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The Evolution and Present Status of New York Drug Control Legislation

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THE EVOLUTION AND PRESENT STATUS OF NEW YORK DRUG CONTROL LEGISLATION*

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INTRODUCTION

The New York State Legislature entered the field of drug control in response to the growing problems of addiction and drug abuse in the state. Since the early years of the twentieth century, the New York public has been treated to perennially increasing estimates of the numbers of drug users and addicts in its midst. In 1904, for instance, it was estimated that there were 75,000 drug users within a 25 mile radius of Carnegie Hall.¹ By 1916, the figure had grown to 200,000 "highly dangerous drug fiends roaming the streets" of New York City.² One year later, reports set the figure of addicts in New York City at 300,000.³ In 1918 a prestigious joint legislative committee appointed to investigate narcotics problems gauged the addict population of the city of New York at two to five percent of the total population.⁴ As for more rural areas of the state, the committee observed that "the disease [of addiction] is more prevalent and widespread in the smaller cities and rural communities than has been believed to be possible."⁵

The public and the legislature became increasingly alarmed as the use of drugs became linked with crime (particularly with violent crime) and depravity. The cocaine user was especially feared because the stimulative effect of his drug allegedly rendered him prone to violence.⁶ In popular mythology the cocaine user became the prototype of the drug fiend. Similarly, it was the prevalent feeling that people who used drugs were "among the slothful and immoral populations, gamblers, prostitutes, and others who were already 'undesirables.'"⁷

1. N.Y. Times, Mar. 28, 1904, at 9, col. 5 (estimate by Mrs. Isabella Davis in a fund raising appeal to raise money for a drug and alcoholic rehabilitation center on Long Island).

2. R. KING, *THE DRUG HANG-UP: AMERICA'S FIFTY-YEAR FOLLY* 10 (1972).

3. *Id.* at 25-26.

4. FINAL REPORT OF JOINT LEGISLATIVE COMMITTEE TO INVESTIGATE THE LAWS IN RELATION TO THE DISTRIBUTION AND SALE OF NARCOTIC DRUGS, N. Y. SENATE DOC. NO. 35, at 3 (1918) [hereinafter cited as JOINT LEGISLATIVE COMMITTEE]. In 1919, however, Dr. S. D. Hubbard concluded that even an estimate of one percent of the population of New York City addicted to drugs was too high. See Terry & Pellens, *The Extent of Chronic Opiate Use in the United States Prior to 1921*, in *THE EPIDEMIOLOGY OF OPIATE ADDICTION IN THE UNITED STATES* 60 (J. Ball & C. Chambers eds. 1972).

5. JOINT LEGISLATIVE COMMITTEE, *supra* note 4.

6. R. LINGEMAN, *DRUGS FROM A TO Z: A DICTIONARY* 45 (1969).

7. FIRST REPORT OF THE NATIONAL COMMISSION ON MARIHUANA AND DRUG ABUSE, *MARIHUANA: A SIGNAL MISUNDERSTANDING* 13 (1972) [hereinafter cited as FIRST REPORT ON MARIHUANA].

Such association of drugs with violence and depravity forced addicts from respectable social circles to keep their addiction to themselves. According to one 1917 report: "The attitude of the public toward the narcotic drug addict fostered by the increasing prevalence of the disease in the criminal classes . . . forced such drug users [from respectable society] to keep their affliction a secret."⁸ The public also became alarmed with the rising evidence that youths were becoming addicted to drugs. A 1906 report stated that 60 percent of the white girls (some no more than 14 years of age) living in New York City's Chinatown were "drug fiends."⁹

The public's fears concerning drugs, however, were not confined to the domestic scene alone: drugs were deemed an alien influence and part of a foreign plot to destroy the moral fiber of America. This fear first manifested itself with respect to Chinese immigrants imported to help build railroads in the West.¹⁰ Since opium smoking was quite common among them, the use of the opium pipe came to be regarded as a sinister oriental habit which was sapping America's strength. Various Western States began to adopt measures to stop the practice.¹¹ Similarly, Mexican immigrants and West Indian sailors were blamed for spreading the use of marijuana—particularly in the Gulf and border states.¹²

With the advent of World War I, however, there appeared a new alien threat which in its turn became associated with drug abuse. Rumors spread that German agents were selling drugs to soldiers and children.¹³ There were even published suggestions that Germany had laced exported toothpaste with drugs so as to enslave the world.¹⁴

This climate of fear, shared by public and legislature alike, resulted in an ever-increasing recourse to criminal law and criminal sanctions—first to control and then to suppress the drug traffic. The

8. PRELIMINARY REPORT OF THE JOINT LEGISLATIVE COMMITTEE TO INVESTIGATE AND EXAMINE THE LAWS IN RELATION TO DISTRIBUTION AND SALE OF SO-CALLED HABIT-FORMING DRUGS, N. Y. SENATE DOC. NO. 31, at 4 (1917) [hereinafter cited as PRELIMINARY REPORT].

9. N.Y. Times, Mar. 15, 1906, at 6, col. 3.

10. CABINET COMMITTEE ON INTERNATIONAL NARCOTICS CONTROL, WORLD OPIUM SURVEY 1 (1972).

11. See, e.g., U.S. PUBLIC HEALTH SERVICE, STATE LAWS RELATING TO THE CONTROL OF NARCOTIC DRUGS AND THE TREATMENT OF DRUG ADDICTION 69, 87 (1931) [hereinafter cited as U.S. PUBLIC HEALTH SERVICE] (early laws of Nevada and Oregon).

12. FIRST REPORT ON MARIHUANA, *supra* note 7.

13. R. KING, *supra* note 2, at 26.

14. *Id.*

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purpose of this article is to plot the course of that development in New York State: from the first embryonic efforts in the field to the current fully developed system of drug control embodied in the New York Controlled Substances Act of 1972.¹⁵

For convenience of presentation, the subject has been divided into four parts. Part I deals with the efforts of New York to control the more traditional types of drugs of abuse, i.e., opium, cocaine, morphine and heroin. This period runs from approximately 1886 to 1966. The period from 1946 to 1966 is dealt with in part II, which describes the state's efforts to control drugs such as marijuana, LSD, amphetamines and barbiturates. Part III deals with the brief period from 1966 to 1972, which was characterized by the New York Legislature's efforts to bring some order and unity into its drug control legislation. Part IV describes the present state of the law in New York—the culmination of the evolutionary process described in parts I, II and III. Finally, the article concludes with an epilogue dealing with recent proposals to toughen New York State's drug trafficking penalties.

I. NARCOTIC DRUG LEGISLATION TO 1966

A. *Early Legislative Enactments*

New York was not the first state to pass legislation aimed at combating drug abuse. In 1877 the Territory of Nevada enacted a statute outlawing opium dens and forbidding the sale of opium and its derivatives without a doctor's prescription.¹⁶ The earliest piece of New York drug control legislation was passed in 1886.¹⁷ By its terms the act made it a misdemeanor for any person to sell, give away, dispose of or offer for sale any preparation of opium or morphine without first attaching to the container a scarlet label describing in white letters not only the contents of the container but also the name and residence of the person selling or transferring the drugs. Paregoric and certain prepara-

15. This article does not deal with New York's legislation in the area of drug treatment and rehabilitation. It is concerned solely with New York's drug control legislation. In this regard, see REPORT OF THE STATE OF NEW YORK, JOINT LEGISLATIVE COMMITTEE ON NARCOTIC STUDY 16-19 (1959) [hereinafter cited as 1959 REPORT].

16. U.S. PUBLIC HEALTH SERVICE, *supra* note 11, at 69.

17. Ch. 390 [1886] Laws of New York 610, *as amended*, N.Y. PENAL CODE § 1743 (1909).

tions in which the opium or morphine content was two grains or less per ounce were exempted from the act's coverage.

