Chapter 1

A. The Controlled Substances Act

i. Overview and Constitutionality

The previous sections have focused on the criminalization of controlled substances examining the wisdom of prohibition, the elements of a variety of controlled substances offenses, sentencing of drug offenders and the investigation of drug crimes. The foundation for these criminal laws is a complex regulatory scheme that raises a host of policy questions and legal issues in its own right.

The federal Controlled Substances Act of 1970 (CSA), which is administered primarily by the Drug Enforcement Administration (DEA), aims to provide a comprehensive and uniform structure for classifying drugs of abuse and regulating their manufacture, distribution, as well as use in medical studies. Under the CSA, controlled substances are divided into five “schedules” based on their potential for abuse, medicinal value, and addictiveness. The following chart illustrates the factors for each of the five schedules.

Classification Under the Controlled Substances Act, 21 U.S.C. § 812(b)

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Abuse Potential</th>
<th>Medical Use</th>
<th>Safety and dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule I</td>
<td>High potential for abuse</td>
<td>No currently accepted medical use</td>
<td>Lack of accepted safety for use under medical supervision</td>
</tr>
<tr>
<td>Schedule II</td>
<td>High potential for abuse</td>
<td>Has a currently accepted medical use</td>
<td>Abuse may lead to severe dependence</td>
</tr>
<tr>
<td>Schedule III</td>
<td>Potential for abuse less than Schedules I and II</td>
<td>Has a currently accepted medical use</td>
<td>Abuse may lead to moderate or low physical dependence or high psychological dependence</td>
</tr>
<tr>
<td>Schedule IV</td>
<td>Low potential for abuse relative to Schedule III</td>
<td>Has a currently accepted medical use</td>
<td>Abuse may lead to limited dependence relative to Schedule III</td>
</tr>
<tr>
<td>Schedule V</td>
<td>Low potential for abuse relative to Schedule IV</td>
<td>Has a currently accepted medical use</td>
<td>Abuse may lead to limited dependence relative to Schedule IV</td>
</tr>
</tbody>
</table>

Looking over the chart, can you spot any regulatory holes? How would a substance that was found to have a “low potential for abuse” relative to the substances in Schedules I and II but “no currently medical use” be classified under this scheme?

The federal Controlled Substances Act only governs the classification and control of drugs under federal law and states are generally free to adopt their own regulatory
By and large, however, the state regulatory structure governing controlled substances mirrors federal law. This is because of the Uniform Controlled Substances Act (USCA), which was originally drafted in 1970 by the National Conference of Commissioners on Uniform State Laws during the same time as passage of the federal CSA. The USCA was designed to maintain consistency between state and federal law and the Commissioners have promulgated revisions to the USCA in 1990 and 1994 to account for changes in federal law. Every state except for Vermont and New Hampshire has adopted a version of the USCA, as has the District of Columbia, Puerto Rico, and the Virgin Islands. While the USCA serves as the foundation for the controlled substances laws across the country, each state has modified the USCA in various ways. For example, as we saw previously, while many states follow the USCA in making “distribution” or possession with the intent to “distribute” a crime, others criminalize “sale” or possession for “sale.” See Elaine M. Chiu, The Challenge of Motive in the Criminal Law, 8 BUFF. CRIM. L. R. 653, 699-700 (2005). Moreover, in a few areas, the USCA has intentionally left issues to the discretion of the states. Perhaps most notably, the USCA does not prescribe specific sentences for drug offenders. As a result, sentences between states for the same offense can vary widely. See, e.g., Michael M. O’Hear, National Uniformity/Local Uniformity: Reconsidering the Use of Departures to Reduce Federal-State Sentencing Disparities, 87 IOWA L. REV. 721, 749 (2002) (“A cocaine dealer, for instance, is subject to a two to four year term in California state court, but faces a minimum of five years and a maximum of life in Oklahoma.”).

With respect to the classification of controlled substances, however, the USCA has been especially influential. The UCSA is built around the same five-schedule structure as the federal CSA that classifies substances on the basis of their potential for abuse (and addiction) and usefulness in medical treatment. The states that have adopted the USCA generally follow this system. Nevertheless, because the classification of substances under the CSA changes over time based on federal administrative action, uniformity in the overall classification scheme does not always translate into uniformity as to whether a specific substance has been scheduled (and, if so, which schedule it falls under) at any given time.

To account for this problem, the USCA provides for a “short-form” scheduling process in addition to the standard scheduling procedure. The short form method allows states to incorporate scheduling decisions under the federal CSA into their own regulatory scheme in a streamlined fashion. A number of state courts have struck down this aspect of the USCA, however, on the grounds that their legislatures cannot delegate their “legislative power to a federal agency, nor to Congress.” Louisiana v. Rodriguez, 379 So. 2d 1084, 1087 (1980). See also, F. Scott Boyd, Looking Glass Law: Legislative Reference in the States, 68 LA. L. REV. 1201, 1267-69 (describing the split between states that have upheld this aspect of the USCA and those that have struck it down); Richard L. Braun, Uniform Controlled Substances Act of 1990, 13 CAMPBELL L. REV. 365, 368 (1990) (noting that some states “even prohibit delegation to state administrative agencies
of the power to add to or delete from statutorily created schedules"). As a result, the process for scheduling or rescheduling a substance can vary from state to state. But, the USCA’s substantive criteria for scheduling decisions and the five-schedule classification scheme are followed in almost every state.

Because the essential regulatory features of state controlled substances laws and the federal CSA are so similar, this book does not consider state classification of controlled substances separately, apart from areas where some states have taken a dramatically different approach than the federal government such as medical marijuana. This Chapter considers the classification of controlled substances focuses on the CSA with the understanding that in most states the law is likely to be substantially similar, if not identical, to the CSA.

Though the CSA is primarily responsible for the classification and regulation of illegal recreational drugs, there are a number of other statutes and agencies that regulate medications and legal recreational drugs (like tobacco and alcohol). The excerpt below provides additional insights into drug regulation generally and raises questions about whether the CSA achieves its stated goals of consistently classifying drugs of abuse based on science or whether non-scientific factors motivate how the law regulates drugs.

Making Sense of Drug Regulation: A Theory of Law For Drug Control Policy
Kimani Paul-Emile

The United States is a nation of drug users. The prevalence of drug use in the United States is astounding: from senior citizens who receive Medicare coverage, the largest group of drug users, to people convicted of drug offenses, who constitute a substantial portion of the state and federal prison populace. Today, drugs are consumed by members of nearly every segment of society and affect every aspect of modern life. Due to the sheer ubiquity of drug use today, many Americans may feel confident that they have a reasonable understanding of how drugs are, or should be, regulated. Readers may imagine that in a liberal democratic society, drugs are regulated according to scientific or medical evidence regarding their dangers and benefits.

In fact, however, drug regulatory decision-making in the United States over the past 150 years has often borne very little relationship to science. Many drugs are regulated in ways that belie scientific or medical evidence regarding their pharmacological characteristics. Tobacco products, for example, are the leading cause of preventable death in the United States, yet they can be bought and sold legally by adults, while marijuana—a significantly safer substance—is a Schedule I controlled drug and its use is therefore strictly prohibited. Similarly, although all forms of cocaine share the same active ingredients and produce the same psychotropic effects, simple possession of one particular form of cocaine—crack—renders one subject to some of the most severe sanctions available for any drug. Anabolic steroids are controlled substances; however, their distribution to some people seeking to enhance virility (particularly elderly men) is permissible, while sale to other healthy people seeking the same effects is not.

