such notice ends, the Attorney General shall register the applicant, or serve an order to show cause upon the applicant in accordance with section 824(c) of this title, unless the Attorney General has granted a hearing on the application under section 958(i) of this title.

21 U.S.C. § 823(i)(2).

The purpose of the amendment was clear: to improve transparency and to prioritize applications relating to clinical research. In a section titled "Background and Need for Legislation," the House Report underscores three needs triggering the new "timetable": (1) addressing "[i]nconsistency and lengthy review times at DEA," (2) distinguishing between

"manufacturing of a controlled substance *for marketing* and the manufacturing of a controlled substance *for use in clinical trial*," and (3) putting in place a "*transparent process* for the applicant to determine the reasons for a delay in the application." Ex. 18 at A168-69 (emph. added).

II. SRI falls within the class of researchers Congress sought to protect from delay.

SRI is an Arizona company dedicated to clinical research. To date, it is the only entity federally approved to do clinical research into the effects of cannabis on veterans with treatment-resistant PTSD. SRI does not encourage or sanction recreational cannabis use, but it does support research to determine the applicability of cannabis as medicine. *See* Decl. at ¶ 2.

The journey of SRI's principal, Dr. Sue Sisley, is well-documented. Over a decade ago, she treated veterans with PTSD in her private practice. Sisley prescribed approved medicines on the market, but discovered that for some, none helped. Many clients disclosed that cannabis worked better. For some, it was the only thing that worked. These experiences inspired her to do clinical research into the safety and efficacy of cannabis with veterans suffering from PTSD. *See* Decl. at ¶¶ 7-11.

Little did she know how difficult it would be. Start to finish, it took her *seven* years to amass the necessary approvals just to *begin* the study.

Unlike other controlled substances, clinical research with cannabis requires obtaining approval from four federal agencies, on top of Institutional Review Board approval. *See* Decl. at ¶¶ 8-19 & n.8 (discussing CNN's Weed 3 documentary); *see also* Ex. 21 (A179) (Rolling Stone article titled "Why Is It So Hard to Study Pot?"). She put together a protocol in 2009, which the FDA approved in 2011. Over the next three years, Sisley secured the approvals of the United States Public Health Service and the National Institute on Drug Abuse ("NIDA"), which was necessary to acquire cannabis for the study. Finally, after other significant setbacks, she obtained a Schedule I research license from DEA in April 2016. Only after obtaining these approvals could the research proceed. *See* Decl. at ¶¶ 12-18.

In January 2017, SRI, with the support of the Multidisciplinary Association for Psychedelic Studies ("MAPS"), began its triple-blind clinical study of smoked whole-plant cannabis to treat PTSD symptoms in veterans. A $2.1 million grant to MAPS from the Colorado Department of Public Health and Environment funded the study. Phase II trials[2] finished in

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[2] Phase II trials aim to determine if a treatment works, and usually involve 25 to 100 study subjects. Phase III trials compare the safety and effectiveness of a drug against other treatments and involve far more study subjects.

February 2019. *See* Decl. at ¶ 19. As we next explain, however, low-quality government cannabis hampered the research.

Additional trials with veterans are imminent. SRI also hopes to begin clinical trials to assess the efficacy of cannabis to treat breakthrough pain in cancer patients soon. *See* Decl. at ¶ 26.

III. The current supply of federally legal cannabis stifles clinical research.

a. The NIDA monopoly.

For almost 50 years, the only legal source of cannabis for research in the United States has been a single farm at the University of Mississippi. *See generally Craker*, 714 F.3d at 20 (1st Cir. 2013); Ex. 16 at A158 (81 Fed. Reg. 53,846) ("For nearly 50 years, the United States has relied on a single grower to produce marijuana used in research.").

The quality of the cannabis from this farm—and its delivery logistics—are poor. Some has languished on the shelves for years. It looks more like green talcum powder than medical grade cannabis, Decl. at ¶ 21 & n.11:

Most samples SRI received contained extraneous plant material like sticks and seeds. Ex. 14 at A149-A152 (Lab Report). Others had mold. *See id.* at A146. Also, the government demands researchers indemnify the government to use this study drug, *see* Decl. at ¶22:

SRI complies with federal law, so it had to use this cannabis. Unfortunately, its poor quality undermined results. For example, Sisley observed that sticks and seeds caused bronchial irritation in some subjects. Decl. at ¶ 23. SRI is reticent to indemnify the government, especially because it has told the government it is willing and able to manufacture its own, on-site, high-quality, fresh cannabis under the agency's strict regulations and supervision. *See id.* at ¶ 24. This cannabis is inadequate for a third important reason: Phase III trials require cannabis virtually identical to material used in proposed pharmaceutical medicine. *See id.* at ¶ 25.

Now, SRI looks north of the border for true medical-grade cannabis, because the cannabis from NIDA falls short. *See id.* at ¶ 26.

b. To address supply issues, DEA solicits applications to register additional manufacturers of cannabis for clinical research.

On August 12, 2016, DEA denied a petition from Rhode Island and Washington to reschedule cannabis as a Schedule I substance. Ex. 15 (A153) (81 Fed. Reg. 53,687 (Aug. 12, 2016)). But it also committed to improving the supply of cannabis suitable for clinical research.

DEA explained: "the available evidence is not sufficient to determine that marijuana has an accepted medical use" and "more research is needed into marijuana's effects, including potential medical uses for marijuana and its derivatives." *Id.* at A155 (81 Fed. Reg. at 53,689). In the letter accompanying the denial, DEA declared "[r]esearch . . . the bedrock of science," and committed to "support and promote legitimate research regarding marijuana and its constituent parts." Ex. 22 at A194.

Consistent with that goal, DEA issued a separate notice announcing a new policy to increase the number of entities registered to manufacture cannabis. Ex. 16 (A157) (81 Fed. Reg. 53,846 (Aug. 12, 2016)). DEA declared its "full[] support" of cannabis research and "concluded that the best way to satisfy the current researcher demand for a variety of strains of

marijuana and cannabinoid extracts is to increase the number of federally authorized marijuana growers." *Id.* at A158.

c. Answering DEA's call, SRI applies to manufacture cannabis for its clinical research.

Shortly after DEA's August 2016 policy statement, SRI applied to manufacture cannabis to support its clinical research. Ex. 1 (A001) (Oct. 2016 Application); Decl. at ¶ 27. Weeks later, Sisley answered a supplemental questionnaire the agency had remitted. Ex. 2 (A005) (Questionnaire); Decl. at ¶ 28. Asked how cannabis grown by SRI would be used, Sisley stated that the existing supply was not adequate for its clinical trials:

> [SRI] is preparing for phase 3 FDA approved drug development clinical trials with cannabis. Our ultimate goal involves evaluating whether cannabis can be turned into a prescription medicine. The only way to conduct this analysis is through phase 3 trials. However the current supply of research cannabis from cannot be utilized for prescription drug development. It can only be used for academic research. Which is why we are seeking to cultivate a new supply of cannabis to be used for these Phase 3 FDA trials.

Ex. 2 at A011. Sisley also told DEA that SRI could supply other clinical trials in the future. *See id.* at A008, 010, 012.

d. After soliciting applications, DEA processes none of them.

The number of applications the agency has processed since August 2016 is zero.

This delay is unusual, unprecedented even. The typical time from application submission to a notice in the Federal Register is months, not years. A 2016 DEA presentation says the process takes *as much* as 4-6 months to complete. Ex. 3 at A083 (DEA Presentation). DEA routinely processes applications within this timeframe:

- On December 12, 2018, Siemens Healthcare Diagnostics Inc. applied to be a bulk manufacturer of Ecgonine, a Schedule II substance. A notice in the Federal Register followed on March 21, 2019. 84 Fed. Reg. 10,534.
- On October 12, 2018, Johnson Matthey Inc. applied to be a bulk manufacturer of Schedule I and II substances. A notice in the Federal Register followed on February 21, 2019. 84 Fed. Reg. 5,477.
- On August 22, 2018, Insys Manufacturing, LLC applied to be a bulk manufacturer for Marijuana and Tetrahydrocannabinols to produce synthetic ingredients for product development and distribution to customers. A notice in the Federal Register followed on March 21, 2019. 83 Fed. Reg. 54,611.

The agency approved eight applications in September 2017, *see* 82 Fed. Reg. 44,842 (Sept. 26, 2017), and seven more in May 2018, *see* 83 Fed. Reg. 22,518 (May 15, 2018). In short, these applications do not take years to process.

e. Substantial efforts to obtain agency action without Court intervention have failed.

Sisley has repeatedly reached out to DEA to check the status of SRI's application. *See, e.g.*, Ex. 13 (A139) (Aug. 30, 2018 e-mail); *see also* Decl ¶¶ 30-31. Every time, the message is the same: no progress.

This unusual delay has sparked media attention. *See, e.g.*, Ex. 19 (A170) (article titled "Marijuana-Research Applications Go Nowhere at Justice Department"); Ex. 20 (A174) (article titled "Justice Department at Odds with DEA on Marijuana Research, MS-13" explaining how government officials were "sitting on" applications and that DOJ "effectively shut down" the program). Members of Congress from both sides of the aisle have repeatedly asked the Attorney General and DEA for status updates:

- **April 12, 2018:** former Senator Hatch and Senator Harris ask for an update on applications to manufacture cannabis for research and a commitment to resolve outstanding applications by August 11, 2018. Ex. 5 (A107).
- **July 25, 2018:** a bipartisan group of eight senators inquire about the status of the applications and request answers by August 10. Ex. 9 (A124).
- **August 30, 2018:** a bipartisan group of congressmen write to the Secretary of Veterans Administration about the need to conduct "a rigorous clinical trial into the safety and efficacy of medicinal cannabis for veterans with post-traumatic stress disorder (PTSD) and

chronic pain so that we can better understand the potential benefits or dangers of medicinal cannabis." Ex. 6 (A112).

- **August 31, 2018:** another bipartisan group of congressmen urge DEA to end the delay. Ex. 7 (A115).
- **September 28, 2018:** another bipartisan group of fifteen congressmen express concern over DEA's delay. Ex. 8 (A119).
- **March 28, 2019:** Senators Schatz and Booker urge the Attorney General to move forward. Ex. 10 (A128).
- **April 2, 2019:** another bipartisan group of six senators question DEA's efforts to process applications. Ex. 11 (A131).
- **May 7, 2019:** another bipartisan group of *thirty* congressmen urge the agency to do more "because the matter is of such importance." Ex. 12 (A135).

To SRI's knowledge, neither the Attorney General nor DEA has responded to *any* of these inquiries. In fact, as of December 28, 2018, DEA reported that it "continues to review applications for registration . . . ." 83 Fed. Reg. 67,348, 67,350 (Dec. 28, 2018). Thus, well past the two-and-a-half-year mark, SRI's application continues to languish in agency purgatory.

SUMMARY OF THE ARGUMENT

DEA's delay in noticing or responding to SRI's application is unlawful, unreasonable, and egregious. It contravenes the letter and spirit of the CSA, seriously harms SRI, and hampers SRI's efforts to help suffering veterans through clinical research. Everyone—including the agency—agrees that this research is important and that the need for research generally is urgent. Here, DEA can act with little expenditure of resources.

The Court should issue the extraordinary writ of mandamus because DEA's inexplicable delay is the only remaining impediment to research of urgent importance to the health and welfare of millions of Americans.

STANDING

When a claim is based on an alleged deprivation of a procedural right, such as the right to have an agency process an application consistent with congressional command, "the primary focus of the standing inquiry is not the imminence or redressability of the injury to the [petitioner]" but instead whether "the government act performed without the procedure in question will cause a distinct risk to a particularized interest of the plaintiff." *City of Dania Beach v. FAA*, 485 F.3d 1181, 1185 (D.C. Cir. 2007) (cites omitted). A petitioner in such a case "never has to prove that if he had received the

procedure the substantive result would have been altered." *Sugar Cane Growers Co-op. of Fla. v. Veneman*, 289 F.3d 89, 94 (D.C. Cir. 2002). Instead, "[a]ll that is necessary is to show that the procedural step was connected to the substantive result." *Id.* at 94-95.

Petitioner has standing because it is suffering an injury directly traceable to DEA's delay in processing its application that can be redressed by the relief requested. *See generally Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). Petitioner submitted its application to manufacture cannabis for use in clinical trials and paid DEA thousands of dollars. *See* Ex. 4 at A106 (showing application fee). Under the plain language of both section 823(i)(2) and the APA, Petitioner was entitled to have DEA issue a notice regarding its application in the Federal Register to commence the process for determining whether Petitioner should be registered under the Act. 21 U.S.C. § 823(i)(2); 81 Fed. Reg. at 53,848. Petitioner and its patients have suffered other harms as well from the agency's inaction, including being saddled with cannabis ill-suited for clinical research.

ARGUMENT: REASONS WHY THE WRIT SHOULD ISSUE

I. Legal Standard

To show entitlement to mandamus, SRI must demonstrate: "(1) a clear and indisputable right to relief, (2) the government agency or official is violating a clear duty to act, and (3) that no adequate alternative remedy exists." *Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183, 189 (D.C. Cir. 2016) (citing *United States v. Monzel*, 641 F.3d 528, 534 (D.C. Cir. 2011)). These requirements are jurisdictional; unless all are met, the Court must dismiss. *Id.* (cites omitted). "Even when the legal requirements for mandamus jurisdiction have been satisfied, however, a court may grant relief only when it finds compelling equitable grounds." *Id.* (quoting *In re Medicare Reimbursement Litig.*, 414 F.3d 7, 10 (D.C. Cir. 2005)). SRI must therefore show that its "right to issuance of the writ is clear and indisputable." *Id.* (quoting *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002)).

Mandamus claims like SRI's that "target agency delay[] turn on 'whether the agency's delay is so egregious as to warrant mandamus.'" *Id.* (quoting *In re Core Commc'ns, Inc.*, 531 F.3d 849, 855 (D.C. Cir. 2008)). In making that assessment, this Court looks to the so-called "*TRAC* factors"

> (1) the time agencies take to make decisions must be governed by a "rule of reason"; (2) where Congress has provided a timetable or other indication of the speed with which it expects

> the agency to proceed in the enabling statute, that statutory scheme may supply content for this rule of reason; (3) delays that might be reasonable in the sphere of economic regulation are less tolerable when human health and welfare are at stake; (4) the court should consider the effect of expediting delayed action on agency activities of a higher or competing priority; (5) the court should also take into account the nature and extent of the interests prejudiced by delay; and (6) the court need not "find any impropriety lurking behind agency lassitude in order to hold that agency action is 'unreasonably delayed.'"

TRAC, 750 F.2d at 80 (cites omitted).