During the next year, however, the legislature put additional restrictions on the sale of morphine and opium. Druggists and pharmacists were forbidden from refilling prescriptions containing opium or morphine more than once, unless otherwise directed by the verbal or written order of a physician.¹⁸ A few years later, the legislature added cocaine to this list of restricted drugs.¹⁹

Two further enactments from this early period merit attention. The first, adopted in 1897, forbade any person (other than a duly licensed physician or surgeon engaged in the lawful practice of his profession or someone acting under his direction) from having in his possession any narcotic substance capable of producing stupor or unconsciousness with an intent to administer the substance to another without his consent.²⁰ Curiously the statute provided that concealed possession of any narcotic substance was presumptive evidence of an intent to administer the drug in violation of the act.

The more important of the two statutes, however, was enacted by the legislature in 1900, as an amendment to the Public Health Law.²¹ This act adopted new labeling regulations and, for the first time, imposed certain bookkeeping requirements on drug distributors. With respect to labeling, retailers were prohibited from distributing certain poisons without affixing to the container a label detailing the name of the article, the word poison (distinctly shown), the name of the poison and the name and place of business of the seller. Included in the list of poisons were morphine, cocaine, opium and certain opium preparations. Even wholesalers of these drugs were required to affix to any drug a suitable label with the word poison imprinted in red ink. As for bookkeeping requirements, drug retailers (but not wholesalers) were required to keep records of the date of all drug sales, the name and address of the purchaser, the name and quantity of the particular drug purchased, the purpose for which it was to be used and the name of the dispenser. One exception was made to these bookkeeping regulations—if drugs were dispensed pursuant to a doctor's prescription, no records were required. Doctors who themselves dispensed drugs were

18. Ch. 636 [1887] Laws of New York 848.

19. Ch. 661, § 208 [1893] Laws of New York 1495, 1561.

20. Ch. 42 [1897] Laws of New York 21, *as amended*, N.Y. PENAL LAW § 1752 (1909).

21. Ch. 667, § 198 [1900] Laws of New York 1471, 1480-81.

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exempted from both the labeling and bookkeeping requirements of the act. Violations of these Public Health Law amendments were punishable as misdemeanors. In 1905, the legislature moved the penalty sections from the Public Health Law to the Penal Code,²² but did not increase the severity of the penalties.

Although there are certain exceptions, these early statutes aimed at curbing drug abuse might be generally classified as labeling or consumer protection statutes. Such legislation seemed to be based on the assumption that members of the public, if warned of the presence of harmful drugs, could take adequate measures to protect themselves from addiction. Subsequently, the federal Pure Food and Drug Act of 1906²³ reflected the same view.

B. Cocaine Legislation

In 1907, 1908, 1910, and 1913 New York adopted a series of statutes specifically regulating the use and distribution of cocaine. The pattern of legislation was the first serious effort by the New York Legislature to control drug abuse with harsh criminal sanctions.

The very quantity of the legislation enacted and the harsh penalties imposed on those who violated these laws made one fact readily apparent: cocaine and not opium or heroin seemed to be regarded as the most serious drug threat during this period.²⁴ This phenomenon is perhaps explained by two factors. First, since cocaine is a stimulant, "the intoxicating and debilitating effects of heavy cocaine use" were more readily apparent to the public than those of the use of opium or heroin, both depressants.²⁵ Second, cocaine was not only a common ingredient in patent medicines, but also was used in various soft drinks sold widely throughout the country.²⁶ Thus cocaine may have had a wider distribution—particularly among children—than did the opiates.

22. Ch. 442 [1905] Laws of New York 977, *as amended*, N.Y. PENAL LAW §§ 1742-44 (1909), *as amended*, N.Y. EDUG. LAW §-6808-a (McKinney 1953).

23. Act of June 30, 1906, ch. 3915, 34 Stat. 768, *as amended*, 21 U.S.C. §§ 301-92 (1972).

24. *See*, McLaughlin, *Cocaine: The History and Regulation of a Dangerous Drug*, 58 CORNELL L. REV. 537 (1973).

25. R. KING, *supra* note 2, at 25.

26. *See* Brecher, *Licit & Illicit Drugs*, in CONSUMERS UNION REPORT ON NARCOTICS, STIMULANTS, DEPRESSANTS, INHALANTS, HALLUCINOGENS AND MARIJUANA—INCLUDING CAFFEINE, NICOTINE AND ALCOHOL 275-76 (1972).

Enacted in 1907, the first piece of cocaine legislation added a new section to the penal code prohibiting *any* person from selling, furnishing or disposing of cocaine or its salts except upon written prescription of a duly registered physician.²⁷ The prescription had to be retained by the dispenser of the cocaine. Cocaine sales by wholesalers were permitted if adequate records of these transactions were kept. The sale or dispensing of cocaine contrary to the statute was punishable as a felony. In 1908 the act was amended by the adoption of new record-keeping controls for sales between manufacturers of cocaine and between manufacturers and wholesalers of the drug.²⁸

The 1910 amendments, however, were more significant.²⁹ In that year, the legislature required that any person who legally sold cocaine pursuant to a doctor's prescription must give to the purchaser a certificate stating (among other things) the name and address of the seller and the physician as well as the date of sale and amount of cocaine sold. Possession of cocaine either without the certificate or more than ten days after the date of the certificate was presumptive evidence of an attempt to sell the drug in violation of the law.

As if to underscore its preoccupation with cocaine, the legislature repealed these cocaine provisions in 1913 and substituted a new statute.³⁰ Although similar in most respects to the prior law, the new legislation did impose certain additional restrictions on cocaine distributors. For instance, before a pharmacist could fill a prescription which contained more than one percent cocaine, he was required to verify the prescription by contacting the physician. Doctors who themselves dispensed cocaine were also required to deliver the certificate required of a dispensary druggist. The 1913 act also required all cocaine manufacturers to keep a running inventory of their stock and limited the amount of cocaine a pharmacy could legally stock at any one time. Finally, although felony penalties for illegal sales of cocaine were not disturbed, the act provided only misdemeanor penalties for possession of cocaine or a failure to keep required records.

27. Ch. 424 [1907] Laws of New York 879, *as amended*, N.Y. PENAL LAW § 1746 (1909).

28. Ch. 277 [1908] Laws of New York 764, *as amended*, N.Y. PENAL LAW § 1743 (1909).

29. Ch. 131 [1910] Laws of New York 231, *amending* N.Y. PENAL LAW § 1743 (1909).

30. Ch. 470 [1913] Laws of New York 984, *amending* N.Y. PENAL LAW § 1743 (1909).

C. *The Opiates*

Although the New York Legislature had imposed stringent controls over the distribution of cocaine in 1907, there were no comparable controls for opiate distribution until July 1914, when the Town-Boylan Law became effective.

1. *Town-Boylan Law*. The new law made it illegal for any pharmacist, druggist or any other person to sell at retail or give away any opiate without first receiving a written prescription from a doctor containing: (a) the name of the physician, his office address, office hours and telephone number; (b) the date of the prescription; and (c) the name, age and address of the patient to whom the prescription was issued.³¹ As in the case of cocaine, a pharmacist was now required to verify any prescription which contained any opiates above certain listed amounts. In addition, the pharmacist was required to maintain a file of the opiate prescriptions which he filled. The law also mandated that retailers of opiates supply the purchaser with a certificate containing various pieces of required information.

A doctor could not issue a prescription for opiates except after a physical examination of the patient for the treatment of disease, injury or deformity. If a physician himself dispensed opiates, he was required to keep records of all such transactions. In order for a doctor to purchase opiates, he was required to use a special order form which had to be presented to the person from whom the drugs were being purchased.

The Town-Boylan Law also prohibited the sale of hypodermic needles or syringes without the written order of a physician.³² Originally, violations of the provisions of this act were punishable as misdemeanors; but in 1915 the legislature increased to a felony the penalty for selling opiates to anyone under sixteen years of age.³³

2. *First Whitney Act*. The Town-Boylan Act was not the only piece of drug control legislation to have a dramatic impact on New York State in 1914. In December of that year, Congress enacted the Harrison Act—a statute which forcefully interjected the federal government into the field of local drug regulation and control.³⁴ Although it is not the purpose of this article to discuss the Harrison Act in any

31. Ch. 363 [1914] Laws of New York 1120.

32. *Id.* at 1123.

