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The Evolution of Drug Legislation in Kentucky

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The Evolution of Drug Legislation in Kentucky

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The Kentucky Penal Code chapter[1] directed at the establishment of uniform penalties for standardized drug abuse offenses was a serious effort to achieve a rational basis from which to view the area of drug abuse control. Its failure to be enacted into law must be charged to the intensity of feelings that surround this entire area of concern in contemporary society.

A primary antecedent of the present furor is the centuries old medico-socio-theological-legal debate about use, abuse and/or control of alcohol. From a generic standpoint, one must look at the "drug" controversy as developing along the exact same lines—for alcohol is indeed a drug. All we have done is shift the controversy from alcohol to other drugs.

As long as man has a body and consciousness, he will be exposed to the possibilities of alterations in that body and consciousness through external substances and circumstances. What substances he will use, whether and how he will use them, and for what purposes, are critical questions which each individual must answer, both to himself and in the context of society. Individuals are influenced in these decisions by their concept of personal needs and satisfactions and by their relative desire to accommodate these satisfactions to the demands of their social environment. Society, in turn, often argues that acceptance of the individuals' rights hinges upon subjugation of his desires to the norms or standards of the established society. The degree of separation of these conflicting positions is an index of the degree of social turmoil.

In the case of drugs, many viewpoints of various institutions of society were in such a state of conflict with those of significant

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[1] Kentucky Legislative Research Commission, Kentucky Penal Code §§ 2900-2915 (Final Draft 1971) [hereinafter cited as LRC].

numbers of individuals as to have made a standard solution unacceptable at the time. Thus, the portions of the Penal Code addressed to those areas of social disagreement in which the norms of society and the desires of individuals were not sufficiently resolved as to permit unanimity were not acceptable as proposed. The Legislature, reflecting the mood of these unresolved public attitudes enacted the Penal Code without the controversial sections. It is my intent in this paper to provide some history of the conflict and to describe how the final compromise was reached and how it differs from the rejected chapter.

From the medical viewpoint, use of narcotic drugs has been one of the significant therapeutic advances in the relief of human suffering. As analgesics, morphine and other opium alkaloids have been mainstays of surgical and medical practice since 1803.[2] Massive use of such drugs in the United States began during the Civil War,[3] and, where available, saved many lives through alleviation of pain and subsequent shock during and following amputation and internal exploration. But the years thereafter through the turn of the century brought evidence of a more unhappy state of affairs. Not only did the iatrogenic incidence of addiction grow, but hundreds of other cases occurred through the easy availability of narcotics to the general public.

While medical circles have disagreed for years as to the probability of narcotics addiction in passive-dependent personality types as compared to more stable personalities, there is a solid consensus that physical addiction is a frequent result of long continued use of opiates. Consequently, the trend of legislation has been toward protection of the public through denial of free access to drugs and through control of actions of practitioners and pharmacists. By 1914, this viewpoint was sufficiently popular to bring about major federal legislative action, the Harrison Act.[4] This law used a tax approach for registration and control. One finds little evidence of a punitive outlook at that time; rather, the primary concern was for prevention of the social destructive-

[2] Hanzlik, *125th Anniversary of the Discovery of Morphine by Serturner*, 18 J. AM. PHARM. ASS'N 375-84 (1929).

[3] Macht, *The History of Opium and Some of its Preparations and Alkaloids*, 64 J.A.M.A. 477-81 (1915).

[4] Harrison Act, 38 Stat. 785 (1914); *see also* Federal Import and Export Act, 35 Stat. 614 (1909), 21 U.S.C. § 171.

ness inflicted upon the individual as a consequence of addiction.