The health effects of drug use do not appear to determine how a particular drug will be regulated. And this raises two questions: how are regulators able to treat drugs
differently, irrespective of the dangers they may pose, and what processes do they follow to achieve this phenomenon? The state, at all levels of government, has at its disposal many regulatory mechanisms to control drug production, consumption and sale, including: drug scheduling by the U.S. Drug Enforcement Administration (DEA); imposition of state criminal and civil laws and penalties; market-based strategies, such as production subsidies and taxation; and the U.S. Food and Drug Administration (FDA) drug approval process and corresponding intellectual property laws, among others. The choice among these various mechanisms, however, has often not been based on empirical evidence grounded in science or medicine. Although some drugs carry substantial health risks and others do not, the amount of risk posed is not accurately reflected in the regulatory processes selected to govern each drug. Equally confounding is the fact that the use of these divergent regulatory mechanisms does not appear to have arisen from one overarching goal; nor is it based upon universal principles of public health or even a unified moral or ethical ideal.

This Article posits a model for making sense of this dissonance. Although much has been written on the topic of licit and illicit drug regulation, none of the scholarship in this vast literature has attempted to explain through an examination of pharmaceutical, illicit, and over-the-counter drugs how the apparent inconsistencies and incoherence of the U.S. system of drug control have been achieved and sustained. This Article fills the gap in this literature by proposing an innovative and comprehensive theoretical model for understanding how drugs become "medicalized," "criminalized," or deemed appropriate for recreational use, irrespective of any danger the drugs may pose.

The analytical framework this Article proposes, the "Regulatory Regime/Norms" model, posits that drugs begin as blank slates onto which meaning is conferred. Prior to regulatory intervention, the way any particular drug is perceived or understood is indeterminate and amorphous. As a result, the project of regulating drugs is about allocating specific meaning and significance to a drug in order to prompt individuals to think about the drug in a way that allows for state intervention. This is accomplished by regulatory regimes.

The Regulatory Regime/Norms model identifies three primary regulatory regimes used to control drug consumption and sale: the market regime, public health regime, and criminal regime. Each regime creates and reinforces specific norms with respect to the drugs it regulates: moral norms in the criminal regime, disclosure norms in the public health regime, and assumption of risk and rational choice norms in the market regime. These norms shape public understanding of drugs and the regulatory enterprise undertaken by the regime.

Broadly defined, a drug is a substance other than food that, when absorbed into the body of a living organism, affects the structure or function of the body. Virtually every society and culture in human history has embraced the use of some sort of drug and developed norms governing its consumption. Only the early inhabitants of arctic climates lacked indigenous drugs due to the inhospitable nature of their environment, which did not allow for the cultivation of such substances. Once introduced by outside groups, however, drugs were readily adopted into these cultures. The types of substances consumed and their effects are as varied as the cultures that use them. Some drugs are
taken to cure or ameliorate the symptoms of a disease or illness, while others, such as opiates and cannabis, are taken to relieve pain. There are drugs like coffee, tobacco, coca, tea, and khat that are taken for their stimulant effects. Still other drugs induce relaxation, provoke aggression, remove inhibitions, relieve tension, arouse or suppress the libido, or alter one's temporal experience. While some drugs are taken to help people cope with depression, hardship or tragedy, others are consumed simply as recreational activity to ameliorate the monotony of daily life. Psychotropic plants—organic substances that have the capacity to change the way one experiences time and space—are almost universally the most heavily regulated.

In order to address the prevalence of drug use, government—at the federal, state and local levels—promulgates and enforces laws to control production, consumption, and sale. Thus, today, individuals of all income levels, from rural, suburban, and urban areas, and from virtually every age, racial, and ethnic group are subject to a dizzying array of drug laws and regulations. These drug control measures differ in many critical respects, as do their social and demographic effects; from the highly touted "war on drugs" and the increased policing of tobacco use in public spaces, to regulations that have allowed for the unprecedented proliferation of prescription drugs.

The state justifies these laws as efforts to protect personal and public health, and to curb the social disorganization that may result from unregulated drug use. The specific aims and regulatory mechanisms used by the policy-making bodies that are granted jurisdiction over drug use differ sharply; from the lofty stated goals of the FDA to the punitive powers of the DEA. For example, one regulatory mechanism is drug scheduling. Pursuant to the Controlled Substances Act, the DEA and FDA administer five categories or "schedules" established to classify controlled substances according to their potential for abuse, therapeutic value, and possible addictiveness. Schedule I is the most restrictive classification and includes drugs such as heroin, LSD, and marijuana; while Schedule V is the least restrictive and includes codeine, a commonly prescribed painkiller. The drug regulations enacted according to these schedules are enforced by the DEA.

Another mechanism for drug control is the FDA drug approval process, which involves drug research, testing, and clinical trials undertaken by scientists, including academic researchers who often work in concert with the pharmaceutical companies that will ultimately manufacture and market the drug. Patent and intellectual property laws create financial incentives for innovation.

Other regulatory mechanisms are: state criminal laws and penalties; production subsidies that allow government to encourage the cultivation of certain drugs; regulation that occurs at the point of sale, such as age restrictions on the sale of alcohol and nicotine; taxation that allows the government to discourage, or levy a cost on, certain types of drug use; and the dictates of private associations as with anabolic steroids. An additional regulatory mechanism is litigation, which has increasingly become a dominant means by which drug use, production, and distribution are regulated, particularly when policy-makers are unwilling or unable to act legislatively. Finally, there is the option to not regulate, thereby leaving the issue to be resolved by market forces.

Before the government may regulate drugs or engage in any significant intervention into people's private affairs, it needs legitimating circumstances or a stated justification,
such as a show of harm or a substantial state interest. While the specific types of "threats" that drug regulators deem in need of remedy have differed over time, the most often stated justifications for intervention are harm to self, harm to others, and moral and ethical concerns.

These broad justifications tend to revolve around a few common themes, principally: ensuring the safety and efficacy of commercially manufactured pharmaceutical drugs; protecting children from the direct or indirect effects of drug use; fighting addiction; and reducing the secondary effects of drug use, such as criminal activity. The underlying rationale is that the government can properly intervene when (1) vulnerable populations that may be limited in their ability to make independent, rational decisions about drug use are at risk, such as children; (2) individuals infringe upon the rights and freedoms of others, such as those who engage in secondary criminal activity, etc.; or (3) drug activity conflicts with state expectations about what constitutes appropriate, moral, responsible, and virtuous behavior. Thus, the state must demonstrate whom it is protecting and why. Once the rationale has been stated, the issue then becomes which regulatory regime is the most suitable: the criminal regime, the public health regime, or the market regulatory regime.

Drug regulatory regimes, as operative today, did not exist a century ago. They have taken shape over time and expanded their sphere of influence into areas of social life previously deemed "private" or beyond the proper reach of government. In so doing, they developed specific areas of specialization that enabled them to establish their legitimacy and command authority. Regulatory regimes have evolved into increasingly differentiated and autonomous systems. Each is comprised of specific actors and institutions. And each regime is largely distinct from the others and maintains its own logic, training, and language. Each is bound by its own rules, values, ethics, and culture; employs different regulatory methods; relies upon distinct forms of knowledge; embodies unique preferences, expectations, and commitments; and serves different, although occasionally overlapping, political, commercial, and governmental interests. Each produces discourses that articulate regime norms, philosophies, and agendas. These discourses are deployed strategically and persuasively by the actors who administer and enforce the different regimes. For example, phrases such as "war on drugs," "harm reduction," and "personal responsibility" are not only constitutive parts of the criminal, public health, and market regimes, respectively, but they also work to influence public perceptions of drugs and drug users. The operation of this complex internal matrix allows each regime to erect its own institutional barriers. Thus, while drug regulatory regimes remain sensitive to outside norms and pressures, each regime exhibits a self-referential closure that enables it to reproduce itself as a distinct entity.

The governing principles that structure each regime are assumption of risk and rational choice principles in the market regime, disclosure principles in the public health regime, and moral principles in the criminal regulatory regime.