33. Ch. 327 [1915] Laws of New York 1017.

34. Ch. 1, 38 Stat. 785 (1914), *as amended*, 21 U.S.C. § 801 *et seq.* (1970).

detail, one aspect of that statute does merit attention. As originally conceived, the Harrison Act did not prohibit doctors from continuing to prescribe narcotic drugs for their addict-patients,³⁵ and in 1917, the preliminary report of the New York State Joint Legislative Committee Appointed to Investigate and Examine the Laws in Relation to the Distribution and Sale of So-called Habit-forming Drugs stated that

one of the first duties of the State, in dealing with this grave situation, is to establish a supply of narcotic drugs to which the confirmed addict shall have access, under proper State regulation, pending the establishment of rational and recognized scientific treatment for his disease. . . .

Your Committee contends that any member of the medical or pharmaceutical profession who refuses either to prescribe or to dispense narcotic drugs to the honest addict to alleviate the suffering and pain occasioned by lack of narcotics is not living up to the high standards of humanity and intelligence established by these great professions.³⁶

Adopting this view, the state legislature passed the First Whitney Act on May 9, 1917.³⁷ Under the Act a physician, after a physical examination, could administer to or prescribe for an addict a reasonable amount of opiates provided the doctor acted in good faith and solely for the purpose of relieving physical stress or of effecting a cure for such addict. The doctor was required, however, first to satisfy himself that the addict was seeking a means of relieving physical pain and not procuring or attempting to procure drugs for the purpose of illegal sale or distribution. Similarly, local boards of health might furnish addicts free prescriptions for sufficient quantities of opiates to provide for the necessities of the addict pending treatment. Doctors and medical institutions which prescribed drugs for addicts were required to keep separate records of these prescriptions and deliver a monthly report to the state board of health listing the name, age and residence of each addict for whom narcotics were prescribed. These reports, while described as "confidential," were in fact open to inspection by law enforcement agencies.³⁸

The First Whitney Act seems to have condoned drug maintenance

35. A. LINDESMITH, *THE ADDICT AND THE LAW* 5 (1965).

36. PRELIMINARY REPORT, *supra* note 8, at 5.

37. Ch. 431 [1917] Laws of New York 1341.

38. *Id.* at 1347.

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treatment by physicians by permitting doctors to prescribe drugs solely for the purpose of relieving physical stress, i.e., withdrawal. Also permitted was the so-called "ambulatory treatment" of addicts, whereby a patient would agree to submit to a gradual reduction of his dose while going about his customary business with the hope that eventually the dose would be so small as to enable the patient to abandon it altogether without serious discomfort. The alternative to drug maintenance or ambulatory treatment was custodial treatment, whereby the addict was institutionalized and underwent immediate and rapid detoxification.

3. *Narcotic Drug Control Act of 1918*. The Final Report of the Joint Legislative Committee Appointed to Investigate the Laws in Relation to the Distribution and Sale of Narcotic Drugs was released on March 1, 1918.³⁹ The Committee commented on the confusion caused by the varying procedural and substantive requirements imposed by federal law and the two state laws, one regulating cocaine and the other regulating opiates. The Committee felt that it was "the duty of the Legislature to enact one statute covering the whole subject clear and concise in terms, easily understood, in harmony with the federal statute, elastic in application, to be enforced by a central state authority adequately supported and equipped to effectively cooperate with the federal authorities and with a fixed policy along definite lines."⁴⁰

Heeding the advice of the Committee, the New York State Legislature repealed the separate cocaine and opiate statutes and established a new system of drug control modeled on the Harrison Act.⁴¹ As was recommended by the Joint Committee, a central state authority to administer the act was formed—the Department of Narcotic Drug Control. As with the Harrison Act, the enforcement of drug legislation was entrusted not to general law enforcement agencies but to a specialized law enforcement unit.⁴²

The new regulatory scheme prohibited the unauthorized sale and

39. JOINT LEGISLATIVE COMMITTEE, *supra* note 4.

40. *Id.* at 9.

41. Ch. 639 [1918] Laws of New York 2026, amending N.Y. PUB. HEALTH LAW art. XXII (1909), as amended, N.Y. PUB. HEALTH LAW §§ 3300 *et seq.* (McKinney 1971). See JOINT LEGISLATIVE COMMITTEE, *supra* note 4, at 6-9; 38 Stat. 785 (1914), as amended, INT. REV. CODE OF 1954, § 1 *et seq.*

42. It is interesting to note that the enforcement of the Harrison Act was initially carried out by the same unit in the Treasury Department which enforced prohibition laws. See Bonnie & Whitebread, *The Forbidden Fruit and the Tree of Knowledge: An Inquiry into the Legal History of American Marijuana Prohibition*, 56 VA. L. REV. 971, 990 (1970).

distribution of cocaine and the opiates. Mirroring federal law, each person in the legitimate system of drug distribution was required to register with the new Department of Narcotic Drug Control and receive (in most cases) a certificate authorizing the individual to carry on his business. Record keeping modeled on the federal standards was also mandated.

Unlike its predecessors, the Act created an elaborate system of controls for physicians. Although the statute did not prohibit doctors from dispensing or prescribing drugs to addicts, it represented a tightening of controls over the medical profession—an early forecast of future developments. Specifically, the Act permitted a physician in the course of the legitimate and good faith practice of his profession and for the purpose of relieving or preventing pain or suffering on the part of patient or to effect a cure, to administer, prescribe or dispense the controlled drugs.

Personal Administration. A physician was permitted to administer or dispense drugs to his patients without keeping detailed records if the quantity of the drugs administered was below certain amounts. To administer larger quantities, a doctor was required to record upon a serially numbered official physician's dispensing blank the name and quantity of the drug, the form in which it was administered, the name, age and address of the person to whom it was administered, and the date of administration. The doctor was required to send a copy of this form to the Department of Narcotic Drug Control within 24 hours.

Prescriptions. When prescribing narcotic drugs, a doctor might use either an official or unofficial blank, depending on the circumstances; he could prescribe limited amounts on the unofficial prescription blank. Amounts in excess of what was stipulated could also be prescribed on the unofficial blanks if they were reasonably required in the treatment of a surgical case or a disease other than drug addiction. The official blank was required if the prescription was for the treatment of drug addiction itself. A copy of the official prescription blank was to be mailed by the druggist to the Department of Narcotic Drug Control within 24 hours of filling the prescription. Although violations of the Act were misdemeanors, doctors regarded the use of unofficial prescription blanks as a means of shielding their patients from possible harassment by the Department of Narcotic Drug Control.⁴³ Often-

43. SECOND ANNUAL REPORT OF THE NARCOTIC DRUG CONTROL COMMISSION, N.Y. LEG. DOC. NO. 108, at 25 (1920).

times doctors would say they were treating their patients for cancer or asthma (and therefore were entitled to use the unofficial blank) when in fact they were treating them for drug addiction.⁴⁴

During the year following the enactment of the Narcotic Drug Control Act of 1918, the New York drug clinic opened.⁴⁵ This clinic was not a unique experiment: at about this time at least 44 narcotic clinics were opened throughout the country.⁴⁶ The clinics attempted to serve the humanitarian purpose of providing "a place for a careful physical examination, advice as to needed medical treatment for fundamental conditions, and careful oversight of the progress of the drug disease. . . ."⁴⁷ The clinics were an attempt to save the addict from the illicit drug peddler by providing legal access to drugs and the possibility of medical cure through ambulatory treatment.

4. *Repeal.* In 1921, three years after it had been enacted, the Narcotic Drug Control Act was abruptly repealed.⁴⁸ Two theories may be offered for the sudden repeal. The repeal may have been induced by the onerous regulations adopted by the Commissioner of the Department of Narcotic Drug Control. The strategy of the legislature seems to have been this: the 1918 statute would be repealed and a concurrent reenactment of the statute, without the provisions establishing the Department of Narcotic Drug Control, would immediately be adopted in its place. However, the plan failed when after the reenactment was unanimously passed by the legislature, the Governor failed to sign it because the State Department of Health had not made appropriations for enforcing the new act.⁴⁹ From all reports it seemed hardly conceivable that the legislature would have repealed the 1918 Narcotic Drug Control Act unless it assumed that a new law would be signed by the Governor.