"[W]here the statute imposes a deadline or other clear duty to act, the bulk of the *TRAC* factor analysis may go to the equitable question of whether mandamus *should* issue, rather than the jurisdictional question of whether it *could*." *Am. Hosp. Ass'n*, 812 F.3d at 189-90. That is the case here. Accordingly, SRI folds its discussion of the first two jurisdictional requirements into its analysis of the *TRAC* factors and addresses the only remaining jurisdictional issue—whether an adequate alternative remedy exists—separately.

II. DEA's egregious delay warrants mandamus.

DEA's "recalcitrance . . . in the face of a clear statutory duty" calls out for mandamus. *Pub. Citizen Health Research Grp. v. FDA*, 740 F.2d 21, 32 (D.C. Cir. 1984) (citing 5 U.S.C. §§ 555(b), 706(1)). The first five *TRAC* factors strongly favor the exercise of equitable discretion, and the sixth—improper conduct or motive—is not a prerequisite for mandamus. *TRAC*,

750 F.2d at 80. The APA commands DEA "to conclude a matter presented to it within a reasonable time," 5 U.S.C. § 555(b), and courts must "compel agency action unlawfully withheld or unreasonably delayed," *id.* § 706(1). If those imperatives apply anywhere, they apply here.

a. Congress's mandate that DEA "issue a notice of application not later than 90 days after the application is accepted for filing" supplies the applicable rule of reason.

Of the six *TRAC* factors, "[t]he first and most important . . . is that 'the time agencies take to make decisions must be governed by a "rule of reason."'" *In re Core Comm'cns, Inc.*, 531 F.3d at 855 (quoting *TRAC*, 750 F.2d at 80). Even absent an express statutory deadline, this factor can weigh in favor of mandamus. But as the second *TRAC* factor clarifies, the analysis is simpler where "Congress has provided a timetable or other indication of the speed with which it expects the agency to proceed." *TRAC*, 750 F.2d at 80. When Congress commands an agency to complete a discrete, ministerial duty within a defined timeframe, the "statutory scheme suppl[ies] content for this rule of reason . . . ." *Id.*

That is the case here. Section 823(i)(2)'s command that DEA "shall, in accordance with the regulations issued by the Attorney General, issue a notice of application not later than 90 days after the application is accepted for filing," imposes a non-discretionary duty on DEA to take a discrete,

ministerial action. 21 U.S.C. § 823(i)(2). The statute conveys both a clear duty (on DEA) and an equally clear right (on SRI). Once SRI's application was accepted for filing, DEA had a duty to "issue a notice of [SRI's] application," and SRI's indisputable right to receive that notice within "90 days" arose automatically. *See* Ex. 16 at A160 (recognizing applicants' "due process" interest in having DEA process application to manufacture).[3]

In cases like this one, where Congress has given the agency a *specific* task to complete within a *relatively brief* timeframe, this Court has described "Congress's intent that that agency act promptly" as "manifest[ ]." *In re People's Mojahedin Org. of Iran*, 680 F.3d 832, 837 (D.C. Cir. 2012); *compare, e.g., Baptist Mem. Hosp. v. Sebelius*, 603 F.3d 57, 63 (D.C. Cir. 2010) (denying mandamus relief because there is no clear duty to act where the statutory language—"may"—is permissive and not mandatory). Although there "is 'no *per se* rule as to how long is too long' to wait for agency action," this Court has held that "a reasonable time for agency action is typically counted in weeks or months, not years." *In re Am. Rivers and Idaho Rivers United*, 372 F.3d 413, 419 (D.C. Cir.

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[3] Of course, the agency also has a duty not to unreasonably delay agency action under the APA. *See* 5 U.S.C. §§ 555(b), 706(1). The 90-day deadline confirms that Congress intended reasonable delay to be months, not years.

2004) (quoting *In re Int'l Chem. Workers Union*, 958 F.2d 1144, 1149 (D.C. Cir. 1992) (per curiam)); *see also, e.g.*, *MCI Telecomms. Corp. v. FCC*, 627 F.2d 322, 327 (D.C. Cir. 1980) (over three years); *Midwest Gas Users Ass'n v. FERC*, 833 F.2d 341, 359 (D.C. Cir. 1987) (four years).

In *People's Mojahedin*, for example, this Court held that a twenty-month failure to act on a 180-day statutory deadline "plainly frustrates the congressional intent and cuts strongly in favor of granting [the] mandamus petition." 680 F.3d at 837. DEA's inaction in this case is far more egregious: in the face of a command to complete a ministerial act due in half the time, the agency has unlawfully withheld the required action for almost twice as long. If an agency's refusal to act that exceeds the statutory timeframe by 333% "cuts strongly in favor of granting [the] mandamus petition," as this Court held in *People's Mojahedin*, 680 F.3d at 837, then it is hard to see how unexplained delay outstripping the congressionally-imposed timeframe by a staggering 1200% (and counting) is not also egregious.

DEA's delay also indisputably "frustrates congressional intent." *Id.* Congress imposed the 90-deadline in section 823(i)(2) as a direct response to DEA's delays with respect to applications like SRI's. *See* Ex. 18 at A168-69 (explaining that purpose of amendment was to remedy "[i]nconsistency and *lengthy* review times at DEA" and to establish a "*transparent process*

for the applicant to determine the reasons for a delay in the application.") (emph. added). DEA's flat disregard of that mandate doesn't just *frustrate* Congress's purpose; it eviscerates it. This strongly favors mandamus. *See Cutler v. Hayes*, 818 F.2d 879, 897-98 (D.C. Cir. 1987) ("The court must also estimate the extent to which delay may be undermining the statutory scheme.").

Several other considerations confirm the unreasonableness of the delay. First, DEA interprets similar statutory deadlines under the CSA as requiring agency action by a date certain. Consider, for example, section 811(j), another 90-day deadline Congress added to the CSA with the 2015 Improving Regulatory Transparency for New Medical Therapies Act. 21 U.S.C. § 811(j). In language that mirrors section 823(i)(2)'s mandate, section 811(j) provides that when DEA receives notification from HHS that it has indexed a drug under section 572 of the Food Drug and Cosmetic Act, 21 U.S.C. § 360, "the Attorney General shall, not later than 90 days after the date described in paragraph (2), issue an interim final rule . . . ." 21 U.S.C. § 811(j)(1).

Less than a year after both sections 811(j)(1) and 823(i)(2) were added to the CSA, DEA had already issued an interim final rule within section 811(j)(1)'s 90-deadline. In that interim rule, DEA noted the

deadlines Congress had imposed in the 2015 amendment and interpreted the 90-day deadline in section 811(j)(1) as requiring it to act on HHS's recommendation "not later than 90 days" after the date described in section 811(j)(2). 81 Fed. Reg. 58,834, 58,835 (Aug. 26, 2016). "[I]dentical words used in different parts of the same statute are generally presumed to have the same meaning." *IBP, Inc. v. Alvarez*, 546 U.S. 21, 34 (2005). *See also Ne. Hosp. Corp. v. Sebelius*, 657 F.3d 1,11 (D.C. Cir. 2011) (same).

Here, the agency's disparate treatment of these twin deadlines is not reasonable. Indeed, though Congress gave DEA 90 days to complete the tasks required under sections 811(j)(1) and 823(i)(2), the agency's duty under the former requires substantially more resources than its duty under the latter. Unlike section 823(i)(2), which merely requires DEA to publish a two-page notice in the Federal Register, section 811(j)(1) requires the agency to "issue an interim final rule" controlling a drug. The August 26, 2016 interim final rule discussed above fills 15 pages of the Federal Register. DEA's ability to complete these complex administrative tasks in 90 days underscores the egregiousness of its failure to take simpler action here.

Second, other CSA provisions give DEA *less* time to do *more*. Section 823(i)(1), for example, gives DEA just 180 days to process, review, and decide whether to grant or issue an order show cause as to applications to

manufacture other controlled substances for use in clinical trials. 21 U.S.C. § 823(i)(1). If six months is a reasonable amount of time for DEA to process, review, and issue an initial decision with respect to similar applications, then it is more than enough time to do far less: notice SRI's application. Other examples abound.[4]

Third, DEA routinely notices applications to manufacture controlled substances, including cannabis, months after filing. *See* examples listed *supra* p. 17. And in a presentation DEA's Office of Diversion Control made in mid-April 2016—right around the time that it received SRI's application—the agency described its process for noticing applications in detail before warning that it *sometimes* "takes 4-6 *months* to complete." Ex. 3 at A083 (2016 DEA Presentation) (emph. added). Whether measured by the agency's past practice or its public statements, the delay at issue here is beyond the pale.

Fourth, DEA's extensive delays persist years after (1) Congress amended the statute to demand the very action DEA continues to withhold, (2) DEA told the public it desired applications like SRI's, *see* Ex. 16 (A158), and (3) DEA publicly acknowledged SRI's due process right to

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4 *E.g.*, 21 U.S.C. § 826(h)(1), § 826a, § 827(f)(1)-(3)(A).

consideration of its application, *id.* at A160 ("Any person who applies for a registration to grow marijuana . . . is entitled to due process in the consideration of the application by the Agency."). There is no excuse for DEA's refusal to act in this case. Nor is there any reason to believe it will act absent judicial intervention. Accordingly, the Court should not hesitate to exercise its equitable discretion.

b. DEA's unreasonable delay has caused and continues to cause extreme prejudice and concrete harm to health and human welfare.

The third and fifth *TRAC* factors, which assess the impact of the delay, strongly favor mandamus. 750 F.2d at 80. Under the third *TRAC* factor, courts recognize that delays that relate to health and welfare are more likely to necessitate judicial intervention than those that simply may have economic consequences. *Id.* Under the fifth *TRAC* factor, courts consider the nature and extent of the interests prejudiced by the agency's delay. *Id.* These factors are appropriately addressed together because the prejudice SRI suffers is co-extensive with the harm courts have found particularly suited for mandamus relief: harm to human health and welfare.

It was concern for human health and welfare that prompted Congress to add statutory deadlines to the CSA provisions requiring DEA to process applications to manufacture controlled substances for use in clinical trials.

The Committee Report on H.R. 639—the bill that would eventually become the "Improving Regulatory Transparency for New Medical Therapies Act"—explains that the deadlines were necessary "to facilitate patient access to new therapies in an efficient and transparent manner . . . ." Ex. 18 at A168-69; *see also* Ex. 19 at A164 (representative Pitts stating that deadlines were meant to "improve the transparency and consistency of the [DEA]'s . . . registration process for the manufacture of controlled substances for use in clinical trials" because doing so would "allow new and innovative treatments to get to patients who desperately need them"); *id.* ("This legislation was introduced . . . to provide a solution to delays experienced by patients in need."); *id.* ("Further, section 3 of this bill would bring much-needed certainty to another open-ended DEA process . . . manufacturers of controlled substances intended to be used in clinical trials for products not yet approved by the FDA."). Representative Pitts, Chairman of the House Subcommittee on Health of the Committee on Energy and Commerce explained:

> This bill also establishes a timeline for DEA to grant approval of manufacturers' applications to register controlled substances not yet approved by FDA to be used in clinical trials, allowing companies to properly plan clinical trial schedules for prospective new therapies. *This provision will get products to the market faster because innovators will be able to get clinical*

> *trials under way in a timely and predictable way, which is critical to drug developers and patients alike.*

Ex. 23 at A199 (hearing remarks) (emph. added).

DEA's ongoing delays on an issue so vital to public health have frustrated just about everyone. As one bipartisan group of Senators put it in their July 25, 2018 letter to then Attorney General Jeff Sessions: "Our nation's need for meaningful federally sanctioned research is critical" because "[r]esearch and medical communities should have access to research-grade materials to answer questions around marijuana's efficacy and potential impacts, both positive and adverse." Ex. 9 at A125. And just a week ago, a Second Circuit panel reviewing the propriety of classifying cannabis as a Schedule I substance emphasized that, in light of the "unusual health related circumstances" implicated by DEA's approach to cannabis regulation, "what has counted as appropriate speed in the past may not count as appropriate speed" anymore. *Washington v. Barr,* No. 18-859-CV, 2019 WL 2292194, at *8 (2d Cir. May 30, 2019).

Millions of Americans believe cannabis holds the key to ending their pain and suffering, making the need for clinical trials acute no matter the outcome of SRI's clinical trials. If those studies show that thirty-eight states (and counting), doctors, legislators, and the American public are all

wrong—i.e., that cannabis lacks medical utility—then we must know this now. Those using cannabis to treat conditions like PTSD may be jeopardizing their health and welfare. But in the more likely alternative—i.e., SRI's studies prove that cannabis has medical value—DEA's delay inexcusably deprives combat veterans and others of a treatment option necessary to ease their pain. Either way, more delay is unconscionable.

Simply put, the ongoing harm to human health from DEA's delay in this case is *certain*. As a result, any deference owed the agency is "sharply reduced." *See Cutler*, 818 F.2d at 898 ("The deference traditionally accorded an agency to develop its own schedule is sharply reduced when injury likely will result from avoidable delay.").

DEA's delay is also a disincentive to investors. As DEA has acknowledged, "[f]unding may actually be the most important factor in whether research with marijuana (or any other experimental drug) takes place." Ex. 16 at A158, n.2. But when DEA won't even process applications to obtain the materials to *begin* research, investors are less likely to support the research to completion. Where economic considerations implicate human health and welfare, this Court has favored compelling agency action. *See TRAC*, 750 F.2d at 86 (finding that the third *TRAC* factor weighed in favor of compelling agency action because of impact on health and human

welfare where the agency had delayed adjudicating claims for a form of unemployment assistance payments).

Zooming out brings other important concerns into focus. For example, it is no secret that, despite federal prohibition, medicinal cannabis is a growing billion-dollar industry at the state level; it might be the largest industry focused solely on transacting contraband since Prohibition. And with that comes profound economic consequences. The conflict between state and federal law is reason enough to compel the agency to act. DEA says the main obstacle preventing it from recognizing medicinal cannabis at the federal level is the lack clinical research. SRI is trying to solve that problem. But the agency won't act, making the problem worse, not better.

Were it just human health and welfare at stake, the case for mandamus would be quite compelling. But the convergence of health interests and important national interests behind SRI's application should remove any hesitation this Court may have.

c. No competing priority justifies DEA's delay.

DEA's unlawful delay has not been, and cannot be, justified by any need to attend to competing priorities. *TRAC*, 750 F.2d at 80. Because Congress expressly amended the CSA to add deadlines for clinical-research-based manufacture applications, it necessarily concluded that these

applications must be an agency priority. *See People's Mojahedin*, 680 F.3d at 837 (where command is specific and deadline to act imposed is relatively brief, Congress's intent that the agency act with dispatch is "manifest[]").