In Kentucky, a statute limiting prescription and dispensing of cocaine by physicians, pharmacists and dentists had been passed as early as 1902.[5] In 1908, penalties were stiffened[6] and by 1912, Kentucky had prohibited sales of opium and its salts except on original prescription.[7]

A decade after passage of the Harrison Act, Kentucky further revised its drug control laws,[8] the revision again aimed primarily at regulating professional activities with opiates. This 1924 statute, for the first time, provided imprisonment as a penalty for illegal sales of opiates, and imposed differential penalties for other than the first offense.

Further evidence of advanced thinking by Kentucky lawmakers is presented in a 1928 statute, which provided for care and treatment of persons addicted to narcotic drugs.[9] This law allowed the Kentucky state hospitals, then operated by the Department of Welfare, to admit such persons under "lunacy" commitment. Voluntary patients were required to agree to a minimum six months' hospitalization. Pioneer efforts were later incorporated in principle into statutes such as the Federal Narcotics Addict Rehabilitation Act of 1966[10] and present state laws[11] with respect to utlization of treatment agencies in lieu of penal institutions.

The twenty years following enactment of the Harrison Act were relatively quiet in terms of major federal drug legislation. A notable exception was the passage in 1929 of authority to construct and operate the Public Health Service addiction treatment hospitals at Fort Worth, Texas, and Lexington, Kentucky.[12] However, with the end of the Volstead Act, drugs again became a matter of national legislative attention. Led by a former alcohol prohibition agent named Harry J. Anslinger, then head of the Federal Bureau of Narcotics established by the Harrison

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[5] KY. ACTS ch. 85 (1902).
[6] KY. ACTS ch. 29, at 80 (1908).
[7] KY. ACTS ch. 86, § 1 (1912).
[8] KY. ACTS ch. 104 (1924).
[9] KY. ACTS ch. 16, §§ 64, 65, 66, 67 (1928).
[10] 28 U.S.C. § 2901 *et seq.* (1970).
[11] KY. REV. STAT. § 218A.990(6)(a), (7)(a) (1972) [hereinafter cited as KRS]; *see also* KRS §§ 222.420 and 222.430.
[12] 45 Stat. 1085 (1929).

Act, a militant anti-marijuana group succeeded in convincing the Congress of the need for a marijuana tax law.[13] The Act, passed in 1937, placed cannabis in the status of a narcotic (although the American Medical Association testified to the contrary).

While the crusade against cannabis was being developed by the activities of the Federal Bureau of Narcotics, several state legislatures passed the "Uniform Narcotic Drug Act." The principal effect of this statute was to establish a degree of national uniformity in definition of narcotic drugs and approaches to their control. Kentucky enacted this legislation in 1934.[14]

The Kentucky Legislature controlled illegal possession and sale of cannabis that same year with a separate law. For a first offense, the penalty was thirty days to one year in jail and/or a $100-$500 fine. A subsequent offense drew one to five years' imprisonment.[15]

Following Mr. Anslinger's 1937 success at defining cannabis as a narcotic, the states were urged to follow the federal law, and Kentucky did so in 1944,[16] thus increasing the penalty for illegal possession of cannabis to a felony on first offense. From this point through 1950, relatively little activity occurred in the Kentucky General Assembly with respect to drug controls, but a significant alteration of legislative attitude toward the narcotic *user* was demonstrated in the passage of a 1946 statute which provided imprisonment as an alternative to treatment.[17]

In 1950, additional regulation was imposed upon pharmacists and practitioners regarding prescription, possession, dispensing and administration of barbiturates.[18] These statutes reflected the concern of physicians and pharmacists alike that the incidence of "sleeping pill" suicides and other abuses were too frequent and that tighter controls were needed on supplies. Also, there had

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[13] Federal Marijuana Tax Act of 1937, 26 U.S.C. § 4741. *See* Leary v. United States, 395 U.S. 6 (1969), holding unconstitutional that part of § 176(a) of the Act relating to presumption of defendant's knowledge of illegal importation.

[14] KY. ACTS ch. 143 (1934).

[15] KY. ACTS ch. 142 (1934).