44. *Id.*

45. A. LINDSMITH, *supra* note 35, at 143.

46. *Id.* at 138. In New York State, for instance, addict clinics existed at various times in Albany, Buffalo, Oneonta, Rochester, and eleven other communities. See 1959 REPORT, *supra* note 15, at 18.

47. *Id.* at 144, quoting *Illicit Narcotics Traffic: Hearings Before the Subcomm. on Improvements in the Federal Criminal Code of the Comm. on the Judiciary*, 84th Cong. 1st Sess., pt. 5, at 1706 (1955).

48. Ch. 708 [1921] Laws of New York, formerly N.Y. PUB. HEALTH LAW art. 22 (1909).

49. *Report of the Committee on Legislation in Relation to Narcotic Drug Control of the New York State Bar Association*, in LEGISLATIVE BILL JACKET 20 (accompanying ch. 672 [1927] Laws of New York 1695) [hereinafter cited as LEGISLATIVE BILL JACKET]. See also Letter from Committee on Legislation in Relation to Narcotic Drug Control of N.Y.S. Bar Ass'n to Alfred E. Smith, Mar. 27, 1927, in LEGISLATIVE BILL JACKET at 17.

A more fundamental reason may have caused, or at least contributed to, the repeal. There was a rising dispute among doctors and legislators over the propriety of drug maintenance and ambulatory treatment of addicts. Many were of the opinion that drug addiction was curable and once a person was withdrawn from narcotics, he would have minimal additional problems.⁵⁰ These groups viewed maintenance as something akin to drug peddling.⁵¹ In addition, at about this time the federal government seemed to change its attitude toward narcotic clinics.⁵² In 1919, for instance, the federal government had taken the position in the case of *Webb v. United States* that a doctor's order for morphine given to a habitual user to keep him comfortable by maintaining his customary use was not a valid prescription within the meaning of section 2(b) of the Harrison Act—the exemption for doctors from the rule prohibiting the dispensing of drugs except to a person who has procured a special order form.⁵³ Efforts of law enforcement agents succeeded in closing the New York clinic in 1920—after a scant one year in operation.⁵⁴

For whatever reason, in 1921 New York was left without a state drug law. Of course, the Harrison Act was available, but this was a tax statute requiring supplementation by state laws.⁵⁵ New York City moved quickly to remedy the situation by amending its local code in 1921 to prohibit the distribution of drugs.⁵⁶ Four years later Buffalo enacted its own ordinance to give power to its city court to commit any person “unlawfully using” drugs; but this legislation proved ineffective because the repeal of the 1918 act by the state legislature left no statute declaring the use of drugs to be unlawful.⁵⁷

The legislature made various unsuccessful attempts to reenact comprehensive drug legislation in the early 1920's. For various reasons, there was legislative opposition to a new drug statute—opposition

50. De Long, *Treatment and Rehabilitation*, in DRUG ABUSE SURVEY PROJECT, DEALING WITH DRUG ABUSE—A REPORT TO THE FORD FOUNDATION 173, 175 (1972).

51. *Id.*

52. A. LINDESMITH, *supra* note 35, at 139, citing ANNUAL REPORT OF THE COMMISSIONER OF INTERNAL REVENUE FOR FISCAL YEAR ENDED JUNE 30, 1920, at 33-34.

53. 249 U.S. 96 (1919).

54. A. LINDESMITH, *supra* note 35, at 138-40.

55. For example, there were constitutional limits on how far Congress could go in regulating local activities. See generally Bonnie & Whitebread, *supra* note 42, at 989.

56. *Respectfully Urging Immediate Legislation for Control and Supervision of the Narcotic Drug Evil*, in LEGISLATIVE BILL JACKET, *supra* note 49, at 9.

57. *People ex rel. Sherwood v. City of Buffalo*, 127 Misc. 290, 216 N.Y.S. 468 (Sup. Ct. 1926).

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which was powerful enough to defeat a new law in session after session.⁵⁸ In 1923, however, the legislature did partly remedy the situation by reenacting separate cocaine legislation.⁵⁹ Violation of the act was a felony punishable by imprisonment for not less than one nor more than five years, a fine of not less than one thousand dollars nor more than five thousand dollars, or both. In 1926 the legislature amended the Code of Criminal Procedure to define as a vagrant a person who uses or possesses unlawfully opium, coca leaves or their derivatives.⁶⁰ Provision was made that a person so convicted could be committed to a hospital for care and medical treatment for a period not to exceed one year. Since the act did not specify when use or possession of these drugs was unlawful, it was ineffective for the same reason mentioned in the discussion of the Buffalo ordinance.

5. *The Freiberg-Dickey Act.* By 1927, sentiment for a new state narcotic law had reached fever pitch. One supporter of drug legislation summed up the situation this way: "Behold New York for six years, like a poor pariah in civilized society, impotent to protect its own folk shirking its share in the world-wide warfare to exterminate this monster!"⁶¹ With urgings from various organizations such as the New York State Bar Association, the Freiberg-Dickey Bill was enacted on April 5, 1927.⁶² The new law was a comprehensive drug statute which again modeled itself in most respects on the Harrison Act. When compared to its predecessor, the Narcotic Drug Control Act of 1918, the 1927 Act represented a significant change in approach to drug abuse. For example:

a) The 1927 Act provided that doctors could prescribe, administer and dispense habit forming drugs "in good faith and in the course of their professional practice only." These words were borrowed verbatim from the Harrison Act and marked a triumph for those opposed to the medical profession's prescribing drugs to relieve the symptoms of addiction. Although the language of the Harrison Act had ultimately been

58. Letter from Committee on Legislation in Relation to Narcotic Drug Control of N.Y.S. Bar Ass'n to Alfred E. Smith, Mar. 27, 1927, in LEGISLATIVE BILL JACKET, *supra* note 49, at 13.

59. Ch. 130 [1923] Laws of New York 160, *amending* N.Y. PENAL LAW art. 166 (1909).

60. Ch. 650 [1926] Laws of New York 1198. A 1926 amendment to the Penal Law made it a felony for a person to employ children under sixteen years of age to sell or carry narcotic drugs. Ch. 434 [1926] Laws of New York 756.

61. *Respectfully Urging Immediate Legislation for Control and Supervision of the Narcotic Drug Evil*, in LEGISLATIVE BILL JACKET, *supra* note 49, at 9.

62. Ch. 672 [1927] Laws of New York 1695.

interpreted by the Supreme Court as not prohibiting doctors from prescribing drugs to relieve symptoms of addiction,⁶³ there was still a sufficient fear and uncertainty among doctors about the status of the law that they shied away from prescribing drugs to addicts.⁶⁴

b) The enforcement of the Act was not entrusted to a special department of the State government but rather left to the general judicial and law enforcement authorities of the State and its political subdivisions.

c) Violations of any of the provisions of the Act were punishable as misdemeanors—a change from the 1923 Act which required felony penalties for cocaine offenses. In 1929, however, the penalties for selling all habit-forming drugs were increased to felonies punishable by prison sentences of up to ten years.⁶⁵

In 1931 the legislature specifically forbade the smoking of opium and made the possession of pipes and lamps used for the smoking of opium a crime.⁶⁶ The law against opium smoking and opium pipes was allegedly aimed at supporting earlier federal acts which had banned the importation of smoking opium into the United States.⁶⁷

6. *Uniform Narcotic Drug Act.* With the passage of the Harrison Act in 1914, the federal government intervened to stop the escalating problem of drug addiction in the country. The net effect of this intervention, however, was to create a crazy quilt of various state and federal drug laws—each with different requirements and procedures. In order to unify state laws and harmonize state and federal law, the Commissioners on Uniform State Laws drafted the Uniform Narcotic Drug Act and offered it to the states for adoption.⁶⁸ Although New

63. *Linder v. United States*, 268 U.S. 5 (1925).

64. *See Hawkins v. United States*, 90 F.2d 551 (5th Cir. 1937); *Du Vall v. United States*, 82 F.2d 382 (9th Cir. 1936); *Bush v. United States*, 16 F.2d 709 (5th Cir. 1927); *Teter v. United States*, 12 F.2d 224 (7th Cir. 1926). "Between 1914 and 1938, 25,000 doctors were arrested for supplying opiates and 5,000 of them actually went to jail." De Long, *supra* note 50, at 176.