Moreover, just three months ago, the President issued an Executive Order on a National Roadmap to Empower Veterans and End Suicide declaring "we must do better in fulfilling our solemn obligation to care for all those who have served our country," that it "*is the policy of the United States* to end veteran suicide through the development of a comprehensive plan to empower veterans and end suicide through coordinated suicide prevention efforts, *prioritized research activities*, and strengthened collaboration across the public and private sectors," that "[a]nswering this call to action requires an aspirational, innovative, all-hands-on-deck approach to public health — *not government as usual*." Exec. Order No. 13,861, 84 Fed. Reg. 8,585 (Mar. 5, 2019) (emph. added). Noticing SRI's application would be a great start.

Where an agency offers no "'plea of administrative error, administrative convenience, practical difficulty in carrying out a legislative mandate, or need to prioritize in the face of limited resources,"' this factor favors mandamus. *In re Am. Rivers*, 372 F.3d at 420 (quoting *Cutler*, 818 F.2d at 898). DEA has never offered such a plea, and for good reason. It

cannot seriously argue drafting and publishing a two-page notice in the Federal Register would deplete agency resources. This is the epitome of perfunctory.

Accordingly, this *TRAC* factor also underscores the urgency of mandamus relief.

d. Agency impropriety is not a prerequisite for mandamus.

SRI does not concede the purity of DEA's motives,[5] but ultimately, the agency's intent is of little concern. The manifest egregiousness of its ongoing delay justifies mandamus even without ill intent. *See TRAC*, 750 F.2d at 80.

III. SRI has no adequate alternative remedy.

Mandamus is SRI's only path to relief. The "no adequate remedy" requirement is "'a condition designed to ensure that the writ will not be used as a substitute for the regular appeals process."' *United States v. Jicarilla Apache Nation*, 564 U.S. 162, 206 n.11 (2011) (Ginsburg, J., concurring) (quoting *Cheney v. United States Dist. Ct. for D.C.*, 542 U.S.

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[5] *See* Ex. 19 (A170) (article quoting official who said DOJ "effectively shut down [the] program to increase research registrations"); *cf. Washington*, 2019 WL 2292194, at *7 (May 30, 2019) (average delay in deciding petitions to reclassify drugs approximately nine years).

367, 380-81 (2004)). Mandamus is appropriate, however, when an agency's unreasonable delay threatens to thwart judicial review, making issuance of the writ necessary "to protect its future jurisdiction." *TRAC*, 750 F.2d at 76; *Gottlieb v. Pena*, 41 F.3d 730, 734 (D.C. Cir. 1994) ("[T]he proper recourse for a party aggrieved by delay that violates a statutory deadline is to apply for a court order compelling agency action.") (cites omitted).

Here, DEA's refusal to take even the simplest administrative step cuts off all other avenues of judicial review, thrusting SRI's application into administrative purgatory.

CONCLUSION

Petitioner SRI respectfully requests this Court issue a writ of mandamus compelling the Attorney General, DEA, or its Acting Administrator to issue a "notice of application" by 90 days from the date of service of this amended petition or fifteen days after the writ issues, whichever is later. Notably, mandamus here will not divest the agency of its discretion. It simply allows the process contemplated by the statute to begin, not end. The agency still maintains discretion to deny or delay the application, *see, e.g.*, 21 U.S.C. § 823(i)(2) (". . . the Attorney General shall register the applicant, *or serve an order to show cause* upon the applicant

in accordance with section 824(c) . . ."), should that continue to be its choice.

Dated June 11, 2019

Respectfully Submitted,

Matthew C. Zorn (admission pending)
Shane Pennington
YETTER COLEMAN LLP
811 Main Street, Suite 4100
Houston, Texas 77002
(713) 632-8000
mzorn@yettercoleman.com
spennington@yettercoleman.com

Counsel for Petitioner
Scottsdale Research Institute, LLC

CERTIFICATE OF COMPLIANCE

This Petition complies with the Federal Rule of Appellate Procedure 21(d) because it contains 7,773 words, excluding the accompanying documents required by Rule 21(a)(2)(C).

I further certify that this Petition complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because the Petition has been prepared in Georgia 14-point font for text and footnotes using Microsoft Word.

Dated June 11, 2019

<u>/s/ Shane Pennington</u>
Shane Pennington
YETTER COLEMAN LLP
811 Main St. Suite 4100
Houston, TX 77002
(713) 632-8000

Counsel for Petitioner
Scottsdale Research Institute, LLC

CERTIFICATE OF SERVICE

I certify that on June 11, 2019, I caused this amended petition, including all exhibits and addenda, to be served by U.S. postal mail and/or Federal Express on Respondents, as follows:

William P. Barr, Attorney General
United States Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530

Uttam Dhillon, Acting Administrator
United States Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

United States Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

/s/ Shane Pennington
Shane Pennington

ADDENDA

Certificate as to Parties, Rulings, and Related Cases

Pursuant to D.C. Circuit Rules 21(d) and 28(a)(1), counsel for Petitioner states as follows:

A. Parties and Amici

SRI and Respondents William P. Barr, Uttam Dhillon, and DEA are the only parties to this matter. SRI is not aware of any amici who may appear.

B. Rulings Under Review

This is a corrected petition for a writ of mandamus to redress agency action unlawfully withheld and unreasonable delayed by DEA in noticing Petitioner's application. Accordingly, there is no agency or judicial decision under review.

C. Related Cases

Although there are no related cases that have been litigated in the district court, in this Court, or elsewhere, SRI may file a petition for review in this Court concurrent with this petition in a separate action soon after.

/s/ Shane Pennington
Shane Pennington

Dated: June 11, 2019

Corporate Disclosure Statement

In accordance with Federal Rule of Appellate Procedure 26.1 and D.C. Circuit Rule 26.1, Petitioner provides the following:

Scottsdale Research Institute, LLC states that it is an Arizona-based limited liability company under Arizona law. It is dedicated to advancing the state of medical care through rigorous research. Specifically, Petitioner aims to conduct high quality, controlled scientific studies intended to ascertain the general medical safety and efficacy of cannabis and cannabis products and examine various forms of cannabis administration. Petitioner has no parent corporation and no publicly held company owns a 10 percent or greater interest of its stock.

/s/ *Shane Pennington*
Shane Pennington

Dated: June 11, 2019

Statutory Addendum

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 21. Food and Drugs (Refs & Annos)
Chapter 13. Drug Abuse Prevention and Control (Refs & Annos)
Subchapter I. Control and Enforcement
Part C. Registration of Manufacturers, Distributors, and Dispensers of Controlled Substances

21 U.S.C.A. § 823

§ 823. Registration requirements

Effective: October 24, 2018
Currentness

(a) Manufacturers of controlled substances in schedule I or II

The Attorney General shall register an applicant to manufacture controlled substances in schedule I or II if he determines that such registration is consistent with the public interest and with United States obligations under international treaties, conventions, or protocols in effect on May 1, 1971. In determining the public interest, the following factors shall be considered:

(1) maintenance of effective controls against diversion of particular controlled substances and any controlled substance in schedule I or II compounded therefrom into other than legitimate medical, scientific, research, or industrial channels, by limiting the importation and bulk manufacture of such controlled substances to a number of establishments which can produce an adequate and uninterrupted supply of these substances under adequately competitive conditions for legitimate medical, scientific, research, and industrial purposes;

(2) compliance with applicable State and local law;

(3) promotion of technical advances in the art of manufacturing these substances and the development of new substances;

(4) prior conviction record of applicant under Federal and State laws relating to the manufacture, distribution, or dispensing of such substances;

(5) past experience in the manufacture of controlled substances, and the existence in the establishment of effective control against diversion; and

(6) such other factors as may be relevant to and consistent with the public health and safety.

(b) Distributors of controlled substances in schedule I or II

The Attorney General shall register an applicant to distribute a controlled substance in schedule I or II unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(1) maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels;

(2) compliance with applicable State and local law;

(3) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;

(4) past experience in the distribution of controlled substances; and

(5) such other factors as may be relevant to and consistent with the public health and safety.

(c) Limits of authorized activities

Registration granted under subsections (a) and (b) of this section shall not entitle a registrant to (1) manufacture or distribute controlled substances in schedule I or II other than those specified in the registration, or (2) manufacture any quantity of those controlled substances in excess of the quota assigned pursuant to section 826 of this title.

(d) Manufacturers of controlled substances in schedule III, IV, or V

The Attorney General shall register an applicant to manufacture controlled substances in schedule III, IV, or V, unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(1) maintenance of effective controls against diversion of particular controlled substances and any controlled substance in schedule III, IV, or V compounded therefrom into other than legitimate medical, scientific, or industrial channels;

(2) compliance with applicable State and local law;

(3) promotion of technical advances in the art of manufacturing these substances and the development of new substances;

(4) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;

(5) past experience in the manufacture, distribution, and dispensing of controlled substances, and the existence in the establishment of effective controls against diversion; and

(6) such other factors as may be relevant to and consistent with the public health and safety.

(e) Distributors of controlled substances in schedule III, IV, or V

The Attorney General shall register an applicant to distribute controlled substances in schedule III, IV, or V, unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(1) maintenance of effective controls against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels;

(2) compliance with applicable State and local law;

(3) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;

(4) past experience in the distribution of controlled substances; and

(5) such other factors as may be relevant to and consistent with the public health and safety.

(f) Research by practitioners; pharmacies; research applications; construction of Article 7 of the Convention on Psychotropic Substances

The Attorney General shall register practitioners (including pharmacies, as distinguished from pharmacists) to dispense, or conduct research with, controlled substances in schedule II, III, IV, or V and shall modify the registrations of pharmacies so registered to authorize them to dispense controlled substances by means of the Internet, if the applicant is authorized to dispense, or conduct research with respect to, controlled substances under the laws of the State in which he practices. The Attorney General may deny an application for such registration or such modification of registration if the Attorney General determines that the issuance of such registration or modification would be inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

(1) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(2) The applicant's experience in dispensing, or conducting research with respect to controlled substances.

(3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

Separate registration under this part for practitioners engaging in research with controlled substances in schedule II, III, IV, or V, who are already registered under this part in another capacity, shall not be required. Registration applications by practitioners wishing to conduct research with controlled substances in schedule I shall be referred to the Secretary, who shall determine the qualifications and competency of each practitioner requesting registration, as well as the merits of the research protocol. The Secretary, in determining the merits of each research protocol, shall consult with the Attorney General as to effective procedures to adequately safeguard against diversion of such controlled substances from legitimate medical or scientific use. Registration for the purpose of bona fide research with controlled substances in schedule I by a practitioner deemed qualified by the Secretary may be denied by the Attorney General only on a ground specified in section 824(a) of this title. Article 7 of the Convention on Psychotropic Substances shall not be construed to prohibit, or impose additional restrictions upon, research involving drugs or other substances scheduled under the convention which is conducted in conformity with this subsection and other applicable provisions of this subchapter.

(g) Practitioners dispensing narcotic drugs for narcotic treatment; annual registration; separate registration; qualifications; waiver

(1) Except as provided in paragraph (2), practitioners who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment shall obtain annually a separate registration for that purpose. The Attorney General shall register an applicant to dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment (or both)

(A) if the applicant is a practitioner who is determined by the Secretary to be qualified (under standards established by the Secretary) to engage in the treatment with respect to which registration is sought;

(B) if the Attorney General determines that the applicant will comply with standards established by the Attorney General respecting (i) security of stocks of narcotic drugs for such treatment, and (ii) the maintenance of records (in accordance with section 827 of this title) on such drugs; and

(C) if the Secretary determines that the applicant will comply with standards established by the Secretary (after consultation with the Attorney General) respecting the quantities of narcotic drugs which may be provided for unsupervised use by individuals in such treatment.

(2)(A) Subject to subparagraphs (D) and (J), the requirements of paragraph (1) are waived in the case of the dispensing (including the prescribing), by a practitioner, of narcotic drugs in schedule III, IV, or V or combinations of such drugs if the practitioner meets the conditions specified in subparagraph (B) and the narcotic drugs or combinations of such drugs meet the conditions specified in subparagraph (C).

(B) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to a practitioner are that, before the initial dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, the practitioner submit to the Secretary a notification of the intent of

the practitioner to begin dispensing the drugs or combinations for such purpose, and that the notification contain the following certifications by the practitioner:

(i) The practitioner is a qualifying practitioner (as defined in subparagraph (G)).

(ii) With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to provide directly, by referral, or in such other manner as determined by the Secretary--

(I) all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention; and

(II) appropriate counseling and other appropriate ancillary services.

(iii)(I) The total number of such patients of the practitioner at any one time will not exceed the applicable number. Except as provided in subclause (II), the applicable number is 30.

(II) The applicable number is--

(aa) 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients;

(bb) 100 if the practitioner holds additional credentialing, as defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations);

(cc) 100 if the practitioner provides medication-assisted treatment (MAT) using covered medications (as such terms are defined in section 8.2 of title 42, Code of Federal Regulations (or successor regulations)) in a qualified practice setting (as described in section 8.615 of title 42, Code of Federal Regulations (or successor regulations)); or

(dd) 275 if the practitioner meets the requirements specified in sections 8.610 through 8.655 of title 42, Code of Federal Regulations (or successor regulations).

(III) The Secretary may by regulation change such applicable number.

(IV) The Secretary may exclude from the applicable number patients to whom such drugs or combinations of drugs are directly administered by the qualifying practitioner in the office setting.

(C) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to narcotic drugs in schedule III, IV, or V or combinations of such drugs are as follows:

(i) The drugs or combinations of drugs have, under the Federal Food, Drug, and Cosmetic Act or section 262 of Title 42, been approved for use in maintenance or detoxification treatment.

(ii) The drugs or combinations of drugs have not been the subject of an adverse determination. For purposes of this clause, an adverse determination is a determination published in the Federal Register and made by the Secretary, after consultation with the Attorney General, that the use of the drugs or combinations of drugs for maintenance or detoxification treatment requires additional standards respecting the qualifications of practitioners to provide such treatment, or requires standards respecting the quantities of the drugs that may be provided for unsupervised use.

(D)(i) A waiver under subparagraph (A) with respect to a practitioner is not in effect unless (in addition to conditions under subparagraphs (B) and (C)) the following conditions are met:

(I) The notification under subparagraph (B) is in writing and states the name of the practitioner.

(II) The notification identifies the registration issued for the practitioner pursuant to subsection (f).

(III) If the practitioner is a member of a group practice, the notification states the names of the other practitioners in the practice and identifies the registrations issued for the other practitioners pursuant to subsection (f).