[16] KY. ACTS ch. 136 (1944).

[17] KY. ACTS ch. 167 (1946), (codified as KRS § 218.250), repealed KY. ACTS ch. 106 § 2 (1966) after Robinson v. California, 370 U.S. 660 (1962), but a similar provision was enacted in the 1966 legislative session, KY. ACTS ch. 106, § 1 (KRS § 218.210(4)).

[18] KY. ACTS ch. 65, §§ 1-10 (1950).

been dramatic progress in the synthesis of drugs since the end of World War II, and the number of compounds available was multiplying at a fantastic rate. After 1950, virtually nothing was changed until 1958, when further barbiturate controls were enacted. In Kentucky, continued concern with barbiturate abusers was manifested by stiffening of penalties for forgery of prescriptions and similar efforts to obtain drugs by false representation.[19]

In the decades of the 1940's and 1950's, organized crime was alleged to have actively exacerbated drug addiction through the massive smuggling of heroin—an opiate with two and one-half times the potency of morphine or demerol.[20] During this period, the federal government, with assistance from police of the larger states, conducted a financially limited effort to curtail illegal importation of opiates. These law enforcement efforts, plus the Fort Worth and Lexington hospital facilities, constituted the major portion of the federal effort dealing with the addiction problem.

The Addiction Research Center functioned at the Lexington Public Health Service site and served as the principal, albeit limited, federal research service until passage of the 1970 Federal Comprehensive Controlled Dangerous Substances Act. But research in the field, primarily because of lack of concern, was virtually non-existent. Preconceptions as to the nature of the problem were therefore unchallenged. Public information about drug addiction was substantially restricted to dramas and other unreliable information, and news stories generally featured the criminal aspect.

Several tragic hypotheses may be stated as characteristic of the thinking of the period:

1. Drug addiction is a socio-legal problem, restricted for the most part to certain ethnic and racial groups living in metropolitian ghettos.
2. Drug addiction rehabilitation is useless. (There was a recidivism rate of 95%, but few studies considered the return of the addict from treatment to the same personal-social precipitants without follow-up or supportive activity.)

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[19] KY. ACTS ch. 98, §§ 1-13 (1958).

[20] L. GOODMAN & A. GILMAN, THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 284 (4th ed. 1970).

3. Drug addiction is caused by organized crime seeking to realize high profits from human suffering.
4. Drug addiction can be resolved as a struggle between police and criminals ("junkies" or "pushers"). (This last hypothesis was enhanced by the antisocial acts of addicts in obtaining funds or drugs to support their habits.)
5. Drug addiction is characterized by violent behavior— addicts are "dope fiends" and must be "put away."

These popularly accepted notions tended to focus concepts of drug abuse and addiction into a package labeled "dope." Such stereotyped and superficial concepts left the public, medicine, law, and theology almost helpless in the face of the explosive intellectualization of drug use that burst upon us in the '60's with the "discovery" of LSD and the accelerated use of amphetamines, marijuana and other hallucinogens.

The opening of the famed Kefauver Hearings on December 7, 1959, heralded the advent of the '60's as a decade of turmoil and strife about drugs, both as medicinal and recreational agents. Amphetamines were increasingly in the public view because of the alleged abuse of benzedrine and methamphetamine by students and truck drivers for extending waking hours and as stimulants, and by others for appetite suppression by prescription. Drug manufacturers, physicians and pharmacists all received some degree of censure as Senator Kefauver's committee delved into alleged price fixing, limitless sample distribution, and connections of organized crime to illegal drug traffic. The hearings received great public attention and resulted in the 1962 passage of Public Law 87-781 which amended the Federal Food, Drug and Cosmetic Act to strengthen methods of identification and inspection of drugs.

The alienation of many young people with war and social distress was manifested by their "dropping out" into the drug culture—a practice neither understood nor well tolerated by the social standards of the 1950's. Evidence of fantastically rapid escalation of use of cannabis, LSD and other hallucinogens for psychedelic adventures accumulated, and was widely disseminated in popular publications, legitimate and otherwise.