65. Ch. 377 [1929] Laws of New York 881, *amending* N.Y. PENAL LAW (1909), *as amended*, N.Y. PENAL LAW §§ 220.30, 220.35, 220.40 (McKinney Supp. 1972).

66. Ch. 479 [1931] Laws of New York 1109, *amending* N.Y. PUB. HEALTH LAW (1909).

67. *See* Letters from Walter B. Coughlan, Asst. Corp. Counsel of City of New York to Hon. W. Ray Austin, Chmn. Assembly Comm. on Public Health, Feb. 23, 1931 and to Gov. Franklin D. Roosevelt, Apr. 14, 1931, in LEGISLATIVE BILL JACKET 4-5 (accompanying ch. 479 [1931] Laws of New York 1109). The importation of smoking opium into the United States was banned in 1909. Act of Feb. 9, 1909, ch. 100, 35 Stat. 614.

68. For a discussion of the background of the Uniform Narcotic Drug Act, see Bonnie & Whitebread, *supra* note 42, at 1026-34.

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York had closely followed the Harrison Act in drafting both its 1918 and 1927 statutes (and therefore had already harmonized its law with the federal statutes), it proceeded to adopt the Uniform Act in May of 1933.⁶⁹ Totally apart from making state and federal law complementary, there were important arguments in favor of adopting the Act because the legislation aligned the various drug laws of the states.

In its regulatory scheme, the Uniform Act required that manufacturers and wholesalers of narcotic drugs (defined to include cocaine) obtain a license from the New York State Department of Health. Sales by licensed manufacturers and wholesalers of drugs to authorized individuals were required to be recorded on official order forms. Druggists could sell and dispense narcotics only upon the written prescription of a doctor. The use of narcotics by physicians continued to be regulated by the Harrison Act formula—a physician acting in good faith and only in the course of his professional practice might prescribe, administer and dispense narcotic drugs. The Uniform Narcotic Drug Act also required that records be kept by every individual in the chain of licit drug distribution. Indeed doctors themselves were not exempted from the record-keeping requirements. Finally, the Act specified various labeling requirements before drugs could be distributed. Existing penalties for violating the 1927 Act (which were contained in the Penal Law) were retained under the Uniform Act. With certain amendments, this Act remained the basis of New York narcotic drug control legislation until the enactment of the Controlled Substances Act of 1972.

To enforce the Uniform Act the Legislature in 1937 created the Bureau of Narcotic Control in the Department of Health.⁷⁰ In 1938, certain definitional changes were made in the Penal Law to conform it to the Uniform Narcotic Drug Act.⁷¹ The penalty structure, however, was not altered at that time. Felony penalties for the illegal sale of narcotics remained fixed at a prison term of up to ten years. For all other offenses, the penalties remained at imprisonment for not more than one year, a fine of not more than \$500 or both.

7. *Marijuana Legislation of 1939*. In response to the enactment

69. Ch. 684 [1933] Laws of New York 1395.

70. Ch. 914 [1937] Laws of New York 2069, *amending* N.Y. PUB. HEALTH LAW (1909), *as amended*, N.Y. PUB. HEALTH LAW §§ 3302-04, 3340, 3350 (McKinney 1971).

71. Ch. 168 [1938] Laws of New York 689, *amending* N.Y. PENAL LAW §§ 1751, 1751-a (1909), *as amended*, N.Y. PENAL LAW §§ 220.05, 220.30-40 (McKinney 1967).

of the Federal Marijuana Tax Act of 1937,⁷² New York prohibited the unauthorized sale and possession of marijuana in 1939.⁷³ Four years later in 1943, a special statute was enacted making it a misdemeanor to grow marijuana without a license.⁷⁴

8. *Miscellaneous Enactments of 1950 and 1952.* In 1950 the new offense of possession of a narcotic drug with intent to sell was added to the Penal Law.⁷⁵ The penalty was identical to that for actually selling narcotics—a prison term of up to 10 years. An intent to sell narcotics was presumptively established if the offender possessed two or more ounces of any preparation containing three percent or more of heroin, morphine or cocaine, or 16 or more ounces of a preparation containing opium or cannabis. The presumption, however, could be rebutted by evidence that the drugs were not possessed for the purpose of sale.

The year 1950 also saw certain amendments made to the Uniform Narcotic Drug Act, among them the inclusion of synthetic opiates such as methadone within the coverage of the Act.⁷⁶

In 1952, the legislature adopted a measure providing for the forfeiture of vehicles, vessels, or aircraft used in transporting narcotics⁷⁷ and required physicians to report to the Department of Health the name and, if possible, the address of any habitual narcotics user under their treatment.⁷⁸

D. Increased Sanctions

1. *1951 Increase.* Penalties for narcotics violators were increased drastically in 1951,⁷⁹ a year in which comparable federal penalties

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

73. Ch. 131 [1939] Laws of New York 159, *amending* N.Y. PUB. HEALTH LAW §§ 421, 428-29 (1909), *as amended*, N.Y. PUB. HEALTH LAW §§ 3301, 3324, 3333 (McKinney 1971).

74. Ch. 123 [1943] Laws of New York 521, *amending* N.Y. PENAL LAW (1909), *as amended*, N.Y. PUB. HEALTH LAW § 3315 (McKinney 1971). For a comprehensive study of marijuana legislation in the United States, see Bonnie & Whitebread, *supra* note 42.

75. Ch. 346 [1950] Laws of New York 1073, *amending* N.Y. PENAL LAW § 1751 (1909).

76. Ch. 794, § 8 [1950] Laws of New York 2190.

77. Ch. 415 [1952] Laws of New York 1090.

78. Ch. 632 [1952] Laws of New York 1396.

79. Ch. 529-30 [1951] Laws of New York 1293, *amending* N.Y. PENAL LAW § 1751 (1909). At that time, the Attorney General was empowered to conduct a wide-ranging study of the narcotics problem. Ch. 528 [1951] Laws of New York 1292.

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were also increased.⁸⁰ The legislature provided that drug offenders serve an indeterminate sentence for which the legislature set a harsh statutory minimum term of imprisonment. Thus a conviction for the sale of drugs to a minor would result in a prison term of not less than five nor more than fifteen years. If the transaction was between adults, the term would be not less than two nor more than fifteen years. The penalty for possession with intent to sell was set at not less than two nor more than fifteen years. The penalty for simple possession depended on the amount of drugs found in the person's possession: possession above certain amounts (but below the statutory amount which would trigger the automatic presumption of intent to sell) was a felony punishable by a prison term of not less than two nor more than ten years.

2. 1956—*Further Increases*. Just as with federal penalties for drug abuse,⁸¹ the New York Legislature increased drug penalties in 1956⁸² by amendments which made the following changes. First, the minimum penalties for all drug offenses were increased. For selling drugs to a minor, the minimum sentence was raised from five to seven years; for selling drugs to an adult the minimum was raised from two to five years. Similarly the minimum prison term for someone convicted of possession with intent to sell drugs was increased from two to five years. At the same time, the amount of drugs required to raise the presumption of intent to sell was lowered and penalties for simple possession were increased. There were also inserted in the law provisions that might require an addict to undergo treatment at an appropriate facility as a condition of his parole or probation.⁸³

II. DANGEROUS DRUG LEGISLATION TO 1966

In part I of this article, the Law of New York regarding narcotic drugs was considered. Part II discusses the New York law regarding a separate category of drugs—dangerous drugs. Dangerous drugs fall within three categories: depressants (barbiturates and tranquilizers), stimulants (amphetamines), and hallucinogens.

80. Act of Nov. 2, 1951, ch. 666, 65 Stat. 767.

81. Narcotic Drug Control Act of 1956, ch. 629, 70 Stat. 567 (codified in scattered sections of volumes 21 and 26 of the United States Code).