(ii) Upon receiving a determination from the Secretary under clause (iii) finding that a practitioner meets all requirements for a waiver under subparagraph (B), the Attorney General shall assign the practitioner involved an identification number under this paragraph for inclusion with the registration issued for the practitioner pursuant to subsection (f). The identification number so assigned shall be appropriate to preserve the confidentiality of patients for whom the practitioner has dispensed narcotic drugs under a waiver under subparagraph (A).

(iii) Not later than 45 days after the date on which the Secretary receives a notification under subparagraph (B), the Secretary shall make a determination of whether the practitioner involved meets all requirements for a waiver under subparagraph (B) and shall forward such determination to the Attorney General. If the Secretary fails to make such determination by the end of the such 45-day period, the Attorney General shall assign the practitioner an identification number described in clause (ii) at the end of such period.

(E)(i) If a practitioner is not registered under paragraph (1) and, in violation of the conditions specified in subparagraphs (B) through (D), dispenses narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, the Attorney General may, for purposes of section 824(a)(4) of this title, consider the practitioner to have committed an act that renders the registration of the practitioner pursuant to subsection (f) to be inconsistent with the public interest.

(ii)(I) Upon the expiration of 45 days from the date on which the Secretary receives a notification under subparagraph (B), a practitioner who in good faith submits a notification under subparagraph (B) and reasonably believes that the conditions specified in subparagraphs (B) through (D) have been met shall, in dispensing narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, be considered to have a waiver under subparagraph (A) until notified otherwise by the Secretary, except that such a practitioner may commence

to prescribe or dispense such narcotic drugs for such purposes prior to the expiration of such 45-day period if it facilitates the treatment of an individual patient and both the Secretary and the Attorney General are notified by the practitioner of the intent to commence prescribing or dispensing such narcotic drugs.

(II) For purposes of subclause (I), the publication in the Federal Register of an adverse determination by the Secretary pursuant to subparagraph (C)(ii) shall (with respect to the narcotic drug or combination involved) be considered to be a notification provided by the Secretary to practitioners, effective upon the expiration of the 30-day period beginning on the date on which the adverse determination is so published.

(F)(i) With respect to the dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, a practitioner may, in his or her discretion, dispense such drugs or combinations for such treatment under a registration under paragraph (1) or a waiver under subparagraph (A) (subject to meeting the applicable conditions).

(ii) This paragraph may not be construed as having any legal effect on the conditions for obtaining a registration under paragraph (1), including with respect to the number of patients who may be served under such a registration.

(G) For purposes of this paragraph:

(i) The term "group practice" has the meaning given such term in section 1395nn(h)(4) of Title 42.

(ii) The term "qualifying physician" means a physician who is licensed under State law and who meets one or more of the following conditions:

(I) The physician holds a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties.

(II) The physician holds an addiction certification or board certification from the American Society of Addiction Medicine or the American Board of Addiction Medicine.

(III) The physician holds a board certification in addiction medicine from the American Osteopathic Association.

(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall include--

(aa) opioid maintenance and detoxification;

(bb) appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder;

(cc) initial and periodic patient assessments (including substance use monitoring);

(dd) individualized treatment planning, overdose reversal, and relapse prevention;

(ee) counseling and recovery support services;

(ff) staffing roles and considerations;

(gg) diversion control; and

(hh) other best practices, as identified by the Secretary.

(V) The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.

(VI) The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients.

(VII) The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

(VIII) The physician graduated in good standing from an accredited school of allopathic medicine or osteopathic medicine in the United States during the 5-year period immediately preceding the date on which the physician submits to the Secretary a written notification under subparagraph (B) and successfully completed a comprehensive allopathic or osteopathic medicine curriculum or accredited medical residency that--

(aa) included not less than 8 hours of training on treating and managing opioid-dependent patients; and

(bb) included, at a minimum--

(AA) the training described in items (aa) through (gg) of subclause (IV); and

(BB) training with respect to any other best practice the Secretary determines should be included in the curriculum, which may include training on pain management, including assessment and appropriate use of opioid and non-opioid alternatives.

(iii) The term "qualifying practitioner" means--

(I) a qualifying physician, as defined in clause (ii);

(II) a qualifying other practitioner, as defined in clause (iv), who is a nurse practitioner or physician assistant; or

(III) for the period beginning on October 1, 2018, and ending on October 1, 2023, a qualifying other practitioner, as defined in clause (iv), who is a clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife.

(iv) The term "qualifying other practitioner" means a nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant who satisfies each of the following:

(I) The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain.

(II) The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant has--

(aa) completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause; or

(bb) has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant to treat and manage opiate-dependent patients.

(III) The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is

required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

The Secretary may, by regulation, revise the requirements for being a qualifying other practitioner under this clause.

(H)(i) In consultation with the Administrator of the Drug Enforcement Administration, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Drug Abuse, and the Commissioner of Food and Drugs, the Secretary shall issue regulations (through notice and comment rulemaking) or issue practice guidelines to address the following:

(I) Approval of additional credentialing bodies and the responsibilities of additional credentialing bodies.

(II) Additional exemptions from the requirements of this paragraph and any regulations under this paragraph.

(III) Such other elements of the requirements under this paragraph as the Secretary determines necessary for purposes of implementing such requirements.

Nothing in such regulations or practice guidelines may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which medical services are provided.

(ii) Not later than 18 months after the date of enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act, the Secretary shall update the treatment improvement protocol containing best practice guidelines for the treatment of opioid-dependent patients in office-based settings. The Secretary shall update such protocol in consultation with experts in opioid use disorder research and treatment.

(I) Notwithstanding section 903 of this title, nothing in this paragraph shall be construed to preempt any State law that--

(i) permits a qualifying practitioner to dispense narcotic drugs in schedule III, IV, or V, or combinations of such drugs, for maintenance or detoxification treatment in accordance with this paragraph to a total number of patients that is more than 30 or less than the total number applicable to the qualifying practitioner under subparagraph (B)(iii)(II) if a State enacts a law modifying such total number and the Attorney General is notified by the State of such modification; or

(ii) requires a qualifying practitioner to comply with additional requirements relating to the dispensing of narcotic drugs in schedule III, IV, or V, or combinations of such drugs, including requirements relating to the practice setting in which the qualifying practitioner practices and education, training, and reporting requirements.

(J) Repealed. Pub.L. 114-198, Title III, § 303(b), July 22, 2016, 130 Stat. 723

(h) Applicants for distribution of list I chemicals

The Attorney General shall register an applicant to distribute a list I chemical unless the Attorney General determines that registration of the applicant is inconsistent with the public interest. Registration under this subsection shall not be required for the distribution of a drug product that is exempted under clause (iv) or (v) of section 802(39)(A) of this title. In determining the public interest for the purposes of this subsection, the Attorney General shall consider--

(1) maintenance by the applicant of effective controls against diversion of listed chemicals into other than legitimate channels;

(2) compliance by the applicant with applicable Federal, State, and local law;

(3) any prior conviction record of the applicant under Federal or State laws relating to controlled substances or to chemicals controlled under Federal or State law;

(4) any past experience of the applicant in the manufacture and distribution of chemicals; and

(5) such other factors as are relevant to and consistent with the public health and safety.

(i) Registration to manufacture certain controlled substances for use only in a clinical trial

(1) For purposes of registration to manufacture a controlled substance under subsection (d) for use only in a clinical trial, the Attorney General shall register the applicant, or serve an order to show cause upon the applicant in accordance with section 824(c) of this title, not later than 180 days after the date on which the application is accepted for filing.

(2) For purposes of registration to manufacture a controlled substance under subsection (a) for use only in a clinical trial, the Attorney General shall, in accordance with the regulations issued by the Attorney General, issue a notice of application not later than 90 days after the application is accepted for filing. Not later than 90 days after the date on which the period for comment pursuant to such notice ends, the Attorney General shall register the applicant, or serve an order to show cause upon the applicant in accordance with section 824(c) of this title, unless the Attorney General has granted a hearing on the application under section 958(i) of this title.

(j) Emergency medical services that administer controlled substances

(1) Registration

For the purpose of enabling emergency medical services professionals to administer controlled substances in schedule II, III, IV, or V to ultimate users receiving emergency medical services in accordance with the requirements of this subsection, the Attorney General--

(A) shall register an emergency medical services agency if the agency submits an application demonstrating it is authorized to conduct such activity under the laws of each State in which the agency practices; and

(B) may deny an application for such registration if the Attorney General determines that the issuance of such registration would be inconsistent with the requirements of this subsection or the public interest based on the factors listed in subsection (f).

(2) Option for single registration

In registering an emergency medical services agency pursuant to paragraph (1), the Attorney General shall allow such agency the option of a single registration in each State where the agency administers controlled substances in lieu of requiring a separate registration for each location of the emergency medical services agency.

(3) Hospital-based agency

If a hospital-based emergency medical services agency is registered under subsection (f), the agency may use the registration of the hospital to administer controlled substances in accordance with this subsection without being registered under this subsection.

(4) Administration outside physical presence of medical director or authorizing medical professional

Emergency medical services professionals of a registered emergency medical services agency may administer controlled substances in schedule II, III, IV, or V outside the physical presence of a medical director or authorizing medical professional in the course of providing emergency medical services if the administration is--

(A) authorized by the law of the State in which it occurs; and

(B) pursuant to--

(i) a standing order that is issued and adopted by one or more medical directors of the agency, including any such order that may be developed by a specific State authority; or

(ii) a verbal order that is--

(I) issued in accordance with a policy of the agency; and

(II) provided by a medical director or authorizing medical professional in response to a request by the emergency medical services professional with respect to a specific patient--

(aa) in the case of a mass casualty incident; or

(bb) to ensure the proper care and treatment of a specific patient.

(5) Delivery

A registered emergency medical services agency may deliver controlled substances from a registered location of the agency to an unregistered location of the agency only if the agency--

(A) designates the unregistered location for such delivery; and

(B) notifies the Attorney General at least 30 days prior to first delivering controlled substances to the unregistered location.

(6) Storage

A registered emergency medical services agency may store controlled substances--

(A) at a registered location of the agency;

(B) at any designated location of the agency or in an emergency services vehicle situated at a registered or designated location of the agency; or

(C) in an emergency medical services vehicle used by the agency that is--

(i) traveling from, or returning to, a registered or designated location of the agency in the course of responding to an emergency; or

(ii) otherwise actively in use by the agency under circumstances that provide for security of the controlled substances consistent with the requirements established by regulations of the Attorney General.

(7) No treatment as distribution

The delivery of controlled substances by a registered emergency medical services agency pursuant to this subsection shall not be treated as distribution for purposes of section 828 of this title.

(8) Restocking of emergency medical services vehicles at a hospital

Notwithstanding paragraph (13)(J), a registered emergency medical services agency may receive controlled substances from a hospital for purposes of restocking an emergency medical services vehicle following an emergency response, and without being subject to the requirements of section 828 of this title, provided all of the following conditions are satisfied:

(A) The registered or designated location of the agency where the vehicle is primarily situated maintains a record of such receipt in accordance with paragraph (9).

(B) The hospital maintains a record of such delivery to the agency in accordance with section 827 of this title.

(C) If the vehicle is primarily situated at a designated location, such location notifies the registered location of the agency within 72 hours of the vehicle receiving the controlled substances.

(9) Maintenance of records

(A) In general

A registered emergency medical services agency shall maintain records in accordance with subsections (a) and (b) of section 827 of this title of all controlled substances that are received, administered, or otherwise disposed of pursuant to the agency's registration, without regard to subsection 827(c)(1)(B) of this title.

(B) Requirements

Such records--

(i) shall include records of deliveries of controlled substances between all locations of the agency; and

(ii) shall be maintained, whether electronically or otherwise, at each registered and designated location of the agency where the controlled substances involved are received, administered, or otherwise disposed of.

(10) Other requirements

A registered emergency medical services agency, under the supervision of a medical director, shall be responsible for ensuring that--

(A) all emergency medical services professionals who administer controlled substances using the agency's registration act in accordance with the requirements of this subsection;

(B) the recordkeeping requirements of paragraph (9) are met with respect to a registered location and each designated location of the agency;

(C) the applicable physical security requirements established by regulation of the Attorney General are complied with wherever controlled substances are stored by the agency in accordance with paragraph (6); and

(D) the agency maintains, at a registered location of the agency, a record of the standing orders issued or adopted in accordance with paragraph (9).

(11) Regulations

The Attorney General may issue regulations--

(A) specifying, with regard to delivery of controlled substances under paragraph (5)--

(i) the types of locations that may be designated under such paragraph; and

(ii) the manner in which a notification under paragraph (5)(B) must be made;

(B) specifying, with regard to the storage of controlled substances under paragraph (6), the manner in which such substances must be stored at registered and designated locations, including in emergency medical service vehicles; and

(C) addressing the ability of hospitals, emergency medical services agencies, registered locations, and designated locations to deliver controlled substances to each other in the event of--

(i) shortages of such substances;

(ii) a public health emergency; or

(iii) a mass casualty event.

(12) Rule of construction

Nothing in this subsection shall be construed--

(A) to limit the authority vested in the Attorney General by other provisions of this subchapter to take measures to prevent diversion of controlled substances; or

(B) to override the authority of any State to regulate the provision of emergency medical services consistent with this subsection.

(13) Definitions

In this section:

(A) The term "authorizing medical professional" means an emergency or other physician, or another medical professional (including an advanced practice registered nurse or physician assistant)--

(i) who is registered under this chapter;

(ii) who is acting within the scope of the registration; and

(iii) whose scope of practice under a State license or certification includes the ability to provide verbal orders.

(B) The term "designated location" means a location designated by an emergency medical services agency under paragraph (5).

(C) The term "emergency medical services" means emergency medical response and emergency mobile medical services provided outside of a fixed medical facility.

(D) The term "emergency medical services agency" means an organization providing emergency medical services, including such an organization that--

(i) is governmental (including fire-based and hospital-based agencies), nongovernmental (including hospital-based agencies), private, or volunteer-based;

(ii) provides emergency medical services by ground, air, or otherwise; and

(iii) is authorized by the State in which the organization is providing such services to provide emergency medical care, including the administering of controlled substances, to members of the general public on an emergency basis.

(E) The term "emergency medical services professional" means a health care professional (including a nurse, paramedic, or emergency medical technician) licensed or certified by the State in which the professional practices and credentialed by a medical director of the respective emergency medical services agency to provide emergency medical services within the scope of the professional's State license or certification.

(F) The term "emergency medical services vehicle" means an ambulance, fire apparatus, supervisor truck, or other vehicle used by an emergency medical services agency for the purpose of providing or facilitating emergency medical care and transport or transporting controlled substances to and from the registered and designated locations.