Regulation through the market regime is the default position in a liberal, capitalist democratic society. Within this regime, drugs are understood as consumer goods that are normalized through advertising and the respectability of their distribution through over-the-counter sales. The lack of stigma associated with drugs regulated through this regime
allows the users to be deemed rational consumers who have assumed the risks attendant to their drug use. This risk allocation, according to the market ethos, promotes efficiency by ensuring that the costs and burdens of drug use are borne by those best able to take appropriate measures to reduce injury. Tobacco, alcohol, and caffeine are examples of drugs governed primarily by the market regime.

Corporations are the primary players in this regime. Drug companies (e.g., tobacco, alcohol, etc.) are driven by the self-reinforcing need to maximize profits by increasing their share of the market of potential drug users through the creation of consumers and the generation of sales. Drug companies have become a formidable economic and political force, capable of thwarting most significant governmental attempts to intervene in the market regime to regulate drugs. This is due largely to the fact that the governing principles that structure the market regime reflect the orthodoxy of liberalism: the prevailing social arrangement of contemporary U.S. society. These corporate actors, therefore, work hard to frame their drugs in ways that resonate with the dominant principles of the market regime: rational choice and assumption of risk. This is accomplished primarily through advertising, which normalizes drug consumption by shaping popular understanding of certain drug use as normal, healthy, pleasurable and, indeed, necessary. Advertising is so critical to the operation of the market regulatory regime that corporations spend billions of dollars to carefully engineer advertisements for strategically targeted populations of potential consumers.

The so-called "free market," however, is by no means unfettered by government interference. Rather than reflecting a Hobbesian or natural state, the market is instead a socially conditioned and legally structured entity. It is the laissez-faire state that enforces liberal prescription in the market regime as government plays a much smaller role in this regime than in the others. Thus, many drugs in the market regime are subject to some, albeit minimal, regulation (e.g., alcohol and tobacco as opposed to caffeine or salvia divinorum, a powerful yet unregulated hallucinogen). Because the market regime is the original position in a liberal, capitalist, democratic society, regulators must justify their decisions to intervene in this regime.

The public health regulatory regime governs through science, which is more than just a metaphor; it is, rather, a specific and penetrating form of governance. From the FDA and National Institute on Drug Abuse to the Office of National Drug Control Policy and the National Institutes of Health, the missions of public health institutions and agencies with respect to drug regulation are vast, encompassing, broad-based efforts to: evaluate population health; prevent addiction, reduce the harms attendant to drug use (e.g., diseases passed through shared needles, etc.), assure the safety and efficacy of commercially manufactured drugs, evaluate the quality of and ensure access to drug treatment services, oversee and finance research, and encourage healthy behavior.

The institutes and actors that constitute the public health regime operate under principles of disclosure. These principles have emerged from the creation, evaluation, and dissemination of scientific knowledge, which requires an open, collaborative process, where transparency is paramount, and data is shared freely among those engaged in its research and evaluation. Disclosure, therefore, is essential to the fundamental authority of regulatory decision-making in the public health regime as this authority is based
entirely upon the independence, accuracy, and integrity of the procedures and protocols used to arrive at medical, scientific, and public health policy conclusions.

Disclosure principles also enable the FDA to effectively evaluate drug safety and efficacy during all phases of the drug approval process including requiring commercial drug manufacturers to release research data on drug properties and possible negative side effects, in order to ensure that drugs function according to manufacturers' claims. The disclosure of such health data from drug makers is essential to enabling medical practitioners to make informed professional decisions affecting patient care and for consumers to select the appropriate drugs to address their health needs.

The criminal drug regulatory regime focuses on the investigation, interdiction, arrest, prosecution and incarceration of those involved with illicit drug consumption, distribution, trafficking, and manufacture with the goal of punishing those who have transgressed the boundaries of civilized society. In the criminal regulatory regime, drug regulation is not only a practice of government, a means of shaping conduct, and an exercise of power and authority; it is also an aspirational endeavor to the extent that it seeks to forge notions of whom and what we should be individually and collectively. Thus, for a drug to be moved from the market or public health regimes to the criminal regulatory regime, it must do more than pose an ostensible threat to public health or safety; use of the drug must be perceived to violate fundamental moral values.

The criminal regime creates and reinforces principles derived from moral prescriptives. In addition to its regulatory and juridical functions, the criminal regulatory regime creates and reaffirms the moral principles of the collective consciousness writ large. Understood as such, this type of regulation is preconditioned upon notions of morality; both in terms of how regulators influence values, behavior, and beliefs with regard to that which constitutes good, just, appropriate, and responsible behavior; as well as how individuals perceive and respond to government.

If a group is able to persuasively frame a drug in a way that is consonant with the norms of the regime that suits the group's preferences, then the drug may be placed in that regime, regardless of whether the designation decision is supported by empirical evidence grounded in science or medicine. For example, tobacco was regulated for over a century in the market regime because its manufacturers successfully used advertising to painstakingly shape the meaning of smoking to reflect the prevailing norms of the market regulatory regime: rational choice and assumption of risk.

Despite tobacco's undisputed negative health effects and staggeringly high mortality rate, the tobacco industry has effectively used advertising to portray tobacco consumption as synonymous with freedom, independence, masculinity, sophistication, and cosmopolitanism. This characterization shaped public opinion and drove public acceptance, which was reflected back and popularized through positive media representations of smokers as young, healthy, and attractive. The tobacco industry's success in framing the drug in a way that is consistent with market regime norms has enabled it to not only defeat numerous attempts to shift tobacco into the public health regime, but has made it the second most popular recreational drug in the United States after alcohol.
In the case of marijuana, by contrast, no corporation bankrolled the fight to keep the
drug in the market regime, where marijuana had been widely available as a commonly
used appetite stimulant, muscle relaxant, analgesic, hypnotic, and anticonvulsant.
Instead, marijuana was moved to the criminal regulatory regime due to the success of a
grassroots movement in the Southwestern United States to frame marijuana use in a way
that resonated with the moral norms of the criminal regime. This movement, later joined
by the Federal Bureau of Narcotics, and assisted by the media, successfully labeled
marijuana in the public mind as "Mexican opium," a drug that turned Mexican field
hands violent and high school students insane. Indeed, at the turn of the twentieth
century, marijuana consumption in southwestern states was limited almost exclusively to
the Mexican population, which was perceived by many in the region as posing an
economic threat to the domestic labor force. Before long, racist and xenophobic fears
about Mexican immigrants, fueled by claims of a causal relationship between marijuana
and criminality, prompted southwestern states with large Mexican populations to begin
passing legislation outlawing the drug. By 1937, forty-six states had passed such
legislation, often with little debate.

Similarly, cocaine was a popular recreational and therapeutic drug found in
everything from alcoholic beverages, cigarettes, cough suppressants, baby elixirs and,
most famously, Coca-Cola, until Southern whites, during the early twentieth century,
successfully characterized cocaine as a drug that incited criminality, sexual deviance, and
defiant behavior in African-Americans. This framing of cocaine in moral terms
prompted its movement from the market regime to the criminal regulatory regime. So
persuasive was this characterization of cocaine that in the ensuing hysteria, Southern
police departments switched from .32 to .38 caliber bullets due to widespread reports that
cocaine-endowed African-Americans with extraordinary cunning and strength thus
rendering them virtually invincible to conventional weaponry. Despite whites' fears that
cocaine would provoke an African-American-led revolt and crime spree, none ever
materialized. Nevertheless, the fear that these myths and fantasies evoked was enough to
ease the passage of several laws restricting cocaine use, including the nation's first
criminal drug control law, the Harrison Act of 1914.