82. Ch. 526 [1956] Laws of New York 1248, *as amended*, N.Y. PENAL LAW § 1751 (1909).

83. Ch. 527, § 2 [1956] Laws of New York 1251.

New York's laws regulating dangerous drugs appeared long after the enactment of the first narcotics-control legislation. A 1946 statute—the first to mention specifically dangerous drugs—required that any barbiturate or “other hypnotic and somnifacient drug” could be sold at retail or dispensed only upon the written prescription of a person legally authorized to issue prescriptions.⁸⁴ An appropriate label was required to be affixed to the container of the drugs. Violations of the Act were treated as misdemeanors—punishable by up to one year of imprisonment, a fine of up to \$500, or both.

Amphetamine legislation was enacted ten years later in 1956. Amphetamine sulphate was first marketed in 1938 under the name of Benzadrine.⁸⁵ Until 1949, when the patent expired, only a few companies were engaged in the manufacture of this drug.⁸⁶ By 1956, however, the estimated yearly output was about 900,000,000 tablets of 10 milligrams each.⁸⁷ Reports stated that the drug was being bootlegged at gas stations and lunch counters “throughout the country at ten cents per tablet or one dollar per dozen.”⁸⁸ To regulate these burgeoning sales of amphetamines, the legislature made the possession, sale or exchange of any amphetamine or derivative of an amphetamine a misdemeanor punishable by up to one year in prison, a fine of up to \$500, or both.⁸⁹

The separate statutes regulating barbiturates and amphetamines lasted until 1965 when a comprehensive Depressant and Stimulant Drug Control Act was adopted.⁹⁰ 1965 was also the year in which the federal government moved decisively to regulate these drugs.⁹¹ The New York Act covered not only barbiturates and amphetamines but also any drug which had a potential for abuse because of its depressant or stimulant effect on the central nervous system or

84. Ch. 597 [1946] Laws of New York 1246, *amending* N.Y. EDUC. LAW § 1366-a (McKinney 1969). More severe penalties were provided for second offenders.

85. Memoranda in Support of Assembly Int., in LEGISLATIVE BILL JACKET 8 (accompanying ch. 644 [1956] Laws of New York 1441).

86. *See id.*

87. *Id.*

88. *Id.*

89. Ch. 644 [1956] Laws of New York 1441, *amending* N.Y. PENAL LAW § 1747-c (1909) (repealed 1965). As with barbiturates, more severe penalties were provided for second offenders.

90. Ch. 323 [1965] Laws of New York 1028.

91. Drug Abuse Control Amendments of 1965, Pub. L. No. 89-74, 79 Stat. 226 (codified in scattered sections of volume 21 of United States Code).

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because of its hallucinatory effect. The language was broad enough to include various common tranquilizers.

In order to regulate the distribution of these drugs, the legislature established a control system which was similar to the existing system for narcotics regulation. Specifically, the act provided for licensing of manufacturers and wholesalers, biennial registration with the Department of Public Health and adequate record-keeping. For the illegal sale of these drugs the penalty was set at an indeterminate prison term of one to five years. For illegal possession of these drugs, the maximum prison term was one year. In addition, the 1965 legislature imposed specific controls on hallucinogenic drugs such as peyote, mescaline and LSD.⁹² Subject to one exception, the Act provided that no person could receive, sell or dispense a hallucinogenic drug without first obtaining a license. Licenses were to be issued solely to doctors and then only for a limited time. Violations of the Act (whether by illegal sale or possession) were misdemeanors punishable by up to one year in jail, a fine of not more than \$500, or both.

III. NARCOTIC AND DANGEROUS DRUG LEGISLATION 1966-1972

In 1966 the structure of New York drug control legislation could be briefly summarized in the following way. There existed a regulatory scheme for controlling the distribution of narcotic drugs which had been established pursuant to the Uniform Narcotic Drug Act. A separate, though similar, scheme existed for regulating depressant and stimulant drugs. And a third less complex regulatory scheme existed for hallucinogens. The sanctions for violating each of these regulatory schemes were spread over different sections of the Penal Code. This structure was modified in 1967 when a new Penal Law combined all drug penalties into one uniform structure.⁹³ The new law effected a number of changes.

92. Ch. 332 [1965] Laws of New York 1073, *amending* N.Y. PENAL LAW § 1749-d (1909), *as amended*, N.Y. PENAL LAW §§ 220.00, 220.05, 220.30 (McKinney Supp. 1972). There may have been little need for this legislation since the definition of depressant or stimulant drug in the earlier 1965 statute would seem to have already included a drug with a potential for abuse because of its hallucinatory effect. It should be observed, however, that this law (ch. 332) made the penalty structure for sale of hallucinogenic drugs less severe than the comparable penalty structure for the sale of depressant or stimulant drugs.

93. Ch. 1030, §§ 220.00-45 [1965] Laws of New York 2343, 2440-42, *as amended*, N.Y. PENAL LAW § 220.00-45 (McKinney Supp. 1972).

a) A new definition was added to the Penal Law. The term "dangerous drug" was defined to mean any narcotic drug, depressant, stimulant or hallucinogen.⁹⁴ (In this statutory sense, it has a much broader meaning than the definition given the term in Part II of this article.)

b) Where before there had been separate provisions detailing the criminal sanctions for illegal possession or sale of narcotics, depressants or stimulants, and hallucinogens, the new Penal Law combined the penalties for the criminal possession or criminal sale of any of these "dangerous drugs" into one section.

c) Criminal possession of a dangerous drug was subdivided into four degrees, ranging in severity from a class A misdemeanor (punishable by up to one year in jail), to a class C felony (punishable by from one to fifteen years in jail). The degree of the crime depended on the nature and amount of the drug possessed. For example, the two highest degrees usually required possession of more than a specified amount of a narcotic drug.

d) Criminal sale of a dangerous drug was divided into three degrees, ranging in severity from a class D felony to a class B felony. Again, in order to be convicted of criminal sale of a dangerous drug in the two highest degrees, the drug sold had to be a narcotic and the amount sold had to exceed a certain amount.

e) The revision of the Penal Law in 1965 continued the prohibition on unlawful possession or sale of a hypodermic syringe or needle, making such an offense a class A misdemeanor.

In 1969,⁹⁵ the legislature further reordered the degrees of criminal possession and sale of a dangerous drug by creating two new degrees of criminal possession and one new degree of criminal sale. The seriousness with which the legislature viewed drug crimes was made evident when criminal sale of narcotics in the first degree was made a class A felony punishable by possible life imprisonment. The appendix presents an analysis of the various degrees of criminal sale and possession of a dangerous drug as adopted in 1969.

The legislature enacted further drug legislation in 1971 when two new drug offenses were created. The first was criminal injection of a narcotic drug.⁹⁶ It should be recalled that New York had always pro-

94. Ch. 791 [1967] Laws of New York 2131, 2144-45.

95. Ch. 787-88 [1969] Laws of New York 2022-25.

96. N.Y. PENAL LAW § 220.46 (McKinney Supp. 1972).

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hibited the injection of a narcotic drug into someone without his consent. The new section, however, prohibited a person from injecting narcotic drugs into another even with his consent. The second offense, entitled criminal use of drug paraphernalia, was aimed at eradicating the illicit drug factories where narcotics were "cut" and packaged for distribution to street pushers.⁹⁷ Basically the new provision made it a crime for a person to knowingly possess or sell any dilutants or adulterants (such as mannitol, mannite, lactose or dextrose) under circumstances evincing an intent to use them for compounding or mixing narcotics. The provisions similarly prohibited the unlawful possession and sale of drug packaging materials such as gelatin capsules and glassine envelopes.

IV. THE NEW YORK STATE CONTROLLED SUBSTANCES ACT OF 1972⁹⁸

In 1970 Congress totally revamped federal drug control legislation by enacting the Controlled Substances Act.⁹⁹ In terms of state legislation, the immediate effect of the statute was to destroy existing complementarity between state and federal legislation. The Harrison Act and the Uniform Narcotic Drug Act had provided "an interlocking trellis of Federal and state law to enable government at all levels to control more effectively the drug abuse problem."¹⁰⁰ The new federal Act, created the need for states to revise their legislation and supplant the Uniform Narcotic Drug Act. To reestablish necessary complementarity, the Commissioners on Uniform State Laws proposed to the states the Uniform Controlled Substances Act. In 1972, New York adopted a modified version of that act.¹⁰¹ Although the New York Controlled Substances Act would not take effect until April 1, 1973, the Department of Health was empowered to promulgate rules and regula-

97. *Id.* §§ 220.50-55.

