

Controlled Substances

To most Americans, the word narcotics means drugs that are manufactured and sold illegally.

Pharmacologically, the term refers only to drugs having certain effects, with the prototype being the

narcotic analgesics derived from opium, such as morphine and heroin. Although the 1914 Harrison Act

controlled opioids, which are narcotics, and cocaine, which is not, the enforcement effort focused so

much on the opioids that eventually the enforcement officers became known as narcotics officers, and

people began to refer to the “Harrison Narcotics Act,” though the word narcotics was not in the original

title. The meaning of the term changed so much in political use that later federal laws incorrectly

classified cocaine and then marijuana as narcotics.

After the Harrison Act

In the first quarter of the 20th century, the Treasury Department claimed that about one million

Americans—1 in 10—were dependent on opium or its derivatives. That’s an outrageously high figure,

and of course, it was only an estimate. As you might have guessed, many experts were deeply skeptical,

believing the number was considerably lower. There were good reasons to be leery. For one thing, there

were no reliable data assessing this issue, and for another, the greater number of people addicted to

opioids, the larger the Treasury Department’s Harrison Act budget. The Narcotic Division, within the

Treasury Department, was responsible for enforcing the Harrison Act. Interestingly, when they began

promoting the Division’s enforcement achievements in the mid-1920s, their “official” count of people

addicted to opioids dropped to 100,000 and remained for more than two decades. Together, this information suggests that the one-million figure was an exaggeration for political reasons.

Still, however, there was an appreciable number of Americans who were dependent upon opioids. Some

were artists, doctors, homemakers, lawyers, nurses, and politicians, among other occupations. Many

were even veterans of the war and relied on opioids to deal with injuries sustained in battle. One way to

administer the Harrison Act would have been to allow a continued legal supply of opioids to those

individuals through registered physicians and to focus enforcement efforts on the smugglers and others

who ran afoul of the law. After all, the Harrison Act stated that an unregistered person could purchase

and possess any of the taxed drugs if they had been prescribed or administered by a physician “in the

course of his professional practice and for legitimate medical purposes.” Until the 1920s, most users

continued to receive opioids through their private physicians, and in several large cities, public clinics

dispensed morphine to users who could not afford private care.

In fact, that’s exactly what happened, at least at the outset. Early enforcement efforts focused on

smugglers and did not result in a large number of arrests. However, an important bureaucratic reorganization and two high-profile arrests would change this situation. The reverberations are felt to

this day. The Narcotic Division was merged into the Prohibition Unit of the Treasury Department in

1920. On January 17, that same year, the 18th Amendment took effect and the Prohibition Unit was

tasked with enforcing alcohol prohibition. The Harrison Act, unlike the 18th Amendment, was merely a

tax measure intended to standardize sloppy dispensing practices; prohibition of opioids and cocaine

was not the goal. Simply put, the 18th Amendment and the Harrison Act were different laws, with

different intentions. The problem was, however, that both laws were enforced by a single group of

agents, who believed their job was not just to prevent people from having access to alcohol but also to

cocaine and opioids.

This view was strengthened by two separate U.S. Supreme Court decisions. The first involved the appeal

of Dr. W.S. Webb, a licensed physician from Memphis, who had been arrested and convicted for violating the Harrison Act. Recall that the law required physicians who prescribed opioids or cocaine to

register with the government and pay a small tax. Dr. Webb had complied with these requirements, but

the government contended that he broke the law by prescribing large amounts of morphine to “habitual

users” largely for profit. Within an 11-month period, he had written more than 4,000 prescriptions, at

50 cents apiece, seemingly to anyone willing to pay. Dr. Webb’s morphine prescription numbers far

outpaced the average amount written by other physicians. In 1919, the Supreme Court narrowly upheld

the lower court’s ruling by a five-to-four margin, despite the fact that Harrison Act is not concerned with

physician dosing issues (Webb et al. v. United States, 249 U.S. 96, 99, 1919). In the second case, Dr.

Morris Behrman had been indicted for writing an individual a single prescription for the following:

cocaine (13.6 grams), heroin (9.7 grams), and morphine (23.3 grams). In 1921, the Southern District

of New York Court dismissed the charges. The government appealed the case to the Supreme Court,

who reversed the lower court’s decision the following year (United States v. Behrman, 258 U.S. 280,

288–9, 1922).