(G) The term "hospital-based" means, with respect to an agency, owned or operated by a hospital.

(H) The term "medical director" means a physician who is registered under subsection (f) and provides medical oversight for an emergency medical services agency.

(I) The term “medical oversight” means supervision of the provision of medical care by an emergency medical services agency.

(J) The term “registered emergency medical services agency” means--

(i) an emergency medical services agency that is registered pursuant to this subsection; or

(ii) a hospital-based emergency medical services agency that is covered by the registration of the hospital under subsection (f).

(K) The term “registered location” means a location that appears on the certificate of registration issued to an emergency medical services agency under this subsection or subsection (f), which shall be where the agency receives controlled substances from distributors.

(L) The term “specific State authority” means a governmental agency or other such authority, including a regional oversight and coordinating body, that, pursuant to State law or regulation, develops clinical protocols regarding the delivery of emergency medical services in the geographic jurisdiction of such agency or authority within the State that may be adopted by medical directors.

(M) The term “standing order” means a written medical protocol in which a medical director determines in advance the medical criteria that must be met before administering controlled substances to individuals in need of emergency medical services.

(N) The term “verbal order” means an oral directive that is given through any method of communication including by radio or telephone, directly to an emergency medical services professional, to contemporaneously administer a controlled substance to individuals in need of emergency medical services outside the physical presence of the medical director or authorizing medical professional.

(k) “Factors as may be relevant to and consistent with the public health and safety” defined

In this section, the phrase “factors as may be relevant to and consistent with the public health and safety” means factors that are relevant to and consistent with the findings contained in section 801 of this title.

CREDIT(S)

(Pub.L. 91-513, Title II, § 303, Oct. 27, 1970, 84 Stat. 1253; Pub.L. 93-281, § 3, May 14, 1974, 88 Stat. 124; Pub.L. 95-633, Title I, § 109, Nov. 10, 1978, 92 Stat. 3773; Pub.L. 98-473, Title II, § 511, Oct. 12, 1984, 98 Stat. 2073; Pub.L. 103-200, § 3(c), Dec. 17, 1993, 107 Stat. 2336; Pub.L. 106-310, Div. B, Title XXXV, § 3502(a), Oct. 17, 2000, 114 Stat. 1222; Pub.L. 107-273, Div. B, Title II, § 2501, Nov. 2, 2002, 116 Stat. 1803; Pub.L. 109-56, § 1(a), (b), Aug. 2, 2005, 119 Stat. 591; Pub.L. 109-177, Title VII, § 712(a)(3), Mar. 9, 2006, 120 Stat. 263; Pub.L. 109-469, Title XI, § 1102, Dec. 29, 2006, 120 Stat. 3540; Pub.L. 110-425, § 3(b), Oct. 15, 2008, 122 Stat. 4824; Pub.L. 114-89, § 3, Nov. 25, 2015, 129 Stat. 701; Pub.L. 114-145, § 2(a)(1), Apr. 19, 2016, 130 Stat. 354; Pub.L. 114-198, Title III, § 303(a)(1), (b), July 22, 2016, 130

Stat. 720, 723; Pub.L. 115-83, § 2, Nov. 17, 2017, 131 Stat. 1267; Pub.L. 115-271, Title III, §§ 3201(a) to (d), 3202(a), Oct. 24, 2018, 132 Stat. 3943, 3944.)

Notes of Decisions (12)

21 U.S.C.A. § 823, 21 USCA § 823
Current through P.L. 116-19.

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Declaration of Suzanne Sisley, M.D.

**IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT**

In re Scottsdale Research Institute, LLC, *Petitioner.*	)))))))))))	No. ______________

DECLARATION OF SUZANNE SISLEY, M.D.

1. I am the President and Founder of Scottsdale Research Institute, LLC ("SRI"). I am also the Site Principal Investigator for SRI's FDA-approved clinical trial examining safety/efficacy of whole plant cannabis in combat veterans with treatment-resistant post-traumatic stress disorder ("PTSD"). I make this declaration based on my personal knowledge and in support of the Petition for a Writ of Mandamus.

2. SRI is an Arizona based limited liability company and clinical trials site dedicated to advancing the state of medical care through rigorous research. It is located at 5436 E Tapekim Rd., Cave Creek, AZ 85331 and our website is at http://www.sriresearch.org/. SRI strives to conduct high quality, controlled scientific studies to ascertain the general medical safety

and efficacy of cannabis products and examine forms of cannabis administration. SRI does not encourage recreational use of cannabis.

3. I am also a physician licensed to practice medicine in the State of Arizona and am in good standing. I completed my medical degree at the University of Arizona College of Medicine and did my residency at Good Samaritan Regional Medical Center in the fields of Internal Medicine and Psychiatry. I also served as Clinical Faculty at St. Joseph's Hospital and Medical Center at the MercyCare Adult Medicine Clinic for indigent patients.

4. I have received many honors and awards for my work, both in private practice and in research. For example, in 2001, I won the UA's Leo B. Hart Humanitarian Award from the University of Arizona College of Medicine. I also received the Arizona Medical Association's highest honor, the President's Distinguished Service Award.

5. I have received significant support from patient rights organizations including veteran groups around the country, such as the American Legion. In September 2016, the American Legion passed a resolution in support of our research, urging the DEA to license privately-

funded cannabis production to enable safe and efficient cannabis drug development.[1]

Private Practice

6. My primary care practice has always had a focus on treating veterans as well as underserved populations across Arizona.

7. More than a decade ago, I began noticing intractable PTSD and a suicide epidemic among veterans first-hand. PTSD is a mental health condition experienced by some who go through traumatic events. Symptoms vary from individual to individual. Common symptoms include anxiety, insomnia, depression, and nightmares. Currently there are limited approved pharmaceutical remedies for PTSD. Only two anti-depressants, sertraline (Zoloft) and paroxetine (Paxil), are approved by the FDA to treat PTSD.[2]

8. PTSD is quite prevalent among combat veteran populations. The association between combat exposure and PTSD is established. Measured rates of PTSD among combat veterans consistently exceeds 10%.[3] For example, according to a RAND study published on the VA website, the

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[1] See https://archive.legion.org/bitstream/handle/20.500.12203/5763/2016N011.pdf. See also B. Bender, American Legion to Trump: Allow marijuana research for vets, Politico (May 20, 2017).

[2] See https://www.youtube.com/watch?v=Idujb84MwPE ("Weed 3") at 3:30 (April 19, 2015).

[3] See Hines, L. A., Sundin, J., Rona, R. J., Wessely, S., & Fear, N. T. (2014). Posttraumatic stress disorder post Iraq and Afghanistan: prevalence among military subgroups. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 59(9), 468–479. doi:10.1177/070674371405900903

prevalence of PTSD in Operation Enduring Freedom and Operation Iraqi Freedom was 13.8% out of 1,938 participants. Another study found that prevalence rates for PTSD or depression with serious functional impairment ranged between 8.5% and 14.0%.[4] PTSD is one of the most common psychiatric diagnosis among veterans using the VA hospitals.[5]

9. Suicide rates are also quite high among veteran population. The VA estimates that around 20 veterans per day take their own lives.[6]

10. Many of my veteran clients with PTSD did not respond to conventional medications. Some clients told me that using cannabis helped alleviate their symptoms.[7] For many, cannabis was the only drug that worked, reversing insomnia or easing depression and anxiety. Patients told me that cannabis effectively quelled nightmares, flashbacks, and hypervigilance.

11. This first-hand experience inspired me to conduct clinical trials on the safety and efficacy of cannabis use to suppress treatment resistant

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4 See https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp.

5 Ralevski, E., Olivera-Figueroa, L. A., & Petrakis, I. (2014). PTSD and comorbid AUD: a review of pharmacological and alternative treatment options. Substance abuse and rehabilitation, 5, 25–36. doi:10.2147/SAR.S37399.

6 See https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf at 22.

7 See Weed 3 at 5:00.

PTSD, which I discussed in CNN's "Weed 3: The Marijuana Revolution,"[8] an April 19, 2015 special report by CNN's chief medical correspondent Dr. Sanjay Gupta. This documentary not only explains in detail how veterans that struggle with PTSD have come to rely on cannabis, but also how we overcame numerous obstacles to be able to do our research, which I discuss below.

The Road to Clinical Trials

12. I struggled for seven years to get approval from four different federal agencies to conduct clinical trials of cannabis as a treatment for PTSD symptoms in veterans.

13. In 2009, I began collaborating with the Multidisciplinary Association for Psychedelic Studies (MAPS) on a proposal for the FDA. On Nov. 11, 2010, MAPS' clinical research team submitted our protocol to the FDA, and FDA approval came in April 2011.

14. On July 30, 2012, we submitted the protocol to the University of Arizona Institutional Review Board (IRB), which approved the study in October 2012.

[8] Although the video does not appear to be available from CNN, the video is widely available online, for example on YouTube at https://www.youtube.com/watch?v=Idujb84MwPE. I am introduced in the video at 3:30, and our struggle to obtain all the necessary government permissions begins at 5:30.

15. Shortly after FDA approval, we sent the proposal to NIDA and PHS for approval. After a series of rejections, we finally obtained approval from these agencies around March 2014. That approval was critical because it allowed us to be able to purchase federally legal cannabis from NIDA, the only source of cannabis legal for use in federally regulated research.

16. On April 17, 2014, NIDA informed us that it did not have the cannabis we needed for our study. Shortly after that, NIDA told us that it would have to grow the cannabis we needed for our protocol.

17. In June 2014, I was released by the University of Arizona. They chose not to renew my contract of employment and two other subcontracts. My assistant professorship was terminated. As a result, I lost my healthcare, primary income, and pension. And without an academic appointment, I was unable to continue my research with the university. I discussed this in an interview with CNN's Sanjay Gupta in July 2014.[9]

18. On November 2, 2015, we submitted our protocol to the DEA. As part of the approval process, the DEA inspected SRI. In April 2016, the DEA approved my Schedule I license to do research with cannabis, which is still active. That license removed the last barrier to the study.

[9] The interview is available at https://www.cnn.com/2014/07/12/health/marijuana-researcher-arizona/index.html.

19. Our phase II clinical trials titled "Placebo-Controlled, Triple-Blind, Randomized Crossover Pilot Study of the Safety and Efficacy of Four Different Potencies of Smoked Marijuana in 76 Veterans with Chronic, Treatment-Resistant Posttraumatic Stress Disorder (PTSD)" began in early 2017, and we concluded it in early 2019. SRI treated 76 participants as part of the study. MAPS sponsored the study and it was funded with a $2.1 million grant from the Colorado Department of Public Health and Environment. The study's protocol is available online.[10] We are aiming to publish our results in late 2019. The data looks promising, and justifies further examination with an alternative supply of high-quality natural cannabis flower.

NIDA Cannabis

20. On August 10, 2016, NIDA approved SRI's request to order 6.3kg of cannabis for our clinical trials. We had requested multiple cannabis strains with varying levels of THC and CBD, including high THC, high CBD, balanced THC/CBD, and placebo. On August 25, 2016, I received the first shipment. The cannabis arrived frozen, in dried bulk form. SRI tested the cannabis at a DEA-licensed laboratory.

21. Generally speaking, the NIDA cannabis SRI received looked nothing like commercial grade medical cannabis one can buy from

[10] See https://www.sriresearch.org/MJP1-A6V1-FINAL-16MAR2017-Web%20(1).html.

dispensaries states where medicinal cannabis is legal. NIDA cannabis consistently appears to have extraneous material like sticks, stems, and seeds. Many packages looked like the green powder shown below from a 2017 article on pbs.org that I am quoted in:[11]

22. I am also quoted in a 2017 Washington Post article titled "Government marijuana looks nothing like the real stuff. See for yourself," where a side by side comparison of commercial medicinal cannabis and NIDA cannabis can be seen:[12]

[11] See C. Hellerman "Scientists say the government's only pot farm has moldy samples — and no federal testing standards," PBS (Mar. 8, 2017) (https://www.pbs.org/newshour/nation/scientists-say-governments-pot-farm-moldy-samples-no-guidelines). I took this picture.

[12] See C. Ingraham and T. Chappell, "Government marijuana looks nothing like the real stuff. See for yourself," Washington Post (Mar. 13, 2017) (https://www.washingtonpost.com/news/wonk/wp/2017/03/13/government-marijuana-looks-nothing-like-the-real-stuff-see-for-yourself/?utm_term=.2dcae33401d3/).

23. In my opinion, both as a researcher and physician, the quality of this cannabis had an adverse impact on the study results and sometimes on the study subjects. For example, I noticed that bronchial irritation was a common complaint among the study subjects. I believe this side effect could have been mitigated if not eliminated had SRI been able to grow and use its own cannabis (which would have only contained the flowering tops of the plant without the extraneous plant material that can burn more harshly and cause excessive mucosal irritation) or simply if SRI could have used other cannabis that did not have extraneous material and excessively high levels of mold.

24. Before I could use the study drug, I had to sign a Release and Indemnity Agreement and take full responsibility for the preparation and

distribution of the government's cannabis. Physicians and principal investigators should not be put into a position where we must knowingly distribute cannabis flower to enrolled study subjects, while then being forced to accept full liability for this suboptimal study drug.

25. NIDA cannabis was not only inadequate for the Phase II trial we just completed, but will be inadequate for further studies, such as Phase III clinical trials or other Phase II clinical trials. The presence of sticks, stems, and seeds and significant mold makes this drug unsuitable for clinical research in certain patient populations.

26. Because NIDA cannabis is inadequate, SRI is now looking to import cannabis from a Canadian company for other projects, such as clinical trials to test the safety and efficacy of cannabis versus fentanyl for management of breakthrough pain in terminal cancer patients.

Application to DEA

27. On October 1, 2016, I submitted SRI's application for registration under the Controlled Substances Act. I submitted answers to supplemental questionnaire to DEA shortly after.

28. In the supplemental questionnaire, I told DEA that SRI was conducting an FDA approved Phase 2 randomized controlled trial evaluating the safety and efficacy of cannabis for military veterans with PTSD, that SRI

planned to move into Phase 3 trials in next 3 years, and that it would need a supply of cannabis other than from NIDA. The purpose of SRI's application was to allow it to cultivate cannabis that could be used for Phase 3 FDA trials. The only way cannabis could ever be approved as an FDA prescription medicine is through Phase 3 trials.

29. I explained that once SRI was licensed, it would supply its own internal, FDA sanctioned and licensed clinical trials. I also discussed supplying academic and private researchers across the country to provide them with a consistent supply of medical product for clinical trials. I did not list anybody else as prospective customers because I am unaware of any other researchers allowed to do clinical trials involving cannabis.