98. This section of the paper deals with New York legislation presently in effect in New York. While it develops this in some detail, it should be borne in mind that this is not the whole picture since federal legislation blankets the New York area with federal laws, rules and regulations. As a result, an adequate answer to the concrete question of what may or may not be done regarding the distribution and use of any controlled substance in New York can only be answered by consulting both the New York legislation here described and the federal legislation for the same area.

99. 21 U.S.C. §§ 801 *et seq.* (1971).

100. 1970 HANDBOOK OF THE NATIONAL CONFERENCE ON COMMISSIONERS OF UNIFORM STATE LAWS 225.

101. N.Y. PUB. HEALTH LAW §§ 3300 *et seq.* (McKinney Supp. 1972).

tions and take such other steps as would be necessary to permit the Act to become operative on that date.

A. *Controlled Substances*

The basic provision of the Act makes it unlawful for any person to manufacture, sell, prescribe, distribute, dispense, administer, possess, have in his control, abandon or transport a controlled substance except as expressly allowed by the terms of the Act. As with the federal law, controlled substances are defined with reference to five schedules. With certain narrow exceptions, New York has adopted the federal schedules *in toto*.¹⁰² Thus in schedule I are listed those opiates and hallucinogens which have a high potential for abuse but no medical value whatsoever. Among schedule I drugs are heroin, certain compounds containing morphine, peyote, mescaline, LSD and cannabis. Schedule II lists drugs which, while considered extremely dangerous, are believed to have some medical value. Cocaine and methadone are two of the more important drugs within this category. Schedule III substances include derivatives of barbituric acid, nalorphine and certain compounds or mixtures containing minimal amounts of opium or morphine. Schedule IV and V drugs have a less serious potential for abuse than any of the drugs in schedule I, II and III. For instance schedule IV lists phenobarbital and schedule V, compounds or preparations which although they contain extremely limited quantities of narcotic drugs also contain nonnarcotic medicinal ingredients in sufficient proportion to confer upon the compound or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone. The Commissioner of Health has a limited power to reclassify controlled substances or to except certain compounds from the schedules altogether.

B. *Manufacture and Distribution of Controlled Substances*

Under the new Act in order to manufacture or distribute a controlled substance in New York, a person must first obtain a license.

102. There are certain minimal differences. Compare, e.g., 21 U.S.C. § 812(c), Schedule I(c)(10) with N.Y. PUB. HEALTH LAW § 3306, Schedule I(c)(10) (McKinney Supp. 1972) and N.Y. PENAL LAW § 220.02, Schedule I(c)(10) (McKinney Supp. 1972). Although New York does not state the criteria applied in determining inclusion in the various schedules, it implicitly adopts the federal criteria which are set forth in 21 U.S.C. § 812 (1971).

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Licenses are granted to manufacture or distribute a particular substance or substances rather than all controlled substances in general. A person applying for his initial license either to manufacture or distribute a controlled substance must furnish the Department of Health detailed information demonstrating that he (a) is of good moral character, (b) possesses sufficient land, buildings and equipment to do what he proposes, (c) is able to maintain effective control against diversion, and (d) is able to comply with all applicable federal and state laws relating to the manufacture or distribution of the particular controlled substance. After reviewing this information, the Commissioner of Health must take the public interest into account before issuing a license. If the Commissioner issues the license, it is generally valid for two years and may then be renewed for subsequent two year periods.

The New York Controlled Substances Act requires that controlled substances be clearly labeled by each licensed manufacturer or distributor. The law requires that each controlled substance be marked (either on each capsule or if the substance is not distributed in capsule form, on the container) with the individual symbol or number assigned to the manufacturer and a code number or symbol identifying the substance itself. With limited exceptions, distribution of free samples of controlled substances is forbidden. The only lawful distribution of controlled substances may be made to licensed distributors or manufacturers, practitioners, pharmacists, institutional dispensers and certain laboratory, research or instructional facilities authorized by law to possess the particular substance.

C. *Research Activities*

The 1972 Act requires that those involved in scientific research, instruction or chemical analysis of controlled substances obtain a license before embarking upon their research. As in the case of licenses to manufacture and distribute controlled substances, research licenses are valid for two years. The law requires that the applicant for such a license supply the same information about character and physical plant that is required for manufacturing licenses as well as certain additional information such as the qualifications and competence of the applicant to engage in the project. Exempted from the licensing requirements are: practitioners lawfully administering or prescribing a controlled

substance in the course of their professional practice to ultimate users for a recognized medical purpose, and licensed manufacturers engaged in research upon nonhuman subjects.

D. Dispensing Drugs to Nonaddict Users

Under New York law, no practitioner could in good faith and in the course of his practice validly prescribe or administer such a substance except for certain research purposes.

A practitioner in good faith and in the course of his professional practice may, however, prescribe, administer and dispense substances listed in schedules II, III, IV and V. In theory, no substances in any of these schedules may be prescribed, dispensed or administered to an addict or habitual user. There are exceptions to this rule, however, and controlled substances may be prescribed for or dispensed to an addict or habitual user: (a) during emergency medical treatment unrelated to drug abuse; (b) who is a bona fide patient suffering from an incurable and fatal disease such as cancer; and (c) who is aged, infirm or suffering from serious injury or illness if the withdrawal from drugs would endanger his life. Similarly, controlled substances can be ordered for use by an addict to relieve acute withdrawal symptoms. Finally the Act details the requirements for methadone maintenance programs in the state, a subject not covered in this article. While the Act requires that a central registry of all addicts be kept, the information is to remain confidential and is available only to practitioners.

E. Records and Reports

Just as with past drug control legislation, the New York State Controlled Substances Act mandates extensive record keeping. Certain records are required to be kept for a period of at least five years. These records are available for inspection and copying by appropriate state officials.

Doctors must report promptly to the Commissioner of Health the name—and if possible, the address—of any person under their treatment who is an addict. Unless they originate in the course of a criminal proceeding, these reports are confidential and may be used only for statistical, epidemiological or research purposes. Reports originating in the course of a criminal proceeding may be disclosed to law enforce-

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ment agencies, however. In fulfilling his duties under this Act, a doctor cannot rely on a doctor-patient privilege. The statute specifically requires that for the purposes of reporting no communication made to a practitioner shall be deemed confidential within the meaning of the New York rules relating to confidential communications between practitioner and patient.

F. Enforcement

Title VII of the Act contains a series of provisions relating to the enforcement of the Act as a whole. Thus title VII contains a section prohibiting "sniffing glue" for the purpose of intoxication, the unlawful sale of a hypodermic needle or syringe, and growing any species of cannabis without a license. There are also provisions regulating the seizure, forfeiture and disposition of contraband controlled substance and vehicles, vessels or aircraft unlawfully used to transport such contraband. Finally, title VII outlines the procedures for the revocation or suspension of licenses.

Criminal sanctions for violating the New York drug laws are left unchanged by the 1972 Act. Thus for illegal possession or sale of drugs, the six degrees of illegal possession and the four degrees of illegal sale still exist.¹⁰³

G. Amendments to the Penal Law Necessitated by the Controlled Substances Act of 1972

Although there was no change in the existing penalty structure, the new terminology employed by the Controlled Substances Act of 1972 compelled certain definitional changes in the Penal Law.

1. *Prior Law.* The Penal Law had defined the term "dangerous drug" to include four categories of drugs—narcotics, hallucinogens, depressants and stimulants. Each of these categories was in its turn defined in the Penal Law. The severity of penalties depended on whether the drug in question was a nonnarcotic dangerous drug or a narcotic drug. Thus the offense of possession of a dangerous drug in the fourth degree was defined as knowing and unlawful possession of a *narcotic drug* either with intent to sell or above prescribed amounts. (See Appendix.)