The regulation of anabolic androgenic steroids (AAS), a commercially manufactured
pharmaceutical drug, is also illustrative of the Regulatory Regime/Norms Model. For
nearly half a century, AAS had been classified as prescription drugs and the FDA had
regulated them in the public health regime. The sale of AAS for other than medicinal
purposes, however, was criminalized with passage of the Anabolic Steroid Control Act of
1990, which added the drug to Schedule III of the Controlled Substances Act. AAS were
not relegated to the criminal regime because of their alleged health effects or concerns
about illicit trafficking. Rather, AAS were criminalized because of their place at the
center of a cheating scandal at the 1988 Seoul Summer Olympic Games and the
subsequent dramatic coverage of AAS use in a series of articles published in Sports
Illustrated.

On November 18, 1988, scarcely a month after Canadian sprinter Ben Johnson was
stripped of his Olympic gold medal having tested positive for AAS after beating
American rival Carl Lewis in a world record setting race, President Ronald Reagan
signed into law the Anti-Drug Abuse Act of 1988. This law amended the Food, Drug,
Controlled Substances: Crime, Regulation, and Policy, Regulation of CS
Alex Kreit, akreit@tjsl.edu

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and Cosmetics Act by establishing a new criminal provision that significantly increased
the penalties for AAS distribution.

Within months, Congress held a series of hearings on whether to add AAS to the
schedule of controlled substances. At these hearings, scant evidence was presented that
AAS use posed a significant threat to healthy adult men. Furthermore, just months before
the 1988 Olympics, the Drug Enforcement Agency (DEA) and the U.S. Department of
Health and Human Services (HHS) recommended against scheduling AAS. Legislators,
nevertheless, emerged victorious in their efforts to frame AAS to fit the moral norms of
the criminal regime. The morally charged issue of cheating in sports had specific
resonance in the criminal regulatory regime that was not present in the public health or
market regimes. This enabled Congress to criminalize nonmedical AAS sales
legislatively, over objections from the American Medical Association, FDA, and DEA.
In so doing, Congress circumvented the forty-year-old administrative drug scheduling
process and thereby set a drug regulatory precedent.

The Regulatory Regime/Norms model also explains passage of the historic Pure Food
and Drug Act of 1906. Drugs sold prior to 1906 ran the gamut from well-intentioned but
effective medicines to patently phony nostrums. The quality of these drugs was
generally unreliable and of questionable purity because many drugs, including "soothing
syrups" for infants, contained inert substances and often some quantity of cocaine, opium,
alcohol, arsenic, mercury, or other narcotic, addictive, or lethal drug. Estimations at the
time put the death toll from such drugs in the tens of thousands. Despite the obvious
need for regulation, the ethos of the market regime was that it was up to the consumer to
take appropriate precautions against adulterated and fake drugs. Thus, there was little
protection for drug consumers because assumption of risk and rational choice principles
dominated the market regime.

In 1905, however, those who championed drug control legislation—primarily women
and physicians—successfully characterized the issue in a way that resonated with the
norms of the public health regime. Rather than highlight the immorality of selling toxic,
addictive, or lethal drugs—which would have moved dangerous drugs into the criminal
regulatory regime—these reformers instead argued that the contents of hazardous drugs
should be disclosed because individuals cannot make safe decisions about drug
consumption if they are unaware of what is in their drugs. Pointing to high profile
exposes of the drug industry to advance their claims, these reformers persuasively
characterized the problem in a way that resonated with the disclosure norms of the
nascent public health regime and, in so doing, forced passage of the Pure Food and Drug
Act of 1906. The unprecedented legislation did not criminalize or ban the manufacture or
sale of dangerous drugs, but rather centered public health concerns. The Act prohibited
misrepresentation in drug labeling and mandated that manufacturers disclose the presence
and amount of certain drugs, including alcohol, opium, cocaine, heroin, morphine,
chloroform, or acetanilide, although it did not prohibit inclusion of such substances.
Thus, although the Pure Food and Drug Act predated regulatory regimes as we know
them today, by disrupting the norms of the market regime and characterizing drugs in a
way that was consistent with the disclosure norms of the burgeoning public health
regime, reformers were able to pave the way for passage of the first federal law to
regulate drugs in the name of public health.
As we have seen with marijuana, cocaine, AAS, and the passage of the Pure Food and Drug Act, specific social events can create opportunities for those who engage in drug designation contests to succeed in characterizing a drug in a way that penetrates public thinking and makes regulatory regime changes possible. As the Regulatory Regime/Norms model makes clear, there is a contingency as to how a drug becomes vulnerable to the framing contests that lead to drug regulatory regime change. Anabolic steroids demonstrate this contingency. It is quite conceivable that had it not been for the Olympic cheating scandal, anabolic steroids could have become over-the-counter drugs regulated with age restrictions, much like tobacco and alcohol. Likewise, based on its broad social appeal, if marijuana were discovered today it might not be criminalized. Similarly, widely published exposes of the drug industry allowed drug regulation advocates, at the turn of the century, to focus public attention on their argument that drug makers should be required to disclose the contents of their drugs. However, these contingencies of historical context and physical place do not drive regulatory outcomes, but simply create opportunities for interested parties to characterize a drug in a way that shapes its popular understanding.

Kimani Paul-Emile argues that drug classification in the United States cannot be explained solely, or even primarily, by objective markers grounded in science and medicine. In the following case, the National Organization for the Reform of Marijuana Laws argued that the CSA’s classification of marijuana as a Schedule I substance was so irrational, in light of the legal status of other substances such as alcohol, that it should be declared unconstitutional. As a matter of constitutional law, the decision is unexceptional. The court applied the familiar rational basis test to reject NORML’s constitutional challenge. The chief value of the case for purposes of studying the CSA, however, is the policy questions it raises about how substances of abuse should be classified.

**The National Organization for the Reform of Marijuana Laws (NORML) v. Bell**  
**United States District Court for the District of Columbia**  

Tamm, J.

In this action, the National Organization for The Reform of Marijuana Laws (NORML or plaintiff) challenges the provisions of the Controlled Substances Act, 21 U.S.C. §§ 801-904 (CSA or Act), that prohibit the private possession and use of marijuana.

NORML filed this action October 10, 1973, seeking a declaratory judgment that the CSA and District of Columbia Uniform Narcotic Drug Act are unconstitutional in prohibiting the private possession and use of marijuana and requesting a permanent injunction enjoining enforcement of those statutes. This court stayed the proceedings for a year while NORML tried to obtain administrative relief through a proceeding to
reclassify marijuana.\textsuperscript{3} After the stay was vacated, the parties battled over preliminary motions for two years. Finally, in June 1978, this court heard five days of evidentiary hearings. Both sides presented live and documentary evidence concerning the effects of marijuana. Shortly thereafter, the parties submitted proposed findings of fact on the effects of marijuana and legal arguments for the court's consideration.