In Kentucky, the General Assembly approved new statutes in 1960 which prohibited sale, manufacture, possession, dispen-

sing, prescription, or administration of amphetamines other than through authorized (licensed) channels.[21] These laws notably placed few requirements upon manufacturers as to quantity or quality of drugs produced, although a clear definition of amphetamines was established. The light penalties for violations were amended in 1964 to bring them into line (two to five years and/or $1,000-$5,000 fine) with those of barbituate offenses.[22]

The situation remained static until 1968, when the Kentucky Department of Health successfully sought to have enacted "The Kentucky Dangerous Drug Act of 1968."[23] This Act drew little attention, or opposition, as it was enacted. Introduced as departmental legislation, the primary purpose was consolidation of the existing regulations on amphetamines and barbiturates, and extension of controls to cover several hallucinogenic agents, including Peyote, Mescaline and LSD. Marijuana had been placed in the Uniform Narcotic Drug Act in 1944 and it was apparently felt that the two laws, one dealing with "dangerous" drugs and the other dealing with narcotics, would cover the situation adequately.

The new law set relatively severe penalties for possession of hallucinogens,[24] and a multitude of confrontational situations arose immediately. On college campuses and in totally unexpected areas, such as high schools, incidents of arrest and prosecution produced the cultural shock of a generation. Instead of apprehending the usual "junkies," so popularly thought of as drug abusers, police, Health Department and Board of Pharmacy officers (given police powers by Kentucky Revised Statutes § 217.790 (1972) [hereinafter cited as KRS]) frequently found themselves arresting children of middle and upper socio-economic class families, as well as many erudite and highly intelligent persons.[25]

Throughout the nation, the shock waves reverberated and the debates of the '30's rose anew. Drug abuse no longer could

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[21] KY. ACTS ch. 246, §§ 1-9 (1960).
[22] KY. ACTS ch. 190, §§ 1-3 (1964).
[23] KY. ACTS ch. 81, §§ 1-16 (1968).
[24] KRS § 217.995(2) made possession of LSD, Mescaline, Peyote, Psilocybin, Psilocin, DMT and STP punishable by 2-5 years imprisonment and $1000-$5000 fine.
[25] *See* Hill, *Marijuana: Many Believe the Penalty for its Use is too Stiff*, Kentucky Kernel, January 23, 1970.

be stereotyped as an "occupational hazard" of medical people, or the habit of the "social outcast," or the mark of the confirmed criminal. The collision of the heavy penalties for possession and the wide spectrum of society involved produced immediate demands for reassessment of the situation.

By 1970, the federal government was proposing a complete revision of all statutes pertaining to narcotics and dangerous drugs. These federal statutes, basically contained within Titles 21 and 42 of the *United States Code,* with some references under Title 18, were the cumulative results of some sixty years of effort to cope with the problem. The consensus in the United States Congress was that revisions were needed, but for almost a year the hearings held by both the House and Senate Committees sharply indicated the extent of divergence of viewpoint.[26] In fact, the two houses enacted separate and differing bills, and the House refused to act on the bill passed by the Senate, preferring instead to propose its own version. Finally, in October 1970, a compromise bill was accepted by both houses and was approved by the President on October 27.[27]

The final version of the law (which in many aspects served as a model for the 1972 KRS Chapter 218A) covers four general areas of concern. Title I is addressed to rehabilitation of drug abusers. It effected changes in the Community Mental Health Centers Act[28] and the Public Health Service Act[29] which ultimately unifies the approach of federal grant and federally operated programs in the field of drug abuse treatment, education and research.