103. N.Y. PENAL LAW §§ 220.05-44 (McKinney Supp. 1972).

2. *Controlled Substances Act of 1972.* Under the new 1972 Act, the definition of dangerous drug was altered. Dangerous drug now means any substance listed in schedules I through V excepting a compound listed in schedule III or IV which has been exempted from the coverage of the Act by the Commissioner of Health. Similarly, there is a new definition of narcotic drug which meshes with the new schedules of controlled substances listed in the 1972 Act. The definition of narcotic drug includes most substances in schedules I (except for various hallucinogens) and II and certain substances in schedule III. The new definition covers the traditional categories of narcotic drugs such as morphine, heroin, methadone and cocaine but also includes cannabis.

The penalty structure for the unlawful possession and sale of dangerous drugs did not require any changes under the 1972 Act since the terms which it depended upon ("dangerous drug" and "narcotic drug") were kept, albeit in altered form.

EPILOGUE

On January 17, 1973, a bill that would have drastically escalated already severe penalties for certain drug offenses¹⁰⁴ was introduced into the legislature with the strong support of Governor Rockefeller. In some instances (*e.g.*, the sale of any amount of certain controlled substances) a mandatory sentence of life imprisonment without chance of probation or parole would have been imposed. Similarly, the bill would have outlawed plea bargaining where the indictment charged serious drug offenses.

Although the Governor subsequently talked of even more stringent penalties,¹⁰⁵ a less extreme proposal having his support was introduced into the legislature in March of 1973.¹⁰⁶ Among other things, the proposed legislation requires the court to impose mandatory minimum prison sentences on many drug offenders without any chance of probation. After he has served his mandatory term, a drug offender would be subject to lifetime parole supervision. When the charge is a serious drug offense, the new proposal permits plea bargaining only within very limited ranges.

104. S. 1365, 93d Cong., 1st Sess. (1973).

105. See N.Y. Times, Mar. 6, 1973, at 1, col. 1. In this regard see *Furman v. Georgia*, 408 U.S. 238 (1972).

106. Assembly bills 7311, 7312 (Mar. 6, 1973) (these bills passed the New York State Senate on April 27, 1973).

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The proposed legislation (which was passed since this article went to press) does seem to emphasize the law enforcement approach New York State has generally taken with respect to drugs. Although there was some evidence that New York might be turning to a more balanced approach in attempting to solve its drug problem, this bill seems to augur a return to a strict law enforcement attitude with respect to drugs and addiction.

APPENDIX

ANALYSIS OF PENAL LAW RELATING TO CRIMINAL POSSESSION AND SALE OF A DANGEROUS DRUG

It should be noted that the New York Penal Law requires indeterminate prison sentences for felony convictions—that means that the judge must set the maximum and the minimum limits of the sentence. The judge may, as an alternative to imprisonment, place the defendant on probation, except in Class A felonies.

I. *Criminal Possession of a Dangerous Drug*

The term “possession” is not defined in the article of the Penal Law dealing with dangerous drugs.

A. Sixth degree—Class A misdemeanor—knowing and unlawful possession of a dangerous drug.¹⁰⁷

Penalty: not more than one year in jail.

B. Fifth degree—Class E felony—knowing and unlawful possession of a dangerous drug with intent to sell the same.¹⁰⁸

Penalty: 1. maximum—at least three years but not more than four years,

2. minimum—to be decided by the Parole Board (not less than one year).

C. Fourth degree—Class D felony—knowing and unlawful possession of a *narcotic drug* with intent to sell or in quantities in excess of stipulated amounts: e.g., 25 or more cigarettes containing cannabis; 1/8 ounce or more of a preparation, compound or mixture containing

107. N.Y. PENAL LAW § 220.05 (McKinney Supp. 1972).

108. *Id.* § 220.10.

heroin, morphine or cocaine; $\frac{1}{4}$ ounce or more of a preparation, compound or mixture containing any cannabis; or $\frac{1}{2}$ ounce or more of a preparation, compound or mixture containing raw or prepared opium.¹⁰⁹

- Penalty: 1. maximum—at least three years but not more than seven years,
2. minimum—at least one year but not more than $\frac{1}{3}$ of the maximum term imposed. The court has the discretion as to whether or not to fix a minimum term. If it does not, the minimum term is one year.

D. Third degree—Class C felony—knowing and unlawful possession of a *narcotic drug* in amounts larger than those stipulated for a fourth degree offense: e.g., 100 or more cigarettes containing cannabis; one ounce or more of a preparation, compound or mixture containing heroin, morphine or cocaine; one ounce or more of a preparation, compound or mixture containing cannabis or two ounces or more of a preparation, compound or mixture containing raw or prepared opium.¹¹⁰

- Penalty: 1. maximum—at least three years but not more than fifteen years,
2. minimum—at least one year but not more than $\frac{1}{3}$ of the maximum term imposed. The court has discretion as to whether or not to fix a minimum term. If it does not, the minimum term is one year.

E. Second degree—Class B felony—knowing and unlawful possession of a *narcotic drug* consisting of eight ounces or more of a preparation, compound or mixture containing heroin, morphine, cocaine or opium.¹¹¹

- Penalty: 1. maximum—at least three years but not more than twenty-five years,
2. minimum—at least one year but not more than $\frac{1}{3}$ of the maximum term imposed. The court has the discretion as to whether or not to fix a minimum term. If it does not, the minimum term is one year.

109. *Id.* § 220.15. -

110. *Id.* § 220.20.

111. *Id.* § 220.22.

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F. First degree—Class A felony—knowing and unlawful possession of a *narcotic drug* consisting of 16 or more ounces of a preparation, compound or mixture containing heroin, morphine, cocaine or opium.¹¹²

- Penalty: 1. maximum—mandatory life imprisonment,
2. minimum—at least fifteen years but not more than twenty-five years.

As can be seen, the sixth and fifth degrees of criminal possession apply to all dangerous drugs, the fourth and third to all narcotic drugs including cannabis and the second and first to only certain narcotic drugs such as heroin, morphine, cocaine and opium.

In order to ease the burden of proving knowing possession of a dangerous drug, Penal Law Section 220.25 creates presumptions in this area: Subsection 1 creates a presumption of knowing possession when a *dangerous drug* is present in an automobile other than a public omnibus. Subsection 2 creates a presumption of knowing possession when a narcotic drug is present in open view in a room under circumstances evincing an intent to unlawfully mix, compound, or package or otherwise prepare the drug for sale.

II. Criminal Sale of a Dangerous Drug

Penal Law Section 220.00 (5) defines sell to mean “sell, exchange, give or dispose of to another, or to offer or agree to do the same.”

A. Fourth degree—Class D felony—knowing and unlawful sale of a dangerous drug.¹¹³

- Penalty: 1. maximum—at least three years but not more than seven years,
2. minimum—at least one year but not more than $\frac{1}{3}$ of the maximum term imposed. The court has discretion as to whether or not to fix a minimum term. If it does not, the minimum term is one year.

B. Third degree—Class C felony—knowing and unlawful sale of a *narcotic drug*.¹¹⁴

112. *Id.* § 220.23.

113. *Id.* § 220.30.

114. *Id.* § 220.35.

- Penalty: 1. maximum—at least three years but not more than 15 years,
2. minimum—at least one year but not more than $\frac{1}{3}$ of the maximum term imposed. The court has discretion as to whether or not to fix a minimum term. If it does not, the minimum term is one year.

C. Second degree—Class B felony—knowing and unlawful sale of a narcotic drug to a person under 21 or consisting of eight ounces or more of a preparation, compound or mixture containing heroin, morphine, cocaine or opium.¹¹⁵

- Penalty: 1. maximum—at least three years but not more than 25 years,
2. minimum—at least one year but not more than $\frac{1}{3}$ of the maximum term imposed. The court has discretion as to whether or not to fix a minimum term. If it does not, the minimum term is one year.

D. First degree—Class A felony—knowing and unlawful sale of a narcotic drug consisting of sixteen ounces or more of a preparation, compound, or mixture containing heroin, morphine, cocaine or opium.¹¹⁶

- Penalty: 1. maximum—mandatory life imprisonment,
2. minimum—at least 15 years but not more than 25 years.

It should be noted, however, that the court may, in some instances, impose a definite prison sentence of one year or less upon those convicted for a Class D or E felony. Similarly, the Penal Law authorizes more stringent penalties for individuals determined to be “persistent felony offenders.”

115. *Id.* § 220.40.

116. *Id.* § 220.44.