Congress passed the Comprehensive Drug Abuse Prevention and Control Act of 1970 (DAPCA), 21 U.S.C. §§ 801-966 (1976), to fight this nation's growing drug problem. The act was designed to "deal in a comprehensive fashion with the growing menace of drug abuse in the United States (1) through providing authority for increased efforts in drug abuse prevention and rehabilitation of users, (2) through providing more effective means for law enforcement aspects of drug abuse prevention and control, and (3) by providing for an overall balanced scheme of criminal penalties for offenses involving drugs." H.R. Rep. No. 1444, 91st Cong., 2d Sess. 1 (hereinafter cited as 1970 House Report). It ended the patchwork federal effort against drug abuse and signaled a national commitment to deal with this problem by committing federal funds for rehabilitation programs.\textsuperscript{4}

In addition to the rehabilitation programs, DAPCA also revised completely the federal drug laws dealing with drug control.\textsuperscript{5} Title II, called the Controlled Substances Act (CSA), establishes five schedules for classifying controlled substances according to specified criteria. Two criteria[a--]the potential for abuse and the medical applications of

\textsuperscript{3} On May 18, 1972, NORML filed an application with the Attorney General to remove marijuana from control under the CSA or, in the alternative, to reclassify the drug in a different schedule. This endeavor continues today. The Drug Enforcement Administration (DEA) twice rejected these efforts at reclassification, citing American treaty obligations under the Single Convention on Narcotic Drugs. The United States Court of Appeals for the District of Columbia Circuit reversed these determinations. N \textit{ORML v. DEA}, 559 F.2d 735 (D.C. Cir. 1977); N \textit{ORML v. Ingersoll}, 497 F.2d 654 (D.C. Cir. 1974). In the DEA case, the court directed the DEA to "refer the N \textit{ORML} petition to the Secretary of HEW for medical and scientific findings and recommendations for rescheduling, consistent with the requirements of the Single Convention." On remand the DEA again declined to reclassify marijuana. The Administrator of the DEA followed the recommendation of the Secretary of HEW that marijuana remain in Schedule I. N \textit{ORML v. DEA}, No. 79-1660 (D.C.Cir., filed June 27, 1979).

\textsuperscript{4} Title I of DAPCA deals with the rehabilitation of drug abusers and authorizes federal funds for treatment centers and drug abuse programs. Title II establishes controls and registration requirements for drugs, while Title III regulates the import and export of controlled substances.

Marijuana (cannabis sativa L.) is a psychoactive drug made of the leaves, flowers, and stems of the Indian Hemp plant. It derives its psychoactive properties from delta-9-tetrahydrocannabinol (THC), which exists in varying concentrations in the plant, depending on its origin, growing conditions, and cultivation. The concentration of THC within the sections of the plant also varies widely. The resin contains the greatest concentration of THC; smaller amounts are found, respectively, in the flowers, the leaves, and the stems. The most potent form of the drug, hashish, is prepared from the resins of the flowers and contains 5-12% THC. Marijuana generally found in the United States is weaker, with around 1% THC.

The drug produces a number of physiological and psychological effects. The short-term physiological effects have been well documented. They are reddening of the whites of the eye, dryness in the mouth, increased pulse rate, and impaired motor responses. The short-term psychological effects are equally well known:

At low, usual "social" doses, the intoxicated individual may experience an increased sense of well-being; initial restlessness and hilarity followed by a dreamy, carefree state of relaxation; alteration of sensory perceptions including expansion of space and time; and a more vivid sense of touch, sight, smell, taste, and sound; a feeling of hunger, especially a craving for sweets; and subtle changes in thought formation and expression. To an unknowing observer, an individual in this state of consciousness would not appear noticeably different from his normal state.

At higher, moderate doses, these same reactions are intensified . . . . The individual may experience rapidly changing emotions, changing sensory imagery, dulling of attention, more altered thought formation and expression such as fragmented thought, flight of ideas, impaired immediate memory, disturbed associations, altered sense of self-identity and, to some, a perceived feeling of enhanced insight.

At very high doses, psychotomimetic phenomena may be experienced. These include distortions of body image, loss of personal identity, sensory and mental illusions, fantasies and hallucinations. The intensity of these reactions depends on dosage, method of use, metabolism, attitude and setting, tolerance, duration of use, and pattern of use.

Experiences under marijuana intoxication are usually pleasurable, but negative reactions are not infrequent. These negative reactions include distortion of body image, depersonalization, acute panic anxiety reaction, nausea, and, more rarely, psychosis. These reactions may be caused or exaggerated by pre-existing psychological problems.
Studies have dispelled many of the myths about the drug: marijuana is not a narcotic, not addictive, and generally not a stepping-stone to other, more serious drugs. Furthermore, it causes neither aggressive behavior nor insanity.

Despite these findings, questions about long-term use remain. Studies have indicated that marijuana may affect adversely the lungs and the endocrine, the immunity, and the cardiovascular systems. Some of these studies are disputed, but an examination of these adverse findings illustrates the important questions still remaining about marijuana use.

In addition to these problems, other tests have found negative aspects to marijuana use. Amotivational difficulties and changes in brain cells, chromosomes, and cell metabolism have been noted in various studies. These findings have not been corroborated, however, and other research has reached contradictory conclusions. As with the other areas, these questions demand further scientific study to determine conclusively the long-term effects of marijuana. Although we now know that marijuana is not the "killer" drug, as branded in the past, its long-term effects are still an open question and must be approached as unresolved. These lingering questions must be kept in mind in considering the legal issues.

NORML contends that the CSA violates the equal protection component of the due process clause. First, it argues that the classification of marijuana, a relatively harmless drug, as a controlled substance violates equal protection. Second, NORML believes that, even if marijuana may be controlled, its classification as a Schedule I drug is infirm: placement in Schedule I is both underinclusive in failing to include as a controlled substance drugs such as alcohol and nicotine, which satisfy Schedule I criteria, and overinclusive for establishing the same penalties for possession of marijuana as for all other controlled substances and for including marijuana in Schedule I with the more dangerous narcotics and opiates. For the reasons stated below, this court rejects these contentions.

Legislation that does not affect a "fundamental" right or a "suspect" class need only bear a rational relationship to a legitimate state interest. This standard of judicial review gives legislatures wide discretion and permits them to attack problems in any rational manner. The classification will be upheld unless "the varying treatment of different

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Marijuana is not physically addictive, but some studies have found that long-term users develop a psychological addiction.

Clinical studies have failed to discover a relationship between use of marijuana and use of more addictive drugs such as heroin. These laboratory studies may fail to take account of the social and psychological pressures confronting marijuana users "on the street." Testifying before Congress, Doctor Robert W. Baird, director of the Haven Clinic, a narcotics rehabilitation center in Harlem, stated that use of marijuana provided youngsters a pleasurable introduction to the "drug culture"; after initial experimentation with marijuana, young marijuana users were more willing to try stronger, more dangerous, substances. Decriminalization of Marihuana: Hearings Before the House Select Committee on Narcotics Abuse and Control, 95th Cong., 1st Sess. 423-38 (1977) (testimony of Dr. Robert W. Baird).
The inclusion of marijuana as a controlled substance under the CSA easily satisfies this deferential rationality standard. Congress gave the CSA provisions concerning marijuana considerable attention. It recognized that much of the information regarding marijuana was inaccurate and that bias and ignorance had perpetuated many myths about the consequences and dangers of marijuana use. Despite all the concern over the drug, few reliable scientific studies existed that could give accurate information to the legislators. Representative Cohelan acknowledged this lack of accurate information on marijuana during the House discussion of the bill: "Much remains to be done to find out the effects of marijuana. Assertions from both sides are not hard to find, but there is precious little hard clinical data on this subject." Unsure of marijuana's effects, Congress placed marijuana in Schedule I, with its program of strict controls, until it could obtain more scientific information on the drug's effects. In so doing, Congress followed the recommendation of the Department of Health, Education, and Welfare, which had suggested classification in Schedule I until further tests could be completed.

Inclusion of marijuana as a controlled substance in 1970 certainly was rational. The information then available indicated that marijuana might well have substantial detrimental effects, and Congress thus reasonably could decide to include the drug as a controlled substance rather than leave it unregulated. NORML argues that, although classification of marijuana as a controlled substance in 1970 might have been rational, the scientific evidence available today establishes that "private possession and use of marijuana by adults (do) not pose any significant danger to the public health, safety or welfare." NORML therefore asserts the classification of marijuana as a controlled substance is no longer rational and invokes United States v. Carolene Products Co., 304 U.S. 144, 153 (1938): "the constitutionality of a statute predicated upon a particular state of facts may be challenged by a showing to the court that those facts have ceased to exist."