Title II, cited as the "Controlled Dangerous Substances Act," defined terms such as "addict," "controlled substance," and "dispense" (categories of abuse and/or therapeutic potential; distilled spirits are specifically excluded). This title sets up the schedules

[26] The extent of divergence in viewpoints is exemplified by the multiplicity of bills introduced in the 91st Congress; to note just a few—Controlled Dangerous Substance Act, S. 2637, 91st Cong., 1st Sess. (Dirksen); Comprehensive Narcotic Addiction and Drug Abuse Care and Control Act of 1969, S. 2608, 91st Cong., 1st Sess. (Yarborough); Drug Abuse Control Act of 1969, S. 2592, 91st Cong., 1st Sess. (Montoya); Omnibus Narcotic and Dangerous Drug Control and Addict Rehabilitation Act of 1969, S. 1895, 91st Cong., 1st Sess. (Dodd).

[27] The Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (codified in scattered sections of U.S.C.).

[28] 42 U.S.C. §§ 2688k, 2688l, 2688m (Supp. 1972).

[29] 42 U.S.C. §§ 201 *et seq.* (Supp. 1972).

to which various controlled substances will be assigned and defines the authority by which they will be included or deleted. It also details the requirements and procedures for registration, establishes production quota authority over manufacturers, and defines offenses and penalties for violation. The penalties for simple possession are similar to those set in the 1970 amendments to the Kentucky Dangerous Drug Act, except that first offenders in the area of narcotic drugs are also held to a maximum sentence of one year, probatable, and expungable. (A chart demonstrating the penalties provided in KRS chapter 218A is appended.)

The 1970 amendments to the Kentucky Dangerous Drug Act became effective in June of 1970, and the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 became effective in May 1971.

Title III concerns importation and exportation and sets offenses and penalties for individuals and/or other manufacturers of controlled substances who illegally import such substances into the United States. Title IV is a relatively unimportant section relating to advisory councils of the Secretary of the Department of Health, Education and Welfare.

Among the many important rearrangements dictated by this omnibus act was the appointment of a National Study Commission on Marijuana and Drug Abuse, and the transfer of all administrative and enforcement provisions to the jurisdiction of the Attorney General. The latter was one of the more bitterly discussed sections. The Federal Food and Drug Administration and other agencies who had long held some degree of responsibility for the medical approach to drug abuse were placed in a position of tacit admission that they had not used their enforcement powers adequately. This new awareness of the need for both a rehabilitation and enforcement approach was again emulated in the proposed Chapter 29 and the enacted Chapter 218A of the Kentucky Revised Statutes.

(The penalties for various violations of chapter 218A are demonstrated in the chart appended to the paper. A comparison is provided with penalties as they would be established under the Penal Code. Schedule I drugs have high abuse potential and no accepted medical use. Schedules II, III and IV categorize drugs that still have some abuse potential but are frequently prescribed.)

The stage was set for the next act.

As Justice Palmore has noted in his preface, the Kentucky Penal Code revision staff drafted a new drug control law during the 1969-71 period. Shortly after passage of Public Law 91-513 (1970), the Kentucky Department of Health began working on a revision of the Kentucky Uniform Narcotic Drug Act and other existing statutes affecting the functions of the Kentucky Board of Health. The Department of Mental Health became involved with both groups as a result of its role in drug treatment and rehabilitation programs.

After several meetings between staff members of the Department of Mental Health, Department of Health and the Penal Code Revision Review Committee, a bill draft was produced, differing from the proposed Penal Code Chapter only in the continuance of mandatory sentencing of first offenders to the Department of Mental Health (for possession only). The draft specified permissive wording for this offense.

Under the draft proposal, jurisdiction over possession of dangerous drug cases was extended to county and police courts, as well as circuit courts, and the various aspects of licensing and regulation of pharmacists and physicians were worked out. Most importantly, the proposed law was in agreement with the new comprehensive federal law regarding assignment of abuse potential drugs to the various schedules. Interviews with police and department officials in metropolitan and rural areas were held and several adjustments in the statute to cover such controversial areas as confiscation and use of unidentified informants were made, although not without extended debate.