30. Since I filed SRI's application more than two-and-a-half years ago, I have followed up with the DEA numerous times. I believe I called DEA five times between June 2017 to August 2018. I also exchanged e-mails with the agency on June 22, 2017, but after a follow up e-mail on July 15, 2017, I did not hear back from the agency.

31. One year later, I followed up on my application again in an August 30, 2018 e-mail, writing:

> I have contacted my local DEA office regularly asking them the status of our application over the past two years and continue to get a vague response saying they have no idea when the application will ever be processed.

> Can you provide us another update from the national office on when the applications will be evaluated?
>
> I know we've discussed this on the phone several times over the last few years and I continue to hear from you that you are unsure of when this application above will be assessed. So given the continual uncertainty from your office, I've stopped inquiring with national office because this seemed futile.

In response, I was only told that the status of SRI's application remained the same.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on _5_, June 2019.

Suzanne Sisley, M.D.
President of Petitioner SRI, LLC

Congress of the United States
Washington, DC 20510

August 18, 2020

Timothy J. Shea, Acting Administrator
Office of the Administrator
US Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

Dear Mr. Shea,

We write to encourage you to expeditiously finalize and publish the draft rule, Controls to Enhance the Cultivation of Marihuana for Research in the United States and proceed to review applications for additional Cannabis manufacturing licenses.

Cannabis and Cannabis-derived products continue to enter the U.S. marketplace at an accelerating pace, yet the data necessary to assess the potential benefits and risks of these products is impeded by the lack of sufficient, federally authorized Cannabis for research. Many of our citizens firmly believe that Cannabis mitigates symptoms for them and provides a real benefit. Non-FDA-approved cannabis and cannabis-derived products are currently being used for the treatment of several medical conditions. However, FDA has only approved one cannabis-derived product – Epidiolex for the treatment of seizures associated with Lennox-Gastaut syndrome (LGS) and Dravet syndrome – and three synthetic cannabis-related drug products. Without FDA review and approval of cannabis-derived products, there may be outstanding questions about the safety and efficacy of those products, particularly among physicians. This leads to many of our elderly patients and our veterans self-medicating and potentially foregoing appropriate medical care. It is imperative that lawmakers have scientific evidence about potential medical uses, side effects and societal impacts of Cannabis to guide policy decisions. The only way that can occur is if our academic and clinical researchers are permitted to conduct well-controlled, scientific studies on these materials. To do so, they must have access to federally compliant Cannabis and its chemical constituents in sufficient quantity and quality. The current system with a single Cannabis producer has resulted in long delays in obtaining materials. In addition, the materials supplied by the only approved source do not reflect the potency and diversity of Cannabis currently available in the state legal markets. Multiple licensed Cannabis producers would provide sufficient quantities and genetic diversity of Cannabis materials to enable the impactful and realistic research that our nation so critically needs.

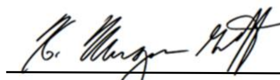
The Drug Enforcement Administration (DEA) began this process on August 11, 2016 when the agency announced that it would increase the number of DEA-registered marihuana manufacturing facilities. The agency received several dozen cultivation license applications in

response to the 2016 announcement. Since then, no licenses have been processed by the agency. Over three years later, on August 26, 2019, instead of taking steps to approve any pending applications, the DEA announced it was going to consider new regulations, and released a proposed rule on March 23, 2020 for public comment. That comment period expired on May 22, 2020, and now is the time to move forward. Delays in approving grower applications for the manufacturing of research-grade marijuana have had potentially detrimental effects on Americans' health as untested products are being widely used for numerous medical conditions without safety or efficacy data to support these uses. It has also cost American jobs as other countries around the world such as Israel, the United Kingdom and Canada, have taken the lead in Cannabis research, reaping the benefits of patents and products derived from this research. Meanwhile, American researchers have resorted to importing Cannabis from overseas. The DEA and its leadership have made a public commitment to fostering Cannabis research. "The Drug Enforcement Administration continues to support additional research into marijuana and its components, and we believe registering more growers will advance the scientific and medical research already being conducted…. we will expedite the necessary steps."

On January 15, 2020, the Subcommittee on Health of the Committee on Energy and Commerce held a legislative hearing on "Cannabis Policies for the New Decade". In his testimony, Matthew Strait, Senior Policy Advisor to the Diversion Control Division of the DEA states, "DEA continues to make the approval of schedule I researchers a top priority and we look forward to continuing our efforts with our inter-agency partners to expand research efforts for all controlled substances, including marihuana." We hold DEA to these commitments and for the reasons outlined above we ask that you proceed to finalize the rule and rapidly move to review applications for additional manufacturing licenses. Thank you for your attention to this matter.

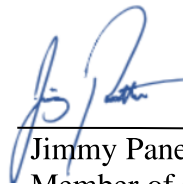
Sincerely,

Cathy McMorris Rodgers
Member of Congress



H. Morgan Griffith
Member of Congress

Matt Gaetz
Member of Congress



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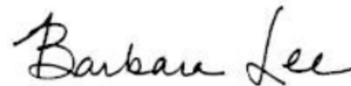

Barbara Lee
Member of Congress

J. Luis Correa
Member of Congress

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19-1120 **September Term, 2019**

Filed On: October 18, 2019

In re: Scottsdale Research Institute, LLC,

Petitioner

BEFORE: Millett, Pillard, and Wilkins, Circuit Judges

O R D E R

Upon consideration of the amended petition for writ of mandamus, the response thereto, the reply, and respondent's Rule 28(j) letter; and the motion to supplement the appendix, it is

ORDERED that the motion to supplement the appendix, and the Federal Register notice that petitioner seeks to include in the appendix, be construed as a Federal Rule of Appellate Procedure 28(j) letter advising of supplemental authority, because the Federal Register notice is a judicially noticeable public record document. Therefore, petitioner's motion to supplement the appendix was unnecessary. It is

FURTHER ORDERED that the amended petition for writ of mandamus be denied. In light of respondent's October 11, 2019 publication in the Federal Register of a corrected notice of petitioner's application to manufacture controlled substances in bulk, petitioner's request for a writ of mandamus directing respondent to issue a notice of application is now moot. See McBryde v. Comm. to Review, 264 F.3d 52, 55 (D.C. Cir. 2001) ("If events outrun the controversy such that the court can grant no meaningful relief, the case must be dismissed as moot."). Further, because respondent's publication of the corrected notice "is more accurately characterized as the provision of appropriate relief to petitioner than as the 'cessation of illegal conduct,'" the "voluntary cessation" exception to mootness does not apply here. Nat. Res. Def. Council v. Nuclear Regulatory Comm'n, 680 F.2d 810, 814 n.8 (D.C. Cir. 1982).

Finally, to the extent petitioner requests that this court retain jurisdiction over this case to ensure respondent's compliance with future statutory deadlines to act on its application, petitioner has not demonstrated a "history of chronic delay and [the agency's] repeated failure to meet its own projections," In re: Ctr. for Auto Safety, 793 F.2d 1346, 1354 (D.C. Cir. 1986), or that respondent has acted in bad faith, see In re: Monroe Commc'ns Corp., 840 F.2d 942, 947 (D.C. Cir. 1988). Denial of this aspect of the mandamus petition is without prejudice to renewal in the event of significant delay.

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19-1120 **September Term, 2019**

Pursuant to D.C. Circuit Rule 36, this disposition will not be published.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/
Amanda Himes
Deputy Clerk

ALCOHOLISM AND NARCOTICS

HEARINGS

BEFORE THE

SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

INQUIRY INTO THE PROBLEM OF ALCOHOLISM AND NARCOTICS

FEBRUARY 14, 1970
DES MOINES, IOWA

PART 5

Printed for the use of the Committee on Labor and Public Welfare

U.S. GOVERNMENT PRINTING OFFICE
38-737 WASHINGTON : 1970

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research carried out on marihuana from 1937 until now consists of six studies adding up to a total of 218 subjects. This is the amount of investigation we have on a substance which between 5 and 20 million Americans have experimented with and which between 250 to 400 million people in the world have used. I might also add that the results of these studies have been equivocal.

They do not provide sufficient or the kind of information that would justify current or proposed repressive laws which treat marihuana as though it were worse than many major crimes.

On the other hand what little they tell us does not justify those who are so complacent about the legalization of marihuana.

The adversary system may be the most effective way of arriving at just decisions in the courtroom but it is a poor method of determining scientific truth. Those who would lend themselves and their scientific reputations to either extreme of this issue are doing a disservice to humanity.

Control based on ignorance will not be effective.

We have already seen demonstrated the possible effects of education on the consumption of drugs. When the genetic studies on LSD suggested possible harmful effects, this information did what no law could do. It rapidly decreased the consumption of LSD. Laws cannot be effective unless there is some consensus upon their need and usefulness.

We cannot educate effectively without facts and we cannot get facts without research.

These are critical questions to which we have no answers.

What is the incidence of mental complications? What are the long-term effects of marihuana use? Does marihuana release antisocial behavior? What is effective treatment?

I fear we have introduced a credibility gap and people do not believe what we say or will say about marihuana. They also do not believe what we say about other drugs about which we do have information—the hard drugs such as amphetamines, barbiturates, and hallucinogens. The use of these drugs is also climbing.

Have we cried wolf so often that no one will believe us when we do learn about the real dangers of drugs? Will anyone listen when the wolf is outside the door?

Senator HUGHES. Dr. Norris, I would like to ask you a few questions in relationship to the bill that just passed the Senate of the United States, and on which I offered several amendments.

As a professional, do you think that classification or harmful substance of the United States ought to be under the Office of the Attorney General?

Dr. NORRIS. I am only vaguely familiar with this having read a small abstract of this bill. But this is horrifying to me. May I take a moment to describe and experience I had with this?

About two and a half years ago, I applied for LSD, because we don't know very much about that drug either. I wanted to do some research with it regarding its possible harmful effects and also its possible treatment effects which do exist.

I received approval for this study by two committees in our medical school in the University of Iowa and a Federal agency at that time headed by Dr. Goddard. This application went forward to the Department of Public Health where I was to obtain the LSD. Six

months later I heard nothing. Several months after that, I received a vague statement from this agency indicating that they wanted me to rewrite and replan my research proposal with no specific criticisms.

This proposal had been examined and passed by three committees. It got tied up in bureaucracy. I received yesterday a request from the initial agency in Washington for a progress report on my LSD study, LSD which I still don't have.

Senator, we are talking about research. We are talking about things that save lives. We are talking about things that people die about because we don't have information.

In this particular instance, two and a half years has gone by. When the initial restrictions were placed on LSD the number of researchers dropped from 94 to nine. I was one of those nine that survived except I was not. This is the kind of communications system we have.

Now I understand that the LSD must be obtained from the Department of Justice. I don't expect to get it. I am going through the same route with marihuana attempting to get standardized quantified marihuana to do research. I don't know what is going to happen.

Senator HUGHES. I find this to be pretty universally true.

Many States prohibit the medical research that is absolutely essential. If I could describe some of the procedures that some of the researchers have had to go through to try to get clearance, it is absolutely unbelievable, because if it wasn't for a violation of law, they could have bought it on a street corner.

Dr. NORRIS. I know several illegal sources.

Senator HUGHES. It would have been very easy to come by. But in order to run it with the proper controls, it had to be done legally.

Also, I would like to ask you about the areas of that bill which allow expenditure of funds for scientific research and educational research under the Attorney General's direction.

Dr. NORRIS. My feeling about that, Senator, is that I don't enforce the law other than in my own personal life. I wish they would not practice medicine, because I think this is what they are doing.

Senator HUGHES. That is what I thought they were doing also. But the majority of the Senate disagreed with me. But the House is taking a very close look at those provisions, and the American Medical Association is now, I think, finally realizing what happened when that bill passed and we are going to perhaps have a chance to review it a little later on.

However, this bill originated in the Judiciary Committee, dealing with law enforcement, so if it comes out of the House now and back to the Senate and goes to the conference committee, those of us who are on the Committee of Health, Education, and Welfare in the Senate won't be a member of the conference because the bill originated in our Judiciary Committee. Reverend Shopshire thinks he has a problem with law enforcement, we have our own in Congress, trying to get jurisdiction where it belongs for research, scientific evaluation, and classification of narcotics and dangerous drugs.

All of these things are for medical science and medical research, in my opinion. They should never be under the chief law enforcement officer in the country.

Dr. NORRIS. I certainly agree.

Senator HUGHES. Do you run any other research programs in relationship to dangerous drugs and narcotics?

UNITED STATES DEPARTMENT OF JUSTICE

Drug Enforcement Administration

In The Matter Of)
MARIJUANA RESCHEDULING PETITION)

Docket No. 86-22

OPINION AND RECOMMENDED RULING, FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION OF ADMINISTRATIVE LAW JUDGE

FRANCIS L. YOUNG, Administrative Law Judge

APPEARANCES:

KEVIN B. ZEESE, Esq.
ARNOLD S. TREBACH, Esq.
for National Organization For The Reform of Marijuana Laws

FRANK B. STILWELL, III, Esq.
for Alliance for Cannabis Therapeutics

DAVID C. BECK, Esq.
for Cannabis Corporation of America

CARL ERIC OLSEN, *Pro Se*

CHARLOTTE J. MAPES, Esq.
MADELEINE R. SHIRLEY, Esq.
for the Government

KARL BERNSTEIN
for National Federation of Parents for Drug-Free Youth

VIRGINIA PELTIER, Esq.
for the International Association of Chiefs of Police

DATED: SEP 6 1988

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UNITED STATES DEPARTMENT OF JUSTICE

Drug Enforcement Administration

In The Matter Of MARIJUANA RESCHEDULING PETITION	Docket No. 86-22

OPINION AND RECOMMENDED RULING, FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION OF ADMINISTRATIVE LAW JUDGE

I.

INTRODUCTION

This is a rulemaking pursuant to the Administrative Procedure Act, 5 U.S.C. § 551, et seq., to determine whether the marijuana plant (Cannabis sativa L) considered as a whole may lawfully be transferred from Schedule I to Schedule II of the schedules established by the Controlled Substances Act (the Act), 21 U.S.C. § 801, et seq. None of the parties is seeking to "legalize" marijuana generally or for recreational purposes. Placement in Schedule II would mean, essentially, that physicians in the United States would not violate Federal law by prescribing marijuana for their patients for legitimate therapeutic purposes. It is contrary to Federal law for physicians to do this as long as marijuana remains in Schedule I.