The record, however, is not so clear as NORML contends. Experts still strongly disagree about the safety of marijuana, and its long-term effects remain an open question. Studies indicate that marijuana may impair the circulatory, the endocrine, and the immunity systems of the body, alter chromosomes, and change cell metabolism. Although many dispute these findings, this contradictory evidence demonstrates that important questions about marijuana use persist.

Given the continuing debate over marijuana, this court must defer to the legislature's judgments on disputed factual issues. The classification need not change continually as more information becomes available. Congressional action must be upheld as long as a

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32 In an effort to secure more information about marijuana, Congress established the Commission on Marihuana and Drug Abuse to study marijuana use and its effects. The Commission, headed by Governor Raymond P. Shafer, issued its report, Marihuana: A Signal of Misunderstanding, in 1972. The Commission recommended that federal and state penalties for private possession of marijuana be eliminated and that governmental efforts should focus on discouraging marijuana use.
rational basis still exists for the classification. The continuing questions about marijuana and its effects make the classification rational.

In a related equal protection challenge, NORML argues that classification of marijuana in Schedule I is irrational as being both underinclusive and overinclusive. The CSA does not regulate alcohol and tobacco, which are more harmful than marijuana, and it places marijuana in the same schedule with such dangerous substances as heroin and other narcotics. Thus, even if the classification of marijuana as a controlled substance is rational, the plaintiff believes that the legislation nonetheless is unconstitutional because marijuana's treatment within the Act is irrational in relation to other controlled substances.

"Underinclusive classifications do not include all who are similarly situated with respect to a rule, and thereby burden less than would be logical to achieve the intended government end." L. Tribe, American Constitutional Law, § 16-4, at 997 (1978). To be successful in a challenge based on underinclusiveness, plaintiff must show that the governmental choice is "clearly wrong, a display of arbitrary power, not an exercise of judgment[."

Mathews v. de Castro, 429 U.S. 181, 185 (1976). Few challengers can sustain such a heavy burden of proof. Courts have recognized the very real difficulties under which legislatures operate difficulties that arise due to the nature of the legislative process and the society that legislation attempts to reshape. As Professor Tribe has explained: "underinclusive" or "piecemeal legislation is a pragmatic means of effecting needed reforms, where a demand for completeness may lead to total paralysis . . . ."

Legislatures have wide discretion in attacking social ills. "A State may direct its law against what it deems the evil as it actually exists without covering the whole field of possible abuses, and it may do so none the less that the forbidden act does not differ in kind from those that are allowed." Hughes v. Superior Court, 339 U.S. 460, 468 (1950). Failure to address a certain problem in an otherwise comprehensive legislative scheme is not fatal to the legislative plan.

Given this policy of legislative freedom in confronting social problems, the exclusion of alcohol and tobacco from the CSA does not render the scheme unconstitutional. Different legislative schemes control the sale and distribution of alcohol and tobacco. The specific exemption of alcohol and tobacco from the provisions of the CSA, 21 U.S.C. § 802(6)), reflects Congress's view that other regulatory schemes are more appropriate for alcohol and tobacco. That alcohol and tobacco may have adverse effects on health does not mean the CSA is the only proper means of regulating these drugs, nor does it mean that marijuana should be treated identically. As a Presidential commission on drug abuse pointed out, "While alcoholism constitutes a major social problem, surely it is not valid to justify the adoption of a new abuse on the basis that it is no worse than a presently

36 In discussing the regulation of alcohol and tobacco, one district court observed: "The legislative judgment concerning alcohol and nicotine may well have taken into account the degree to which their dangers are known, the adverse consequences of prohibition, and the economic significance of their production. Whether such factors should lead to similar judgments concerning marijuana is within legislative discretion." United States v. Maiden, 355 F. Supp. 743, 747-48 (D.Conn.1973).
Congress, having the power to deal with drug abuse in any reasonable manner, decided to exclude alcohol and tobacco from the CSA. This court will not disturb that judgment.

A law also may be challenged for including within a prohibited class an item that does not rationally belong with the other members of that class. NORML once again draws its support from the *Carolene Products* decision: “[T]he constitutionality of a statute, valid on its face, may be assailed by proof of facts tending to show that the statute as applied to a particular article is without support in reason because the article, although within the (particular) class, is so different from others of the class as to be without the reason for the prohibition.” *United States v. Carolene Products* Co., 304 U.S. at 153-54. The plaintiff here argues marijuana's classification in Schedule I is impermissible because the drug does not fit the statutory criteria for placement in that schedule.

NORML argues that marijuana does not belong in Schedule I, for it does not satisfy that schedule's statutory criteria high potential for abuse, no medically accepted use, and no safe use of the drug even under medical supervision. The Government disagrees and contends that all three criteria are met. It claims the drug has a "high potential for abuse," in that millions of Americans use marijuana on their own initiative rather than on the basis of medical advice. While tests have indicated that marijuana may have therapeutic uses in the treatment of glaucoma and cancer, the Food and Drug Administration does not currently accept it for any form of medical treatment. Finally, the Government claims that marijuana cannot be used safely due to the differing concentrations of THC in cannabis.

Even assuming, arguendo, that marijuana does not fall within a literal reading of Schedule I, the classification still is rational. Placing marijuana in Schedule I furthered the regulatory purposes of Congress. The statutory criteria of section 812(b)(1) are guides in determining the schedule to which a drug belongs, but they are not dispositive. Indeed, the classifications at times cannot be followed consistently, and some conflict exists as to the main factor in classifying a drug potential for abuse or possible medical use. The district court in *United States v. Maiden*, 355 F. Supp. 743 (D.Conn.1973), discussed this problem in rejecting the identical claim raised here by NORML:

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40 According to the House Report, "(a) key criterion for controlling a substance, and the one which will be used most often, is the substance's potential for abuse." Senator Hughes, on the other hand, believed the existence of an accepted medical use was the primary factor in a drug's classification. Discussing the penalties for possession of marijuana and heroin, he noted: “Classification in the bill depends primarily upon whether there is an accepted medical use for the drug. Because heroin and marijuana have no recognized medical use, they are classified in the same category. . . . If there is no valid use for a drug, there is a sound reason to impose the strictest recordkeeping controls. But criminal sanctions for illegal distribution and use should be based upon the danger to society and the individual, not upon whether there is any valid medical use.”

Other members of Congress indicated the two criteria were equally important.
The statutory classifications cannot logically be read as cumulative in all situations. For example, finding (B) for Schedule I requires that "The drug or other substance has no currently accepted medical use in treatment in the United States." Finding (B) for the other four schedules specifies that the drug has a currently accepted medical use. At the same time, finding (A) requires that the drug has a "high potential for abuse" for placement in Schedule I, but a "potential for abuse less than the drugs or other substances in Schedules I and II" for placement in Schedule III. If the findings are really cumulative, where would one place a drug that has no accepted medical use but also has a potential for abuse less than the drugs in Schedules I and II? According to finding (A) for Schedule III it belongs in Schedule III, but finding (B) for that schedule precludes Schedule III; according to finding (B) for Schedule I it belongs in Schedule I, but finding (A) for that schedule appears to preclude Schedule I.

The legislative history also indicates the statutory criteria are not intended to be exclusive. The House report states that "[a]side from the criterion of actual or relative potential for abuse, subsection (c) of section 201 (21 U.S.C. § 811(c)) lists seven other criteria . . . which must be considered in determining whether a substance meets the specific requirements specified in section 202(b) (21 U.S.C. § 812(b)) for inclusion in particular schedules . . . ." 1970 House Report, *supra* at 35, reprinted in (1970) U.S. Code Cong. & Admin. News at 4602. The criteria listed in section 811(c) include the state of current knowledge, the current pattern of abuse, the risk to public health, and the significance of abuse. These more subjective factors significantly broaden the scope of issues to be considered in classifying a drug. Given these other concerns, Congress might well want marijuana in Schedule I for regulatory purposes. Such a classification carries heavier penalties for sale, distribution, and importation, thus aiding law enforcement officials in their effort to reduce the supply of marijuana.