In short, the approach taken in the proposed statute was much the same as that taken by the federal revision with rehabilitation, enforcement, penalties and administration comprehensively covered. The primary difference had been the absence of public hearings during the drafting phase. This was to be left to the General Assembly.

The joint draft, Senate Bill 274, now KRS Chapter 218A, was introduced as departmental legislation from the Department of Health in the belief that it would function as the primary drug control bill during any interim period that might occur prior to an effective date for Chapter 29. However, the public hearings

that were held by the joint Senate-House Judiciary Subcommittee quickly revealed how divergent were the opinions of various public groups. As was the case with the federal statute, experts from medical, legal and legislative fields differed widely in their opinions. Chapter 29 was amended out of the Penal Code Bill and Senate Bill 274 was left as the vehicle carrying the brunt of the debate.

During the committee hearings on this bill, various amendments were offered and accepted, perhaps the most notable of which differentiated the treatment of possession and transfer offenses involving cannabis. As may be seen in the appendix charts, a significantly different approach was taken with respect to the degree of penalty assigned to these offenses as opposed to those assigned to other hallucinogens.

In the final bill enacted by the General Assembly, mandatory sentencing of first offenders to the Department of Mental Health for possession of cannabis was changed to provide more discretion to the court. The new law provides for a fine, a jail sentence of not more than 90 days *or* sentencing to the Department of Mental Health for possession or *transfer* of marijuana, regardless of the number of offenses.

With respect to other dangerous drugs, the General Assembly continued the mandatory provisions for educational and rehabilitation opportunities on first offense. This approach is supported by some as yet unpublished reports of the Kentucky Department of Mental Health. During the 1970-72 period, a trial group of three persons sentenced to prison on first offense under the 1968 law were paroled to the Department of Mental Health. This group, having been exposed to the prison drug culture for over a year each before being paroled, *without exception,* were returned to prison for violation of parole within six months of release. On the other hand, in an 18-month period of 1970-72, only eighteen of 375 offenders sentenced were rearrested. These figures can only suggest that further efforts at prevention and early rehabilitation are warranted.

Whatever viewpoint the reader may espouse regarding drug abuse, there is the certain knowledge that others are in disagreement. From that standpoint, although the enactment of Senate Bill 274 as Chapter 218A could be said to have completely satisfied

no one, it was successful in that almost everyone was willing to accept it as a fair and comprehensive approach to a problem that is as complex and unsettled as any in our society.

Since schedules for abuse drugs are in accord with Public Law 91-513, there is now unanimity between federal and state enforcement statutes as to what constitutes a felony and what constitutes a misdemeanor. Schedules I and II differ in that allocation of a drug to Schedule I allows its legitimate use only for research, whether it be narcotic or otherwise. Examples are heroin (narcotic) and cannabis (non-narcotic). Schedule II drugs have legitimate medical utilization but still have great abuse and dependency potential. Examples are morphine (narcotic) and amphetamines (non-narcotic). Schedule III drugs are also medically valuable and have even less abuse and dependency potential. These generally include hypnotics and cough syrup. Finally, drugs categorized in Schedules IV and V have the least dependency and abuse potential, but still are sensitive enough to require control. The drugs may be narcotic, but are in compound state. These schedules are adjusted at the state level by the Kentucky Board of Health, and for federal purposes, by the Attorney General, with the advice and consent of the Secretary of Health, Education and Welfare.

SUMMARY

The period from 1960-72 dramatically illustrated the turmoil that resulted from "too little, too late." The aftermath of the Kefauver hearings, the tragedy of thalidomide, the popularity of Timothy Leary's writings on LSD, and the apathy of the Food and Drug Administration, combined with the general disinterest of the medical profession and the avarice of some drug manufacturers, all helped to propel the "drug scene" into the popular press, with virtually no competent public leadership and knowledge with which to place it in perspective. The public was understandably upset, and the resultant nation wide anxiety produced cries for answers—immediate ones.