This proceeding had its origins on May 18, 1972 when the National Organization for the Reform of Marijuana Laws (NORML) and two other groups submitted a petition to the Bureau of Narcotics and Dangerous Drugs (BNDD)[1], predecessor

[1] The powers and authority granted by the Act to the Attorney General were delegated to the Director of BNDD and subsequently to the Administrator of DEA. 28 C.F.R. § 0.100, et seq.

agency to the Drug Enforcement Administration (DEA or the Agency), asking that marijuana be removed from Schedule I and freed of all controls entirely, or be transferred from Schedule I to Schedule V where it would be subject to only minimal controls. The Act by its terms had placed marijuana in Schedule I thereby declaring, as a matter of law, that it had no legitimate use in therapy in the United States and subjecting the substance to the strictest level of controls. The Act had been in effect for just over one year when NORML submitted its 1972 petition.

On September 1, 1972 the Director of BNDD announced his refusal to accept the petition for filing, stating that he was not authorized to institute proceedings for the action requested because of the provisions of the Single Convention on Narcotic Drugs, 1961. NORML appealed this action to the United States Court of Appeals for the District of Columbia Circuit. The court held that the Director had erred in rejecting the petition without "a reflective consideration and analysis," observing that the Director's refusal "was not the kind of agency action that promoted the kind of interchange and refinement of views that is the lifeblood of a sound administrative process." NORML v. Ingersoll, 162 U.S. App. D.C. 67, 497 F.2d 654, 659 (1974). The court remanded the matter in January 1974 for further proceedings not inconsistent with its opinion, "to be denominated a consideration on the merits." Id.

A three-day hearing was held at DEA[2] by Administrative Law Judge Lewis Parker in January 1975. The judge found in NORML's favor on several issues but the Acting Administrator of DEA entered a final order denying NORML's petition "in all respects." NORML again petitioned the court for review. Finding fault

2 DEA became the successor agency to BNDD in a reorganization carried out pursuant to Reorganization Plan No. 2 of 1973, eff. July 1, 1973. 38 Fed. Reg. 15932 (1973).

with DEA's final order the court again remanded for further proceedings not inconsistent with its opinion. NORML v. DEA, 182 U.S. App. D.C. 114, 559 F.2d 735 (1977). The Court directed the then-Acting Administrator of DEA to refer NORML's petition to the Secretary of the Department of Health, Education and Welfare (HEW) for findings and, thereafter, to comply with the rulemaking procedures outlined in the Act at 21 U.S.C. § 811 (a) and (b).

On remand the Administrator of DEA referred NORML's petition to HEW for scientific and medical evaluation. On June 4, 1979 the Secretary of HEW advised the Administrator of the results of the HEW evaluation and recommended that marijuana remain in Schedule I. Without holding any further hearing the Administrator of DEA proceeded to issue a final order ten days later denying NORML's petition and declining to initiate proceedings to transfer marijuana from Schedule I. 44 Fed. Reg. 36123 (1979). NORML went back to the Court of Appeals.

When the case was called for oral argument there was discussion of the then-present status of the matter. DEA had moved for a partial remand. The court found that "reconsideration of all the issues in this case would be appropriate" and again remanded it to DEA, observing: "We regrettably find it necessary to remind respondents [DEA and HEW] of an agency's obligation on remand not to 'do anything which is contrary to either the letter or spirit of the mandate construed in the light of the opinion of [the] court deciding the case.'" (Citations omitted.) NORML v. DEA, et al., No. 79-1660, United States Court of Appeals for the District of Columbia Circuit, unpublished order filed October 16, 1980. DEA was directed to refer all the substances at issue to the Department of Health and Human Services (HHS), successor agency to HEW,for scien-

tific and medical findings and recommendations on scheduling. DEA did so and HHS has responded. In a letter dated April 1, 1986 the then-Acting Deputy Administrator of DEA requested this administrative law judge to commence hearing procedures as to the proposed rescheduling of marijuana and its components.

After the judge conferred with counsel for NORML and DEA, a notice was published in the Federal Register on June 24, 1986 announcing that hearings would be held on NORML's petition for the rescheduling of marijuana and its components commencing on August 21, 1986 and giving any interested person who desired to participate the opportunity to do so. 51 Fed. Reg. 22946 (1986).

Of the three original petitioning organizations in 1972 only NORML is a party to the present proceeding. In addition the following entities responded to the Federal Register notice and have become parties, participating to varying degrees: the Alliance for Cannabis Therapeutics (ACT), Cannabis Corporation of America (CCA) and Carl Eric Olsen, all seeking transfer of marijuana to Schedule II; the Agency, National Federation of Parents for Drug-Free Youth (NFP) and the International Association of Chiefs of Police (IACP), all contending that marijuana should remain in Schedule I.

Preliminary prehearing sessions were held on August 21 and December 5, 1986 and on February 20, 1987.[3] During the preliminary stages, on January 20, 1987, NORML filed an amended petition for rescheduling. This new petition abandoned NORML's previous requests for the complete de-scheduling of marijuana or rescheduling to Schedule V. It asks only that marijuana be placed in Schedule II.

At a prehearing conference on February 20, 1987 this amended petition was

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3 Transcripts of these three preliminary prehearing sessions are included in the record.

discussed.[4] All parties present stipulated, for the purpose of this proceeding, that marijuana has a high potential for abuse and that abuse of the marijuana plant may lead to severe psychological or physical dependence. They then agreed that the principal issue in this proceeding would be stated thus:

Whether the marijuana plant, considered as a whole,[5] may

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4 The transcript of this prehearing conference and of the subsequent hearing sessions comprise 15 volumes numbered as follows:

Vol. I - Prehearing Conference, October 16, 1987

Vol. II - Cross Examination, November 19, 1987

Vol. III - Cross Examination, December 8, 1987

Vol. IV - Cross Examination, December 9, 1987

Vol. V - Cross Examination, January 5, 1988

Vol. VI - Cross Examination, January 6, 1988

Vol. VII - Cross Examination, January 7, 1988

Vol. VIII - Cross Examination, January 26, 1988

Vol. IX - Cross Examination, January 27, 1988

Vol. X - Cross Examination, January 28, 1988

Vol. XI - Cross Examination, January 29, 1988

Vol. XII - Cross Examination, February 2, 1988

Vol. XIII - Cross Examination, February 4, 1988

Vol. XIV - Cross Examination, February 5, 1988

Vol. XV - Oral Argument, June 10, 1988

Pages of the transcript are cited herein by volume and page, e.g. "Tr. V-96"; "G-" identifies an Agency exhibit.

5 Throughout this opinion the term "marijuana" refers to "the marijuana plant, considered as a whole".

lawfully be transferred from Schedule I to Schedule II of the schedules established by the Controlled Substances Act.

Two subsidiary issues were agreed on, as follows:

1. Whether the marijuana plant has a currently accepted medical use in treatment in the United States, or a currently accepted medical use with severe restrictions.

2. Whether there is a lack of accepted safety for use of the marijuana plant under medical supervision.

As stated above, the parties favoring transfer from Schedule I to Schedule II are NORML, ACT, CCA and Carl Eric Olsen. Those favoring retaining marijuana in Schedule I are the Agency, NFP and IACP.

During the Spring and Summer of 1987 the parties identified their witnesses and put the direct examination testimony of each witness in writing in affidavit form. Copies of these affidavits were exchanged. Similarly, the parties assembled their proposed exhibits and exchanged copies. Opportunity was provided for each party to submit objections to the direct examination testimony and exhibits proffered by the others. The objections submitted were considered by the administrative law judge and ruled on. The testimony and exhibits not excluded were admitted into the record. Thereafter hearing sessions were held at which witnesses were subjected to cross-examination. These sessions were held in New Orleans, Louisiana on November 18 and 19, 1987; in San Francisco, California on December 8 and 9, 1987; and in Washington, D.C. on January 5 through 8 and 26 through 29, and on February 2, 4 and 5, 1988. The parties have submitted proposed findings and conclusions and briefs. Oral arguments were heard by the judge on June 10, 1988 in Washington.

II.

RECOMMENDED RULING

It is recommended that the proposed findings and conclusions submitted by the parties to the administrative law judge be rejected by the Administrator except to the extent they are included in those hereinafter set forth, for the reason that they are irrelevant or unduly repetitious or not supported by a preponderance of the evidence. 21 C.F.R. § 1316.65(a)(1).

III.

ISSUES

As noted above, the agreed issues are as follows:

> Principle issue:
>
> Whether the marijuana plant, considered as a whole, may lawfully be transferred from Schedule I to Schedule II of the schedules established by the Controlled Substances Act.
>
> Subsidiary issues:
>
> 1. Whether the marijuana plant has a currently accepted medical use in treatment in the United States, or a currently accepted medical use with severe restrictions.
>
> 2. Whether there is a lack of accepted safety for use of the marijuana plant under medical supervision.

IV.

STATUTORY REQUIREMENTS FOR SCHEDULING

The Act provides (21 U.S.C. § 812(b)) that a drug or other substance may not be placed in any schedule unless certain specified findings are made with respect to it. The findings required for Schedule I and Schedule II are as follows:

> Schedule I. -
>
> (A) The drug or other substance has a high potential for abuse.
>
> (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
>
> (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.
>
> Schedule II. -
>
> (A) The drug or other substance has a high potential for abuse.
>
> (B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
>
> (C) Abuse of the drug or other substances [sic] may lead to severe psychological or physical dependence.

As noted above the parties have stipulated, for the purpose of this proceeding, that marijuana has a high potential for abuse and that abuse of it may lead to severe psychological or physical dependence. Thus the dispute between the two sides in this proceeding is narrowed to whether or not marijuana has a currently accepted medical use in treatment in the United States, and whether or not there is a lack of accepted safety for use of marijuana under medical supervision.

The issues as framed here contemplate marijuana's being placed only in

Schedule I or Schedule II. The criteria for placement in any of the other three schedules established by the Act are irrelevant to this proceeding.

V.

ACCEPTED MEDICAL USE IN TREATMENT

- CHEMOTHERAPY

With respect to whether or not marijuana has a "currently accepted medical use in treatment in the United States" for chemotherapy patients, the record shows the following facts to be uncontroverted.

Findings Of Fact

1. One of the most serious problems experienced by cancer patients undergoing chemotherapy for their cancer is severe nausea and vomiting caused by their reaction to the toxic (poisonous) chemicals administered to them in the course of this treatment. This nausea and vomiting at times becomes life threatening. The therapy itself creates a tremendous strain on the body. Some patients cannot tolerate the severe nausea and vomiting and discontinue treatment. Beginning in the 1970's there was considerable doctor-to-doctor communication in the United States concerning patients known by their doctors to be surreptitiously using marijuana with notable success to overcome or lessen their nausea and vomiting.

2. Young patients generally achieve better control over nausea and vomiting from smoking marijuana than do older patients, particularly when the older patient has not been provided with detailed information on how to smoke marijuana.

3. Marijuana cigarettes in many cases are superior to synthetic THC capsules in reducing chemotherapy-induced nausea and vomiting. Marijuana

cigarettes have an important, clear advantage over synthetic THC capsules in that the natural marijuana is inhaled and generally takes effect more quickly than the synthetic capsule which is ingested and must be processed through the digestive system before it takes effect.

4. Attempting to orally administer the synthetic THC capsule to a vomiting patient presents obvious problems - it is vomited right back up before it can have any effect.

5. Many physicians, some engaged in medical practice and some teaching in medical schools, have accepted smoking marijuana as effective in controlling or reducing the severe nausea and vomiting (emesis) experienced by some cancer patients undergoing chemotherapy for cancer.

6. Such physicians include board-certified internists, oncologists and psychiatrists. (Oncology is the treatment of cancer through the use of highly toxic chemicals, or chemotherapy.)

7. Doctors who have come to accept the usefulness of marijuana in controlling or reducing emesis resulting from chemotherapy have done so as the result of reading reports of studies and anecdotal reports in their professional literature, and as the result of observing patients and listening to reports directly from patients.

8. Some cancer patients who have acknowledged to doctors that they smoke marijuana for emesis control have indicated in their discussions that, although they may have first smoked marijuana recreationally, they accidentally found that doing so helped reduce the emesis resulting from their chemotherapy. They consistently indicated that they felt better and got symptomatic relief from the intense nausea and vomiting caused by the chemotherapy. These patients

were no longer simply getting high, but were engaged in medically treating their illness, albeit with an illegal substance. Other chemotherapy patients began smoking marijuana to control their emesis only after hearing reports that the practice had proven helpful to others. Such patients had not smoked marijuana recreationally.

9. This successful use of marijuana has given many cancer chemotherapy patients a much more positive outlook on their overall treatment, once they were relieved of the debilitating, exhausting and extremely unpleasant nausea and vomiting previously resulting from their chemotherapy treatment.

10. In about December 1977 the previously underground patient practice of using marijuana to control emesis burst into the public media in New Mexico when a young cancer patient, Lynn Pearson, began publicly to discuss his use of marijuana. Mr. Pearson besought the New Mexico legislature to pass legislation making marijuana available legally to seriously ill patients whom it might help. As a result, professionals in the public health sector in New Mexico more closely examined how marijuana might be made legally available to assist in meeting what now openly appeared to be a widely recognized patient need.

11. In many cases doctors have found that, in addition to suppressing nausea and vomiting, smoking marijuana is a highly successful appetite stimulant. The importance of appetite stimulation in cancer therapy cannot be overstated. Patients receiving chemotherapy often lose tremendous amounts of weight. They endanger their lives because they lose interest in food and in eating. The resulting sharp reduction in weight may well affect their prognosis. Marijuana smoking induces some patients to eat. The benefits are obvious, doctors have found. There is no significant loss of weight. Some patients will gain weight.

This allows them to retain strength and makes them better able to fight the cancer. Pyschologically, patients who can continue to eat even while receiving chemotherapy maintain a balanced outlook and are better able to cope with their disease and its treatment, doctors have found.

12. Synthetic anti-emetic agents have been in existence and utilized for a number of years. Since about 1980 some new synthetic agents have been developed which appear to be more effective in controlling and reducing chemotherapy-induced nausea and vomiting than were some of those available in the 1970's. But marijuana still is found more effective for this purpose in some people than any of the synthetic agents, even the newer ones.

13. By the late 1970's in the Washington, D.C. area there was a growing recognition among health care professionals and the public that marijuana had therapeutic value in reducing the adverse effects of some chemotherapy treatments. With this increasing public awareness came increasing pressure from patients on doctors for information about marijuana and its therapeutic uses. Many patients moved into forms of unsupervised self-treatment. While such self-treatment often proved very effective, it has certain hazards, ranging from arrest for purchase or use of an illegal drug to possibly serious medical complications from contaminated sources or adulterated materials. Yet, some patients are willing to run these risks to obtain relief from the debilitating nausea and vomiting caused by their chemotherapy treatments.