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41 This section states: “In making any finding under subsection (a) of this section or under subsection (b) of section 202 (21 U.S.C. § 812(b)), the Attorney General shall consider the following factors with respect to each drug or other substance proposed to be controlled or removed from the schedules:

1. Its actual or relative potential for abuse.
2. Scientific evidence of its pharmacological effect, if known.
3. The state of current scientific knowledge regarding the drug or other substance.
4. Its history and current pattern of abuse.
5. The scope, duration, and significance of abuse.
6. What, if any, risk there is to the public health.
7. Its psychic or physiological dependence liability.
8. Whether the substance is an immediate precursor of a substance already controlled under this title. 21 U.S.C. § 811(c).
In addition, Congress itself made the initial classifications and established a procedure for reclassifying drugs and controlled substances: "Schedules I, II, III, IV, and V shall, unless and until amended pursuant to section 811 of this title, consist of the following drugs and other substances . . . ." 21 U.S.C. § 812(c). In making the initial determination, Congress placed marijuana in Schedule I. The clear meaning of section 812(c) is that Congress intended marijuana to remain in Schedule I until such time as it might be reclassified by the Attorney General on the basis of more complete scientific information about the drug. In such a reclassification hearing, the statutory criteria would be the guides to determining the most appropriate schedule for marijuana. By providing for periodic review and constant revision of drug classifications, Congress enacted a sensible mechanism for scrutinizing the classification of marijuana. As Judge Feinberg stated in United States v. Kiffer:

[T]he very existence of the statutory scheme indicates that, in dealing with the "drug" problem, Congress intended flexibility and receptivity to the latest scientific information to be the hallmarks of its approach. This . . . is the very antithesis of the irrationality (plaintiff) attributes to Congress.

The legislative scheme under section 811 offers a flexible means of reclassifying controlled substances, and the Attorney General may reclassify marijuana pursuant to that scheme. The propriety of any administrative determination on the reclassification of marijuana is not before this court. The constitutional legitimacy of the classification of marijuana in Schedule I is challenged, however, and this court concludes that the classification is constitutionally permissible. Thus, plaintiff's equal protection challenge must be rejected.

In this case, NORML has asked this court to overturn the CSA prohibition on private possession of marijuana. In so doing, NORML misdirects its efforts. This challenge presents the difficult social questions that legislatures are especially adept at resolving, and we do not sit to second-guess their judgments. Under our system of checks and balances, it is the court's duty to examine legislation and to determine the legality or illegality of that legislation within the confines of the law. The legislative system may not always work efficiently, or fairly, but we have staked our fortunes on it, and our history would support the wisdom of our forefathers' judgment.

NORML's efforts have seared the conscience of many representatives. Eleven states have decriminalized possession of marijuana and efforts to decriminalize are continuing in many others. The legislative branch, and not the judicial, is the proper battleground for the fight to decriminalize the possession of marijuana. The people, and not the courts, must decide whether the battle will be won or lost.

The court in NORML v. Bell concludes that NORML’s constitutional challenge is misdirected and that advocates for marijuana decriminalization or reclassification should address their arguments to the legislature or the Controlled Substances Act’s administrative procedure for rescheduling controlled substances. But was it constitutional for Congress to delegate the power to criminalize substances under the
CSA to the same administrative entity responsible for enforcing the CSA? In the following case, the Supreme Court addresses this question.

**Touby v. United States**  
*Supreme Court of the United States*  
500 U.S. 160 (1991)

Justice O’Connor delivered the opinion of the Court.

Petitioners were convicted of manufacturing and conspiring to manufacture "Euphoria," a drug temporarily designated as a schedule I controlled substance pursuant to § 201(h) of the Controlled Substances Act. We consider whether § 201(h) unconstitutionally delegates legislative power to the Attorney General and whether the Attorney General's subdelegation to the Drug Enforcement Administration (DEA) was authorized by statute.

In 1970, Congress enacted the Controlled Substances Act (Act). The Act establishes five categories or "schedules" of controlled substances, the manufacture, possession, and distribution of which the Act regulates or prohibits. Violations involving schedule I substances carry the most severe penalties, as these substances are believed to pose the most serious threat to public safety. Relevant here, § 201(a) of the Act authorizes the Attorney General to add or remove substances, or to move a substance from one schedule to another.

When adding a substance to a schedule, the Attorney General must follow specified procedures. First, the Attorney General must request a scientific and medical evaluation from the Secretary of Health and Human Services (HHS), together with a recommendation as to whether the substance should be controlled. A substance cannot be scheduled if the Secretary recommends against it. Second, the Attorney General must consider eight factors with respect to the substance, including its potential for abuse, scientific evidence of its pharmacological effect, its psychic or physiological dependence liability, and whether the substance is an immediate precursor of a substance already controlled. Third, the Attorney General must comply with the notice-and-hearing provisions of the Administrative Procedure Act (APA), 5 U. S. C. §§ 551-559, which permit comment by interested parties. In addition, the Act permits any aggrieved person to challenge the scheduling of a substance by the Attorney General in a court of appeals.

It takes time to comply with these procedural requirements. From the time when law enforcement officials identify a dangerous new drug, it typically takes 6 to 12 months to add it to one of the schedules. Drug traffickers were able to take advantage of this time gap by designing drugs that were similar in pharmacological effect to scheduled substances but differed slightly in chemical composition, so that existing schedules did not apply to them. These "designer drugs" were developed and widely marketed long before the Government was able to schedule them and initiate prosecutions.

To combat the "designer drug" problem, Congress in 1984 amended the Act to create an expedited procedure by which the Attorney General can schedule a substance on a temporary basis when doing so is "necessary to avoid an imminent hazard to the public
safety." Temporary scheduling under § 201(h) allows the Attorney General to bypass, for a limited time, several of the requirements for permanent scheduling. The Attorney General need consider only three of the eight factors required for permanent scheduling. Rather than comply with the APA notice-and-hearing provisions, the Attorney General need provide only a 30-day notice of the proposed scheduling in the Federal Register. Notice also must be transmitted to the Secretary of HHS, but the Secretary's prior approval of a proposed scheduling order is not required. Finally, § 201(h)(6) provides that an order to schedule a substance temporarily "is not subject to judicial review."

Because it has fewer procedural requirements, temporary scheduling enables the Government to respond more quickly to the threat posed by dangerous new drugs. A temporary scheduling order can be issued 30 days after a new drug is identified, and the order remains valid for one year. During this 1-year period, the Attorney General presumably will initiate the permanent scheduling process, in which case the temporary scheduling order remains valid for an additional six months.

The Attorney General promulgated regulations delegating to the DEA his powers under the Act, including the power to schedule controlled substances on a temporary basis. See 28 CFR § 0.100(b) (1990). Pursuant to that delegation, the DEA Administrator issued an order scheduling temporarily 4-methylaminorex, known more commonly as "Euphoria," as a schedule I controlled substance. 52 Fed. Reg. 38225 (1987). The Administrator subsequently initiated formal rulemaking procedures, following which Euphoria was added permanently to schedule I.

While the temporary scheduling order was in effect, DEA agents, executing a valid search warrant, discovered a fully operational drug laboratory in Daniel and Lyrissa Touby's home. The Toubys were indicted for manufacturing and conspiring to manufacture Euphoria. They moved to dismiss the indictment on the grounds that § 201(h) unconstitutionally delegates legislative power to the Attorney General, and that the Attorney General improperly delegated his temporary scheduling authority to the DEA. The United States District Court for the District of New Jersey denied the motion to dismiss and the Court of Appeals for the Third Circuit affirmed petitioners' subsequent convictions. We granted certiorari and now affirm.