Arresting Patients, Pharmacists, and Physicians

The newly created Prohibition Unit interpreted the Webb and Behrman cases to mean that any prescription of opioids or cocaine to a drug user was not a “legitimate medical purpose.” The

American Medical Association supported the view that reputable physicians would not prescribe

morphine or other opioids to users, even if they might benefit from regular, legitimate prescriptions. By

1923, the government had closed all of the country’s municipal morphine maintenance clinics. Narcotic

agents began to charge many physicians under the Harrison Act, which precipitated a rapid retreat from

prescribing opioids and cocaine. This meant that there was no legal way to obtain opioids, forcing

users to either to abstain or to seek opioids in the illegal market, which exploded in response to the new

Harrison Act enforcement approach. Thus, users in possession of heroin, morphine, opium, or cocaine

who could not produce a valid prescription were presumed to have obtained the drug illegally and were

charged with violating the Harrison Act. From 1919 to 1929, the Narcotics Division arrested about

75,000 people, including 25,000 physicians and pharmacists. Thus, the use of opioids and cocaine

was effectively criminalized for the first time, not because that was the intent of the 1914 Harrison Act,

but because of the Narcotics Division's interpretation of it. Thus, a compelling case can be made that

the single most important legislation that has shaped the federal government's approach to controlled

substances wasn't a "drug law" at all but, rather, the 18th Amendment prohibiting alcohol.

Steeper Fees and Stiffer Penalties

One thing for certain is that the times were changing. Less than a decade after passage of the Harrison

Act, its nominal annual fee had significantly rose. The tax that dealers and dispensers of opioids and

cocaine were now required to pay increased from 1 dollar to 24 dollars for importers, manufacturers,

and producers; 12 dollars for wholesale dealers; 6 dollars for retail dealers; and 3 dollars for physicians,

dentists, veterinarians, and other practitioners. In addition, federal punishment for drug law violations,

virtually unheard of previously, was harsh. Partly in response to the growing illicit market, in 1922

Congress passed the Jones-Miller Act, which more than doubled the maximum penalties for drug

trafficking to \$5,000 and 10 years of imprisonment. Included also was the stipulation that the mere

possession of illegally obtained opioids or cocaine was sufficient basis for conviction, thus officially

making the user a criminal. Because illegal opioids were so expensive, up to 50 times more than the

legal retail price, many users came to prefer the most potent type available, heroin. In 1924, another act

prohibited importing opium for the manufacture of heroin. Already by this time several important trends

had been set: Users were viewed as criminals by large portions of society, including the regulatory

agency, the growth of the illicit market was responded to with greater penalties and more aggressive law

enforcement, and the focus was on attempting to eliminate a substance (heroin) as though the drug itself

were the problem. Then, in 1925, the U.S. Supreme Court handed down a ruling that reversed course, or

so it seemed. Dr. Charles O. Linder, a well-respected Spokane physician, had been arrested and convicted on charges similar to the indictments of Dr. Webb and Behrman. He had prescribed four

tablets—three cocaine and one morphine—to an informant impersonating a patient. Ida Casey, who was

working with narcotic agents, claimed she told Dr. Linder that she was an addict. Dr. Linder said that she

reported having a painful stomach condition and that her treating physician was out of town. In a

unanimous decision, the Court overturned Dr. Linder's conviction. Justice McReynolds wrote the

Court's opinion, which is unequivocal in its intent and emphatic in its tone. The opinion admonished the

government that the Harrison Act was a tax law, and that:

"It says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment. They are

diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted

improperly or unwisely or for other than medical purpose solely because he has dispensed to one of them, in the

ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to

addiction.”

In other words, the highest court in the land declared it was legal for a physician to prescribe opioids to

a person dependent upon these drugs, if it was part of the patient’s treatment regimen. A reasonable

expectation, based on the Linder decision, is that physicians resumed prescribing these drugs to

addicted patients in the course their treatment. One might have also predicted that morphine maintenance

clinics reopened, especially in cities that once housed them. Neither event occurred. The damage had

been done. Physicians continued to retreat and wanted no part in treating patients with addictions.

Meanwhile, narcotic agents virtually ignored the Linder ruling and were undeterred in their zeal to

enforce the Harrison Act as if it was a prohibition statute.

Prison versus Treatment

By 1928, individuals sentenced for drug violations made up one-third of the total population in federal

prisons. Even though the 1920s was the period of alcohol prohibition, during those years twice as many

people were imprisoned for drug violations as for liquor violations. In 1929, Congress viewed this

enormous expenditure for drug offenders as an indicator that something was wrong and decided that

users should be cured rather than repeatedly jailed. It voted to establish two federal hospitals for treating

drug addiction (including opioids, marijuana, among others) and for conducting research on the patients. The facility in Lexington, Kentucky, with approximately one thousand beds, opened in 1935.

The one in Fort Worth, Texas, had about 600 beds and opened in 1938. Most of the individuals “treated”

at these hospitals were there as a condition of their penalty for violating federal narcotic laws. A much

smaller proportion voluntarily sought drug treatment at these research centers. Another distinction was

that the treatment-seeking volunteers were charged a daily rate of about \$5—the prisoners were not

required to pay a fee—but were not turn away if they couldn't afford to pay.