14. Every oncologist known to one Washington, D.C. practicing internist and board-certified oncologist has had patients who used marijuana with great success to prevent or diminish chemotherapy-induced nausea and vomiting. Chemotherapy patients reporting directly to that Washington doctor that they

have smoked marijuana medicinally vomit less and eat better than patients who do not smoke it. By gaining control over their severe nausea and vomiting these patients undergo a change of mood and have a better mental outlook than patients who, using the standard anti-emetic drugs, are unable to gain such control.

15. The vomiting induced by chemotherapeutic drugs may last up to four days following the chemotherapy treatment. The vomiting can be intense, protracted and, in some instances, is unendurable. The nausea which follows such vomiting is also deep and prolonged. Nausea may prevent a patient from taking regular food or even much water for periods of weeks at a time.

16. Nausea and vomiting of this severity degrades the quality of life for these patients, weakening them physically, and destroying the will to fight the cancer. A desire to end the chemotherapy treatment in order to escape the emesis can supersede the will to live. Thus the emesis, itself, can truly be considered a life-threatening consequence of many cancer treatments. Doctors have known such cases to occur. Doctors have known other cases where marijuana smoking has enabled the patient to endure, and thus continue, chemotherapy treatments with the result that the cancer has gone into remission and the patient has returned to a full, active satisfying life.

17. In San Francisco chemotherapy patients were surreptitiously using marijuana to control emesis by the early 1970's. By 1976 virtually every young cancer patient receiving chemotherapy at the University of California in San Francisco was using marijuana to control emesis with great success. The use of marijuana for this purpose had become generally accepted by the patients and increasingly by their physicians as a valid and effective form of treatment. This was particularly true for younger cancer patients, somewhat less common for

older ones. By 1979 about 25% to 30% of the patients seen by one San Francisco oncologist were using marijuana to control emesis, about 45 to 50 patients per year. Such percentages and numbers vary from city to city. A doctor in Kansas City who sees about 150 to 200 new cancer patients per year found that over the 15 years 1972 to 1987 about 5% of the patients he saw, or a total of about 75, used marijuana medicinally.

18. By 1987 marijuana no longer generated the intense interest in the world of oncology that it had previously, but it remains a viable tool, commonly employed, in the medical treatment of chemotherapy patients. There has evolved an unwritten but accepted standard of treatment within the community of oncologists in the San Francisco, California area which readily accepts the use of marijuana.

19. As of the Spring of 1987 in the San Francisco area, patients receiving chemotherapy commonly smoked marijuana in hospitals during their treatments. This in-hospital use, which takes place in rooms behind closed doors, does not bother staff, is expected by physicians and welcomed by nurses who, instead of having to run back and forth with containers of vomit, can treat patients whose emesis is better controlled than it would be without marijuana. Medical institutions in the Bay area where use of marijuana obtained on the streets is quite common, although discrete, include the University of California at San Francisco Hospital, the Mount Zion Hospital and the Franklin Hospital. In effect, marijuana is readily accepted throughout the oncologic community in the Bay area for its benefits in connection with chemotherapy. The same situation exists in other large metropolitan areas of the United States.

20. About 50% of the patients seen by one San Francisco oncologist

during the year 1987 were smoking marijuana medicinally. This is about 90 to 95 individuals. This number is higher than during the previous ten years due to the nature of this physician's practice which includes patients from the "tenderloin" area of San Francisco, many of whom are suffering from AIDS-related lymphosarcoma. These patients smoke marijuana to control their nausea and vomiting, not to "get high." They self-titrate, i.e., smoke the marijuana only as long as needed to overcome the nausea, to prevent vomiting.

21. The State of New Mexico set up a program in 1978 to make marijuana available to cancer patients pursuant to an act of the State legislature. The legislature had accepted marijuana as having medical use in treatment. It overwhelmingly passed this legislation so as to make marijuana available for use in therapy, not just for research. Marijuana and synthetic THC were given to patients, administered under medical supervision, to control or reduce emesis. The marijuana was in the form of cigarettes obtained from the Federal government. The program operated from 1979 until 1986, when funding for it was terminated by the State. During those seven years about 250 cancer patients in New Mexico received either marijuana cigarettes or THC. Twenty or 25 physicians in New Mexico sought and obtained marijuana cigarettes or THC for their cancer patients during that period. All of the oncologists in New Mexico accepted marijuana as effective for some of their patients. At least ten hospitals were involved in this program in New Mexico, in which cancer patients smoked their marijuana cigarettes. The hospitals accepted this medicinal marijuana smoking by patients. Voluminous reports filed by the participating physicians make it clear that marijuana is a highly effective anti-emetic substance. It was found in the New Mexico program to be far superior to the best available conventional

anti-emetic drug, Compazine, and clearly superior to synthetic THC pills. More than 90% of the patients who received marijuana within the New Mexico program reported significant or total relief from nausea and vomiting. Before the program began cancer patients were surreptitiously smoking marijuana in New Mexico to lessen or control their emesis resulting from chemotherapy treatments. They reported to physicians that it was successful for this purpose. Physicians were aware that this was going on.

22. In 1978 the Louisiana legislature became one of the first-State legislatures in the nation to recognize the efficacy of marijuana in controlling emesis by enacting legislation intended to make marijuana available by prescription for therapeutic use by chemotherapy patients. This enactment shows that there was widespread acceptance in Louisiana of the therapeutic value of marijuana. After a State Marijuana Prescription Review Board was established, pursuant to that legislation, it became apparent that, because of Federal restrictions, marijuana could be obtained legally only for use in cumbersome, formal research programs. Eventually a research program was entered into by the State, utilizing synthetic THC, but without much enthusiasm, since most professionals who had wanted to use marijuana clinically, to treat patients, had neither the time, resources nor inclination to get involved in this limited, formal study. The original purpose of the Louisiana legislation was frustrated by the Federal authorities. Some patients, who had hoped to obtain marijuana for medical use legally after enactment of the State legislation, went outside the law and obtained it illicitly. Some physicians in Louisiana accept marijuana as having a distinct medical value in the treatment of the nausea and vomiting associated with certain types of chemotherapy treatments.

23. In 1980 the State of Georgia enacted legislation authorizing a therapeutic research program for the evaluation of marijuana as a medically recognized therapeutic substance. Its enactment was supported by letters from a number of Georgia oncologists and other Georgia physicians, including the Chief of Oncology at Grady Hospital and staff oncologists at Emory University Medical Clinic. Sponsors of the legislation orginally intended the enactment of a law making marijuana available for clinical, therapeutic use by patients. The bill was referred to as the "Marijuana-as-Medicine" bill. The final legislation was crafted, however, of necessity, merely to set up a research program in order to obtain marijuana from the one legitimate source available - the Federal Government, which would not make the substance available for any purpose other than conducting a research program. The act was passed by an overwhelming majority in the lower house of the legislature and unanimously in the Senate. In January 1983 an evaluation of the program, which by then had had 44 evaluable marijuana smoking patient-participants, accepted marijuana smoking as being an effective anti-emetic agent.

24. In Boston, Massachusetts in 1977 a nurse in a hospital suggested to a chemotherapy patient, suffering greatly from the therapy and at the point of refusing further treatment, that smoking marijuana might help relieve his nausea and vomiting. The patient's doctor, when asked about it later, stated that many of his younger patients were smoking marijuana. Those who did so seemed to have less trouble with nausea and vomiting. The patient in question obtained some marijuana and smoked it, in the hospital, immediately before his next chemotherapy treatment. Doctors, nurses and orderlies coming into the room as he finished smoking realized what the patient had been doing. None of them

made any comment. The marijuana was completely successful with this patient, who accepted it as effective in controlling his nausea and vomiting. Instead of being sick for weeks following chemotherapy, and having trouble going to work, as had been the case, the patient was ready to return to work 48 hours after that chemotherapy treatment. The patient thereafter always smoked marijuana, in the hospital, before chemotherapy. The doctors were aware of it, openly approved of it and encouraged him to continue. The patient resumed eating regular meals and regained lost weight, his mood improved markedly, he became more active and outgoing and began doing things together with his wife that he had not done since beginning chemotherapy.

25. During the remaining two years of this patient's life, before his cancer ended it, he came to know other cancer patients who were smoking marijuana to relieve the adverse effects of their chemotherapy. Most of these patients had learned about using marijuana medically from their doctors who, having accepted its effectiveness, subtly encouraged them to use it.

26. A Boston psychiatrist and professor, who travels about the country, has found a minor conspiracy to break the law among oncologists and nurses in every oncology center he has visited to let patients smoke marijuana before and during cancer chemotherapy. He has talked with dozens of these health care oncologists who encourage their patients to do this and who regard this as an accepted medical usage of marijuana. He has known nurses who have obtained marijuana for patients unable to obtain it for themselves.

27. A cancer patient residing in Beaverton, Michigan smoked marijuana medicinally in the nearby hospital where he was undergoing chemotherapy from early 1979 until he died of his cancer in October of that year. He smoked it in

his hospital room after his parents made arrangements with the hospital for him to do so. Smoking marijuana controlled his post-chemotherapy nausea and vomiting, enabled him to eat regular meals again with his family, and he became outgoing and talkative. His parents accepted his marijuana smoking as effective and helpful. Two clergymen, among others, brought marijuana to this patient's home. Many people at the hospital supported the patient's marijuana therapy, none doubted its helpfulness or discouraged it. This patient was asked for help by other patients. He taught some who lived nearby how to form the marijuana cigarettes and properly inhale the smoke to obtain relief from nausea and vomiting. When an article about this patient's smoking marijuana appeared in a local newspaper, he and his family heard from many other cancer patients who were doing the same. Most of them made an effort to inform their doctors. Most physicians who knew their patients smoked marijuana medicinally approved, accepting marijuana's therapeutic helpfulness in reducing nausea and vomiting.

28. In October 1979 the Michigan legislature enacted legislation whose underlying purpose was to make marijuana available therapeutically for cancer patients and others. The State Senate passed the bill 29-5, the House of Representatives 100-0. In March 1982 the Michigan legislature passed a resolution asking the Federal Congress to try to alter Federal policies which prevent physicians from prescribing marijuana for legitimate medical applications and prohibit its use in medical treatments.

29. In Denver, Colorado a teenage cancer patient has been smoking marijuana to control nausea and vomiting since 1986. He has done this in his hospital room both before and after chemotherapy. His doctor and hospital staff know he does this. The doctor has stated that he would prescribe marijuana for

this patient if it were legal to do so. Other patients in the Denver area smoke marijuana for the same purpose. This patient's doctor, and nurses with whom he comes in contact, understand that cancer patients smoke marijuana to reduce or control emesis. They accept it.

30. In late 1980 a three year old boy was brought by his parents to a hospital in Spokane, Washington. The child was diagnosed as having cancer. Surgery was performed. Chemotherapy was begun. The child became extremely nauseated and vomited for days after each chemotherapy treatment. He could not eat regularly. He lost strength. He lost weight. His body's ability to ward off common infections, other life-threatening infections, significantly decreased. Chemotherapy's after-effects caused the child great suffering. They caused his watching parents great suffering. Several standard, available anti-emetic agents were tried by the child's doctors. None of them succeeded in controlling his nausea or vomiting. Learning of the existence of research studies with THC or marijuana the parents asked the child's doctor to arrange for their son to be the subject of such a study so that he might have access to marijuana. The doctor refused, citing the volume of paperwork and record-keeping detail required in such programs and his lack of administrative personnel to handle it.

31. The child's mother read an article about marijuana smoking helping chemotherapy patients. She obtained some marijuana from friends. She baked cookies for her child with marijuana in them. She made tea for him with marijuana in it. When the child ate these cookies or drank this tea in connection with his chemotherapy, he did not vomit. His strength returned. He regained lost weight. His spirits revived. The parents told the doctors and nurses at the hospital of their giving marijuana to their child. None objected.

They all accepted smoking marijuana as effective in controlling chemotherapy-induced nausea and vomiting. They were interested to see the results of the cookies.

32. Soon this child was riding a tricycle in the hallways of the Spokane hospital shortly after his chemotherapy treatments while other children there were still vomiting into pans, tied to intervenous bottles in an attempt to re-hydrate them, to replace the liquids they were vomiting up. Parents of some of the other patients asked the parents of this "lively" child how he seemed to tolerate his chemotherapy so well. They told of the marijuana use. Of those parents who began giving marijuana to their children, none ever reported back encountering any adverse side effects. In the vast majority of these cases, the other parents reported significant reduction in their children's vomiting and appetite stimulation as the result of marijuana. The staff, doctors and nurses at the hospital knew of this passing on of information about marijuana to other parents. They approved. They never told the first parents to hide their son's medicinal use of marijuana. They accepted the effectiveness of the cookies and the tea containing marijuana.

33. The first child's cancer went into remission. Then it returned and spread. Emotionally drained, the parents moved the family back to San Diego, California to be near their own parents. Their son was admitted to a hospital in San Diego. The parents informed the doctors, nurses and social workers there of their son's therapeutic use of marijuana. No one objected. The child's doctor in San Diego strongly supported the parent's giving marijuana to him. Here in California, as in Spokane, other parents noticed the striking difference between their children after chemotherarpy and the first child.

Other parents asked the parents of the first child about it, were told of the use of marijuana, tried it with their children, and saw dramatic improvement. They accepted its effectiveness. In the words of the mother of the first child: ". . . When your kid is riding a tricycle while his other hospital buddies are hooked up to IV needles, their heads hung over vomiting buckets, you don't need a federal agency to tell you marijuana is effective. The evidence is in front of you, so stark it cannot be ignored."[6]

34. There is at least one hospital in Tucson, Arizona where medicinal use of marijuana by chemotherapy patients is encouraged by the nursing staff and some physicians.

35. In addition to the physicians mentioned in the Findings above, mostly oncologists and other practicioners, the following doctors and health care professionals, representing several different areas of expertise, accept marijuana as medically useful in controlling or reducing emesis and testified to that effect in these proceedings:

a. George Goldstein, Ph.D., psychologist, Secretary of Health for the State of New Mexico from 1978 to 1983 and chief administrator in the implementation of the New Mexico program utilizing marijuana;

b Dr. Daniel Danzak, psychiatrist and former head of the New Mexico program utilizing marijuana;

c. Dr. Tod Mikuriya, psychiatrist and editor of Marijuana: Medical Papers, a book presenting an historical perspective of marijuana's medical use;

d. Dr. Norman Zinberg, general psychiatrist and Professor of Psychiatry at Harvard Medical School since 1951;

6 Affidavit of Janet Andrews, ACT rebuttal witness, par. 98.