We have long recognized that the nondelegation doctrine does not prevent Congress from seeking assistance, within proper limits, from its coordinate Branches. Thus, Congress does not violate the Constitution merely because it legislates in broad terms, leaving a certain degree of discretion to executive or judicial actors. So long as Congress "lay[s] down by legislative act an intelligible principle to which the person or body authorized to [act] is directed to conform, such legislative action is not a forbidden delegation of legislative power." J. W. Hampton, Jr., & Co. v. United States, 276 U.S. 394, 409 (1928).
Petitioners wisely concede that Congress has set forth in § 201(h) an "intelligible principle" to constrain the Attorney General's discretion to schedule controlled substances on a temporary basis. We have upheld as providing sufficient guidance statutes authorizing the War Department to recover "excessive profits" earned on military contracts; authorizing the Price Administrator to fix "fair and equitable" commodities prices; and authorizing the Federal Communications Commission to regulate broadcast licensing in the "public interest". In light of these precedents, one cannot plausibly argue that § 201(h)'s "imminent hazard to the public safety" standard is not an intelligible principle.

Petitioners suggest, however, that something more than an "intelligible principle" is required when Congress authorizes another Branch to promulgate regulations that contemplate criminal sanctions. They contend that regulations of this sort pose a heightened risk to individual liberty and that Congress must therefore provide more specific guidance. Our cases are not entirely clear as to whether more specific guidance is in fact required. We need not resolve the issue today. We conclude that § 201(h) passes muster even if greater congressional specificity is required in the criminal context.

Although it features fewer procedural requirements than the permanent scheduling statute, § 201(h) meaningfully constrains the Attorney General's discretion to define criminal conduct. To schedule a drug temporarily, the Attorney General must find that doing so is "necessary to avoid an imminent hazard to the public safety." In making this determination, he is "required to consider" three factors: the drug's "history and current pattern of abuse"; "the scope, duration, and significance of abuse"; and "what, if any, risk there is to the public health." 21 U. S. C. §§ 811(c)(4)-(6), 811(h)(3). Included within these factors are three other factors on which the statute places a special emphasis: "actual abuse, diversion from legitimate channels, and clandestine importation, manufacture, or distribution." The Attorney General also must publish 30-day notice of the proposed scheduling in the Federal Register, transmit notice to the Secretary of HHS, and "take into consideration any comments submitted by the Secretary in response."

It is clear that in §§ 201(h) and 202(b) Congress has placed multiple specific restrictions on the Attorney General's discretion to define criminal conduct. These restrictions satisfy the constitutional requirements of the nondelegation doctrine.
Petitioners point to two other aspects of the temporary scheduling statute that allegedly render it unconstitutional. They argue first that it concentrates too much power in the Attorney General. Petitioners concede that Congress may legitimately authorize someone in the Executive Branch to schedule drugs temporarily, but argue that it must be someone other than the Attorney General because he wields the power to prosecute crimes. They insist that allowing the Attorney General both to schedule a particular drug and to prosecute those who manufacture that drug violates the principle of separation of powers. Petitioners do not object to the permanent scheduling statute, however, because it gives "veto power" to the Secretary of HHS.

This argument has no basis in our separation-of-powers jurisprudence. The principle of separation of powers focuses on the distribution of powers among the three coequal Branches; it does not speak to the manner in which authority is parceled out within a single Branch. The Constitution vests all executive power in the President, U. S. Const., Art. II, § 1, and it is the President to whom both the Secretary and the Attorney General report. Petitioners' argument that temporary scheduling authority should have been vested in one executive officer rather than another does not implicate separation-of-powers concerns; it merely challenges the wisdom of a legitimate policy judgment made by Congress.

Petitioners next argue that the temporary scheduling statute is unconstitutional because it bars judicial review. They explain that the purpose of requiring an "intelligible principle" is to permit a court to "ascertain whether the will of Congress has been obeyed." By providing that a temporary scheduling order "is not subject to judicial review," § 201(h)(6), the Act purportedly violates the nondelegation doctrine.

We reject petitioners' argument. Although § 201(h)(6) states that a temporary scheduling order "is not subject to judicial review," another section of the Act plainly authorizes judicial review of a permanent scheduling order. 21 U. S. C. § 877. Thus, the effect of § 201(h)(6) is merely to postpone legal challenges to a scheduling order for up to 18 months, until the administrative process has run its course. This is consistent with Congress' express desire to permit the Government to respond quickly to the appearance in the market of dangerous new drugs. Even before a permanent scheduling order is entered, judicial review is possible under certain circumstances. The United States contends, and we agree, that § 201(h)(6) does not preclude an individual facing criminal charges from bringing a challenge to a temporary scheduling order as a defense to prosecution. This is sufficient to permit a court to "ascertain whether the will of Congress has been obeyed." Under these circumstances, the nondelegation doctrine does not require, in addition, an opportunity for preenforcement review of administrative determinations.

Having concluded that Congress did not unconstitutionally delegate legislative power to the Attorney General, we consider petitioners' claim that the Attorney General improperly delegated his temporary scheduling power to the DEA. Petitioners insist that delegation within the Executive Branch is permitted only to the extent authorized by Congress, and that Congress did not authorize the delegation of temporary scheduling power from the Attorney General to the DEA.
We disagree. Section 501(a) of the Act states plainly that "the Attorney General may delegate any of his functions under [the Controlled Substances Act] to any officer or employee of the Department of Justice." 21 U. S. C. § 871(a). We have interpreted § 501(a) to permit the delegation of any function vested in the Attorney General under the Act unless a specific limitation on that delegation authority appears elsewhere in the statute. No such limitation appears with regard to the Attorney General's power to schedule drugs temporarily under § 201(h).

The judgment of the Court of Appeals is

Affirmed.

ii. Classifying Substances Under the CSA

In the 1980 case NORML v. Bell, the court described the Controlled Substances Act’s scheduling factors as “guides in determining the schedule to which a drug belongs, but they are not dispositive. Indeed, the classifications at times cannot be followed consistently, and some conflict exists as to the main factor in classifying a drug potential for abuse and possible medical use.” 488 F. Supp. 123, 140 (D.D.C. 1980).

In the cases that follow, courts and administrative decision makers apply the CSA’s scheduling criteria to classify substances. When reading these cases, consider whether the conflicts and inconsistencies described in NORML v. Bell have been resolved and, if not, whether you believe the Controlled Substances Act achieves its aim of facilitating consistent, predictable, and science-based classifications of substances of abuse. Is the term “accepted medical use,” for example, sufficiently well defined? Are you able to discern from the cases how much weight each of the scheduling criteria is to be given in scheduling decisions? If a substance were found to have a negligible potential for abuse and no currently accepted medical use, in what schedule would it fall?

Before you continue, be sure to take a moment to refer back to the chart at the beginning of this Chapter (which illustrates the factors for each of the five schedules) so that you have the CSA’s basic classification structure in mind while reading the material that follows.

Grinspoon v. Drug Enforcement Administration
United States Court of Appeals for the First Circuit
828 F.2d 881 (1987)

Coffin, J.

On November 13, 1986, the Administrator of the Drug Enforcement Administration ("DEA") issued a final rule placing the substance 3,4-methylenedioxymethamphetamine ("MDMA") into Schedule I of the Controlled Substances Act ("CSA"). In reaching this decision, the Administrator found that MDMA met all three of the statutory requirements for classification as a Schedule I substance, namely, (A) The drug or other substance has

* MDMA is also commonly referred to as “ecstasy.”