Here one can easily observe the application of the old axiom that "nature abhors a vacuum." As blow after blow fell in the public arena, experts appeared as if by magic. Most of them vanished as quickly as they had appeared, but one fact remains

indisputable. A contemporary generation, perhaps better educated and more inclined to analyze, and certainly more willing to intellectualize the situation, is emerging. Despite the stereotypes of the '30's-'50's, and the impressions locked in the culture of our middle and older generations, there are major sociocultural changes evolving in our efforts to control all alien substances. This is the most hopeful sign in an otherwise funereal situation.

What one can hope for in the future, as hysteria assumes a less commanding role, is the straightforward adoption by officials and the public alike of a rational and intensive application of our skills to the problem.

Public safety must of course be maintained. It is as unrealistic to cry out for "instant change" as it is to demand "maintain the status quo." Such simplistic answers are not beneficial to the *solution of complex* problems. Prohibiting drinkers from driving has not resulted in removal of all drinking drivers from the road, and if it did, one would still have *drinkers.* The problem has only *shifted.* If we are to attain an intelligent, fair and lasting solution to our still existing problems in drug abuse control, we must approach it from all directions at once with full intent to solve it cooperatively.

To that end, I am sure that almost no one will be *totally* satisfied with Chapter 218A. But it is progressive legislation, responsive to the contemporary as well as the traditional values of our society. Until there is more time for our culture to reach a consensus about drug use, and to bridge the gaps of these past forty years, I believe it to be conceptually more satisfactory to more people than any drug law we have had in many years.

KRS 218A.990

Schedule	Drug Classification	Possession (for personal use)		Transfer (non-profit)		Traffic	
		First offense	Each subsequent offense	First offense	Each subsequent offense	First offense	Each subsequent offense
I	Narcotic	1-5 years and/or $3,000-$5,000	5-10 years and/or $5,000-$10,000	5-10 years and/or $5,000-$10,000	10-20 yrs. and/or $10,000-$20,000	5-10 years and/or $5,000-$10,000	10-20 yrs. and/or $10,000-$20,000
	Non-narcotic	Up to 1 year with DMH → Discharge ↓ *Up to 1 year jail and/or $500 max.	Up to 1 year jail ↑ ↓ and/or $500 (DMH) max.	Up to 1 year jail and/or $500 max.	1-5 years and/or $3,000-$5,000	1-5 years and/or $3,000-$5,000	5-10 years and/or $5,000-$10,000
	Marijuana	Not more than 90 days in jail or DMH; or $250 max.	Not more than 90 days in jail or DMH; or $250 max.	Not more than 90 days in jail or DMH; or $250 max.	Not more than 90 days in jail or DMH; or $250 max.	Up to 1 year in jail and/or $500 max.	1-5 years and/or $3,000-$5,000

* If a person fails to cooperate in DMH program, he is remanded to sentencing court.

Proposed Penal Code

Schedule	Drug Classification	Possession		Transfer (non-profit)	Trafficking**	
		First offense	Each subsequent offense			
I	Narcotic	Class D felony 1-5 years Prison*		Not a separately defined offense	Class C felony	5-10 years*
	Non-narcotic	Class A misdemeanor. Jail or DMH up to 1 year. Fine not more than $500	Class A misdemeanor. Jail up to 1 year. Fine not more than $500	Class A misdemeanor Jail up to 1 year Fine not more than $500	Class D felony	1-5 years*

* Sec. 303. If placed on probation or conditional discharge, provision for fine not to exceed $10,000 or double the gain from commission of the offense, whichever is greater.

** Trafficking includes manufacture, sale, transfer or possession with intent to sell, of any controlled substance.

KRS 218A.990

Schedule	Drug Classification	Possession (for personal use)		Transfer (non-profit)		Traffic	
		First offense	Each subsequent offense	First offense	Each subsequent offense	First offense	Each subsequent offense
II	Narcotic	1-5 years and/or $3,000-$5,000	5-10 years and/or $5,000-$10,000	5-10 years and/or $5,000-$10,000	10-20 yrs. and/or $10,000-$20,000	5-10 years and/or $5,000-$10,000	10-20 yrs. and/or $10,000-$20,000
	Non-narcotic	Up to 1 yr. with DMH ➤ Discharge ▼ *Up to 1 year jail and/or $500 max.	Up to 1 year jail and/or $500 ▲ ▼ (DMH) max.	Up to 1 year jail and/or $500 max.	1-5 years and/or $3,000-$5,000	1-5 years and/or $3,000-$5,000	5-10 years and/or $5,000-$10,000

* If a person fails to cooperate in DMH program, he is remanded to sentencing court.

Proposed Penal Code

Schedule	Drug Classification	Possession		Transfer (non-profit)	Trafficking**	
		First offense	Each subsequent offense			
II	Narcotic	Class D felony 1-5 years Prison*		Not a separately defined offense	Class C felony	5-10 years*
	Non-narcotic	Class A misdemeanor. Jail or DMH up to 1 year. Fine not more than $500	Class A misdemeanor. Jail up to 1 year. Fine not more than $500	Class A misdemeanor Jail up to 1 year Fine not more than $500	Class D felony	1-5 years*

* Sec. 303. If placed on probation or conditional discharge, provision for fine not to exceed $10,000 or double the gain from commission of the offense whichever is greater.

** Trafficking includes manufacture, sale, transfer or possession with intent to sell, of any controlled substance.

KRS 218A.990

Schedule	Drug Classification	Possession (for personal use)		Transfer (non-profit)		Traffic	
		First offense	Each subsequent offense	First offense	Each subsequent offense	First offense	Each subsequent offense
III	Narcotic or Non-narcotic°°	Up to 1 year with DMH ➔ Discharge ⇓ Up to 1 year jail and/or $500 max.	Up to 1 year jail ⇑⇓ and/or $500 (DMH) max.	Up to 1 year jail and/or $500 max.	1-5 years and/or $3,000-$5,000	1-5 years and/or $3,000-$5,000	5-10 years and/or $5,000-$10,000
IV-V	Narcotic or Non-narcotic	Up to 1 year with DMH ➔ Discharge ⇓ °Up to 1 year jail and/or $500 max.	Up to 1 year jail ⇑⇓ and/or $500 (DMH) max.	90 days jail or $500	90 days jail or $500	Up to 1 year jail and/or $500 max.	1-5 years and/or $3,000-$5,000

° If a person fails to cooperate in DMH program, he is remanded to sentencing court.
°° Statute specifies non-narcotic for Schedule III possession penalties, but is ambiguous concerning penalties for possession of Schedule III narcotic drugs.

Proposed Penal Code

Schedule	Drug Classification	Possession		Transfer (non-profit)	Trafficking°°	
		First offense	Each subsequent offense			
III	Narcotic or Non-narcotic	Class A misdemeanor. Jail or DMH up to 1 year. Fine not more than $500	Class A misdemeanor. Jail up to 1 year. Fine not more than $500	Class A misdemeanor Jail up to 1 year Fine not more than $500	Class D felony	1-5 years°
IV-V	Narcotic or Non-narcotic	Class A misdemeanor. Jail up to 1 year. Fine not more than $500	Class A misdemeanor. Jail or DMH up to 1 year. Fine not more than $500	Not a separately defined offense	Class A misdemeanor Jail up to 1 year Fine not more than $500	

° Sec. 303. If placed on probation or conditional discharge, provision for fine not to exceed $10,000 or double the gain from commission of the offense, whichever is greater.
°° Trafficking includes manufacture, sale, transfer or possession with intent to sell, of any controlled substance.